

Preventing Violence, Trauma and the Use of Seclusion &  
Restraint in Social Service Settings

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# **The Connecticut Restraint & Seclusion Prevention Initiative: A Statewide Partnership**

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**New Britain, CT**

# The Healthcare System in the US is Changing Quickly

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- The Affordable Care Act has launched.
- Federal USDOJ is in over 20 states and focused on implementing the ADA (1990) and Olmstead (1999)
- The Building Bridges Initiative has launched for Children and Families (2005).
- States are starting to apply for Medicaid Waivers that support youth and adults w/ disabilities to live, go to school and work in the community.

# The Healthcare System in the US is Changing Quickly

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- Historical practices such as long term hospitalization & residential programming; point and level systems; the use of seclusion and restraint; and the overzealous use of forced medications are now understood to NOT be best practice.
- As service providers we are now under a lot of public scrutiny and the internet has greatly ramped this up.
- We now have much more knowledge on evidence-informed and evidence-based practices that have positive outcomes.

# The Healthcare System in the US is Changing Quickly

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- Our systems provide services to our friends, neighbors, colleagues and the citizenry.
- If we fail to provide the services “our customers” want and need we will fail overall. And that means we all need to get on board with CHANGE (in capital letters). And anyone who thinks they can duck, and avoid these changes, will become an obstacle to what we need to do.
- That starts with understanding the impact of the prevalence of trauma in the lives of the people we serve.

# The Healthcare System in the US is Changing Quickly

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- The people we serve all share at least one issue and that is a significant history of traumatic life experiences.
- It does not really matter if the trauma happened before or after their difficulties started. The basic issue is that the youth, adults and, often families, have experienced numerous traumatic life events from 1) Healthcare services; 2) from Police and Corrections; 3) from Social Services; 4) from Education; and/or 5) from simply living in poverty.

# The Healthcare System in the US is Changing Quickly

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- It is important that everyone serving children, youth, and adults in our various systems GET the importance of the “trauma connection” in what you do everyday.
- Because, if you “*get this*”, the changes we need to make are really kind of “no brainers...”.
- The “Umbrella” of the Trauma Paradigm is evidence –informed and -based, compelling, and urgently directs systemic changes.

# Preventing Violence, Trauma and the use of Seclusion and Restraint in our Settings

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- I am now going to focus on why we are all here today.
- To learn about the Six Core Strategies© which is currently the only Evidence Based Practice (EBP) for preventing and reducing Seclusion/Restraint (S/R), and
- To hear about what other settings, similar to those in CT have done in their agencies or facilities.

# Preventing Violence, Trauma, and the use of Seclusion and Restraint in our Settings

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- The Six Core Strategies© is an evidence-based model that is effective in preventing the use of S/R.

These strategies are as follows:

1. Leadership toward Organizational Change (culture)
2. Using Data to Inform Practice (practices)
3. Workforce Development (staff competencies)
4. Use of S/R Prevention Tools (interventions)
5. Full inclusion of consumers and families (practices)
6. Rigorous Debriefing of events in real time (practices)

# Leadership Roles and Responsibilities

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- Leadership's roles and duties are probably the most important of the 6 strategies.
- Agency leaders, no matter what setting, are the only people who can make this kind of culture change occur.
- They must “get it” and “direct” the changes required.
- Agencies where leaders delegate this work “down” or do not get it are not effective.

# Using Data to Inform Practice

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- All agencies embarking on preventing violence and reducing S/R use need to get baseline data for at least a year to use as their RULER. Otherwise you will have no data to manage by.
- In 2014, any agency serving leader, needs to collect and analyze data-based information. This is now an expectation for all service agencies.
- Re S/R use, you should be collecting data on the “when, why, where, who, and what” happened for every event.
- And analyzing and posting this information a minimum of monthly - and widely.

# Workforce Development

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This strategy has two components:

1. Has to do with high level 24/7 oversight by senior leaders on when S/R is used. A senior leader on call who gets notified in real time when these events happen and is briefed on why, when, how etc. Who has the power to use this information the next day to change practices.
2. Includes the need for all levels of staff training starting with information on trauma and how to avoid the use of S/R, w/ strong emphasis on hiring practices, supervision/mentoring, and staff evaluation against agency values/expected practices.

# Use of Seclusion and Restraint Prevention Tools

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- This strategy has many components:
  1. Use of an admission trauma assessment, w/ info gathered integrated into safety plans/treatment.
  2. Development, on admission, of a crisis/safety/soothing plan that seeks to understand “personal triggers”, warning signs and what works to help the individual “self control/self sooth” in the program and in the community.
  3. Use of sensory modulation interventions that help people learn to manage their emotions and that are transferable to community living.

# Full inclusion of Consumers and Families

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1. This strategy is very important. From my work, it is second only to leadership roles.
2. This strategy is uncomfortable for many agencies.
3. It requires priority hiring of people with lived experiences; youth or adults AND family members to be staff.
4. AND to serve on every policy, procedure, practice and oversight committee/workgroup in your agency.
5. And to pay them for their work and value their contributions.

# Rigorous Debriefing

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1. This strategy SHOULD INFORM all the other strategies.
2. Performing a “rigorous” analysis of every event of S/R will tell you where you need to change your policies, rules, and practices.
3. Debriefing needs to be mandatory and occur after every S/R event if you want to really know why these events have occurred.
4. If you do this you will find out what you can change in your system to avoid this use. It requires a high level performance improvement mentality for this to work.

# Moving Forward...

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- What are some examples of what other states are doing?
- How have the Six Core Strategies worked in other settings?
- Which Core Strategies were used?
- What does the data show?
- What questions do you have?

# Riverview Hospital, CT.

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- 6CS Training occurred in 2005.
- 458 youths were admitted between July 2004-March 2007.
- During that time 278 S/R incidents occurred. In the first 6 months of the study S/R events were numbered at 93 [before training].
- In the last 6 months, S/R events were 31 total.
- Conclusions include that S/R reduction can happen using 6CS. (Azeem et al., 2011)

# Chambersburg Hospital, PA

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- Attended 6CS Training in 2005. Were not public sector but a small non-profit. 26 bed youth program. Acute admissions.
- After 2 weeks, post training, goal became elimination of restraint use.
- We were successful in our goal.
- From baseline in 2002, we saw zero S/R from 2007 on.

(Barton, Johnson, & Price, 2009)

# Recovery Innovations, Inc./ AZ

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- Did not attend training. Was a home-grown but concurrent approach using same strategies.
- RI changed mission and policies; inclusion of peers; trained staff and + new staff selection criterion; and changed environments of care. Defined use of S/R/Meds as “treatment failure.”
- Called new initiative “No Force First.” As a result, restraint and forced medications were reduced to 2.4% and 3.9% respectively. (Ashcraft, Bloss, & Anthony, 2012)

# SC Public State Hospitals

## Five inpatient adult units in study

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- Several SC state facilities trained on 6CS
- Study was an experimental design to examine effects of interventions used on use of S/R.
- Interventions included TIC training, changes to unit rules/language, changes to environment of care, and inclusion of patients in treatment planning.
- Changes to the milieu were most significant and saw a reduction to S/R use of 82.3%. (Borckardt, Maden, Grubaugh, Danielson, Pelic et al., 2011)

# Henry Phipps Psychiatric Clinic

## Johns Hopkins, MD

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- 6CS Training in 2005. Small group of nursing reps from this non profit hospital. 88 psych beds and five units.
- This program initiated the 6CS in 2006. These leaders implemented significant changes in the milieu, client safety plans on admission, admission trauma assessments, daily community meetings, family style meals, increased staff on units, rounds, a patient support sheet, comfort carts, new activities, %+& debriefing.
- Reduced Seclusion by 30-63%; Restraint by 20-97%. There was a reduction in injuries across all units.

(Lewis, Taylor & Parks, 2009)

# Elgin State Hospital

## Elgin, IL

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- Received 6CS training in 2005. 315 bed medium security forensic program & a 75-bed civil hospital.
- Implemented 6CS interventions including active and visible leadership on the units; started to track data on S/R and reduced orders from 4 to 2 hours to one; tracked all injuries reported; trained staff to use new skills and move away from “rule enforcement” to individualized approaches; worked with staff to decrease their anxiety; environments of care were re-tooled to be more comfortable and caring; comfort rooms set up; involvement of consumers in all this work; and debriefing mandated.
- Reduced R by 95% by 2011. (Hardy & Patel, 2011)

# Solnit Center Middletown, CT

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- **52 youth beds. Kids come from ED's and hospitals in CT and have often been secluded or restrained multiple times prior.**
- **Trained on 6CS and implemented all 6CS.**
- **Solnit leaders set a goal to eliminate mechanical restraint first – and to significantly reduce S/R, and they were successful. They used a strategic plan built around the 6CS and each senior leader “adopted” a unit to provide ongoing support.**
- **The topic of use of S/R went on all unit meeting agendas as a standard item.**

# Solnit Center Middletown, CT

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- Leadership: Solnit emphasized primary prevention with a focus on changing their milieus and an unwavering belief that this work would be successful with a strategic plan.
- Data: Solnit gathered and published all their data, by unit, monthly. They used this data to monitor their work and to monitor staff satisfaction ongoing.
- Prevention Tools: Solnit used this as a way to engage the youth they had in care. This engagement work included that staff now spend all their time with the youth and families to get to know them and to develop an individual plan of care. And Solnit implemented mandatory Debriefing after every event.  
(Caldwell et al. In press, 2014)

# Solnit Center Middletown, CT

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- Workforce: All staff were trained on TIC and de-escalation techniques. Perspectives of youth/staff were shared. All these values were integrated into new employee orientation
- Child & Family Inclusion: One of Solnit's most effective strategies was this focus. Their Student Advisory Board has taken on a huge role in their organization.
- OUTCOMES: Have seen reductions (2005-2013) in Mechanical Restraints by 100%; Manual Restraints by 87%; and Seclusions by 67%

# Youth Development Center

## Phoenix, AZ

- YDI, a not-for-profit, serves youth from 10-18 from JJ, CW & MH; 84 residential beds, 48 group home beds, a day treatment program and a variety of other outpatient/community-based services
- Became aware of and started using components of 6CS in 2008 after the Joint Commission introduced leaders to them.
- In 2012 the Building Bridges Initiative Director challenged YDI leaders to fully embrace and use all 6CS, and stressed that every restraint/seclusion was retraumatizing and caused harm to youth.
- Since 2012 YDI leaders committed to implementing each of the 6CS – and has met with great success.

# Youth Development Center Phoenix, AZ

- Leadership: After organizational leaders understood their roles and need to be involved (2012) they were on board. Since then, organization leaders have been fully involved in implementing the 6CS and monitoring use.
- Prevention Tools: YDI implemented sensory integration techniques in their care areas and, over time, converted some S/R to Comfort Rooms. YDI served youth now receive an MP3 player with music of their choice and an individualized “comfort box” of sensory items on arrival.
- Workforce Development: YDI leaders focused on training and support to direct care staff on TIC and Collaborative Problem Solving (Greene & Ablon, 2006).
- YDI taught these same skills to families...

# Youth Development Center Phoenix, AZ

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- Child & Family Inclusion: One of YDI's most effective strategies was/is their focus on youth and family inclusion. Toward that end YDI has set up a student advisory board who now participate in training new staff and evaluations of all disciplines of staff. Families are included in major org. decisions.
- OUTCOMES: YDI is now a "hands off" program. New admissions to YDI are told the same, by staff and youth.
- In January 2012, YDI saw 42 events. Went up to 49 in March, 2012. Since then they have greatly reduced use to 1 or 0 events from November of 2013 to May, 2014

(Caldwell et al., in press)

# Mt. Prospect Academy

## Becket Family Services Plymouth, NH

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- Becket provides a range of services including in-home and residential services. In 2011 the Mt. Prospect Academy, serving 101 male clients (ages 11-21) represented by Child Welfare, Juvenile Justice, or Mental Health WAS SELECTED to participate in NH's Youth Transition to Permanency Project.
- During this project, Becket learned about the Building Bridges Initiative (BBI) and the 6CS.
- Both of these initiatives served to engage and propel Becket forward to change their cultures of care to include TIC and BBI principles that included the need to prevent violence, conflict and use of seclusion or restraint.

# Mt. Prospect Academy

## Becket Family Services, Plymouth, NH

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- Leadership: From the outset Becket leaders adopted the BBI principles of “Family-driven/Youth-guided Care.” Becket leaders determined early that the priority mandate was to prevent the need to “put hands on” in any way necessary. The Becket Board of Directors agreed and principles of BBI and TIC became the new org. mission.
- Data: Becket used data in a number of ways. For one, they monitored client progress in the old ‘point and level’ system and the use of SR in that old model. They then determined that eliminating this model would reduce the use of S/R - so that occurred. In addition, monthly data is now reported on every aspect of S/R use as well as client activities in home and community. (Caldwell, et al., in press)

# Mt. Prospect Academy

## Becket Family Services, Plymouth, NH

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- Workforce Development: Becket Leaders implemented weekly meetings with mid-management/direct care staff to assure that the BBI and TIC values were being implemented into practice. These meetings proved to be critical in getting all on board and answering questions.
- Leaders also got rid of the “time out” rooms in their school and other units and developed a “Student Council” to participate in policy decisions.
- **OUTCOMES**: Becket (Mt. Prospect) programs have reduced S/R use by 75% from 2011 to 2013. 385 events in 2011 to 98 in 2013 (Caldwell, et al. In press).

# My Story of a Significant Culture Change within a state bureaucracy.

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- Am going to end with my, most recent, experience in changing a culture of care. In Delaware.
- Previous to this I also had a role in the same kind of work at another mental health public state hospital, in Broward County in Florida. Same positive outcomes.
- Same strategies.

# Headlines in local news; over 200 Articles (2007-2008)

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- *Families tell of beatings, assaults...*
- *Woman says she was raped at state hospital...*
- *Gov Minner to name a Task force to investigate...*
- *Findings of Patient Abuse kept Secret...*
- *Nurse quits DPC Position...*
- *Mental Illness Official out...*
- *Letter calls for DHSS Secretary to Resign...*
- *Shredding allegations include investigative files...*
- *DPC Hearings begin on Monday...*
- *Chair contradicts Gov on DPC probe...*
- *Abuse whistle blower says bosses retaliated...*

# The Tipping Point

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- These 200 newspaper articles launched 51 unannounced surveys between 2008 and 2010.
- Involved were federal CMS, the DE Division of Long Term Care and Resident Protection, the DE Attorney General's office, local fed P and A (CLASI), the Joint Commission. And the USDOJ.
- Resulted in as many Plans of Correction. Impossible to manage and run a hospital. So things got worse. More staff left.

# USDOJ Visit To Delaware Psych Center (2007-8)

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- The USDOJ came in 2008. They found that clients were at risk for significant harm in the facility; overuse of SR and Involuntary Meds; a lack of active treatment planning; a slow and ineffective discharge process; extensive lengths of stay; and low involvement with community providers.
- They were correct in many of these issues.
- Some problems (due to funding) but most due to old state hospital philosophy and old values.

# Delaware Psychiatric Center in 2007-2009

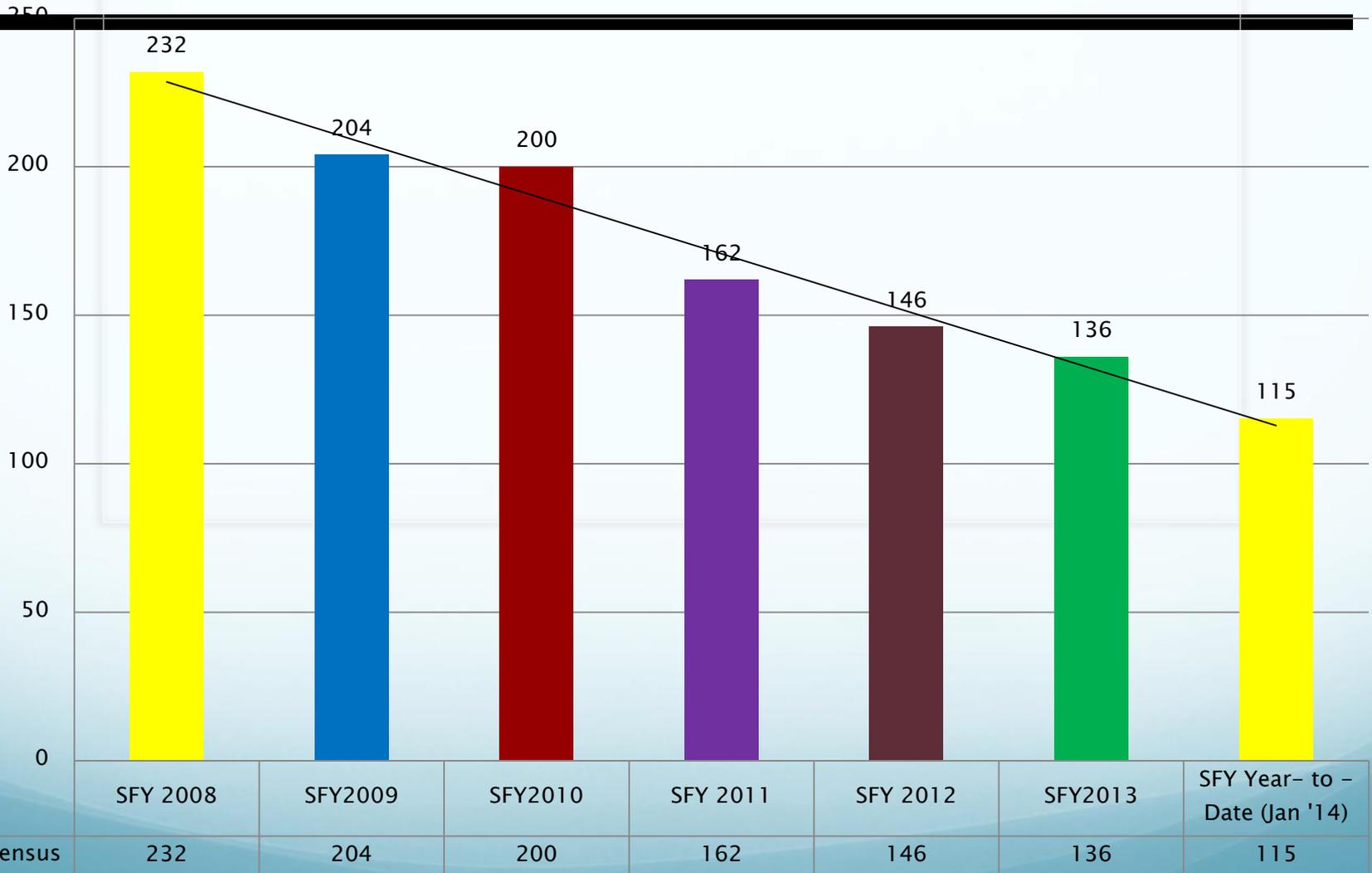
- ▶ Adult state hospital with 8 discrete units including a forensic unit and a nursing home
- ▶ Average daily census of 260+
- ▶ Average LOS: Over 9 years, some there for 25+ yrs, over 90+ did not meet hospital stay criteria
- ▶ No consumer/community involvement
- ▶ Lack of active individualized treatment
- ▶ Outdated policies and procedures
- ▶ 8 CEOs in ten years; 7 different CNOs, same time
  - ▶ Poor staff supervision leading to poor client outcomes and adverse events

# What DE and DPC Leaders did- 2009/11

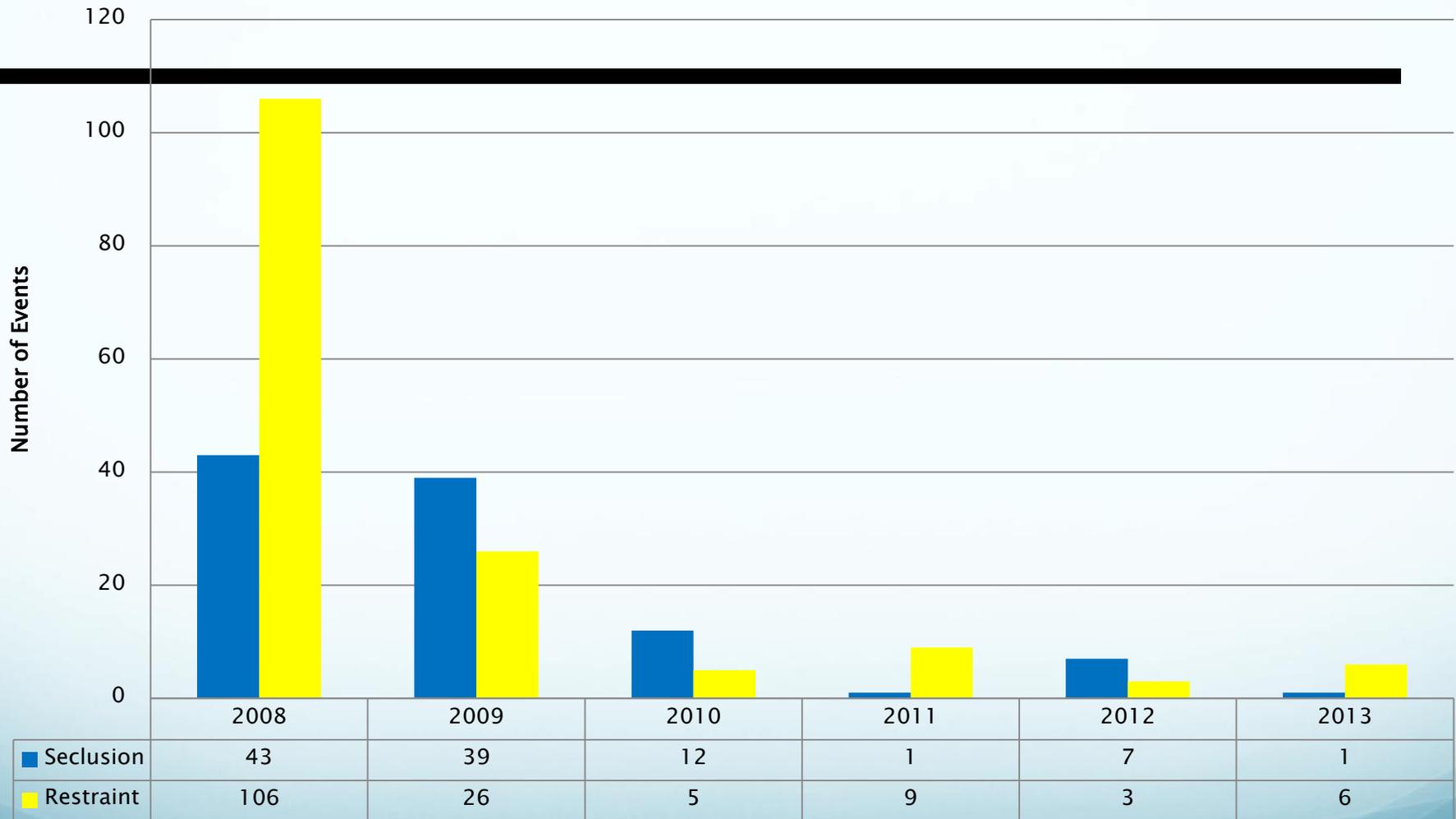
Note: I was asked to participate in the investigation of DPC in 2008 and write a report. I was then hired in 2009. Put together a team and this is a report of what we did initially:

- Revised the hospital's Mission, Vision and Values statements
- Implemented the Six Core Strategies
- Implemented new individualized Recovery Planning processes (Adams and Grieder, 2010) (***Ongoing still***)
- Implemented client centered treatment activities, directed by Recovery Plans/set up communication between unit and treatment staff
- Became highly transparent for all serious Adverse Events

# Annual Average Daily Census: State Fiscal Year 2008 – Year-to-Date 2014



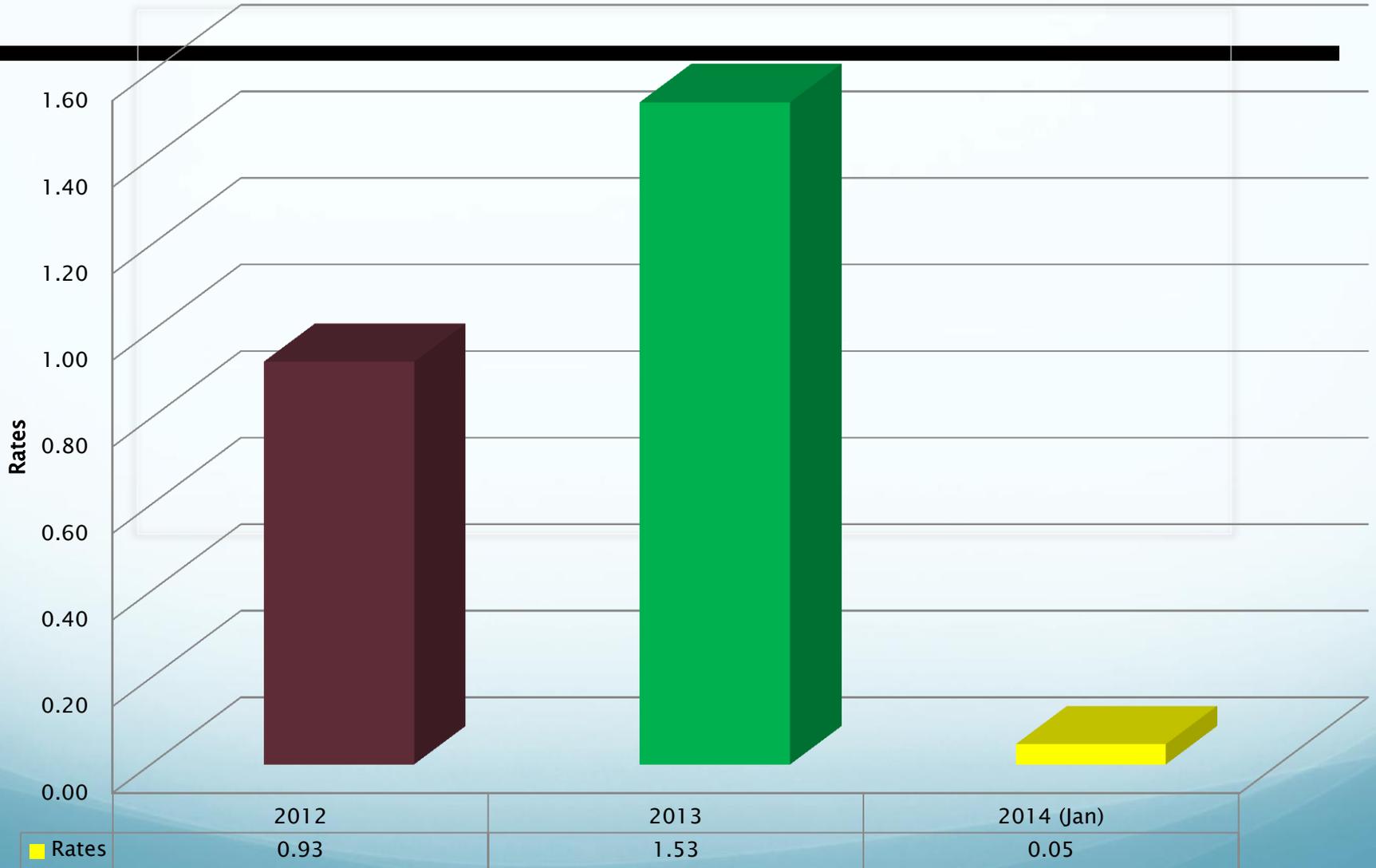
# Delaware Psychiatric Center Seclusion & Mechanical Restraint Events 2008 – December 2013



\*The 2010 and 2011 numbers pictured above do not include 1 outlier (client XX). Of the 39 total seclusion events hospital -wide in 2010, client XX accounted for 34 of the 39 events. For the 2011 year-to-date numbers, client XX accounts for 41 of 50 events. 38 The 2013 numbers do not include an outlier client whose treatment plan included a physician's order for [REDACTED]

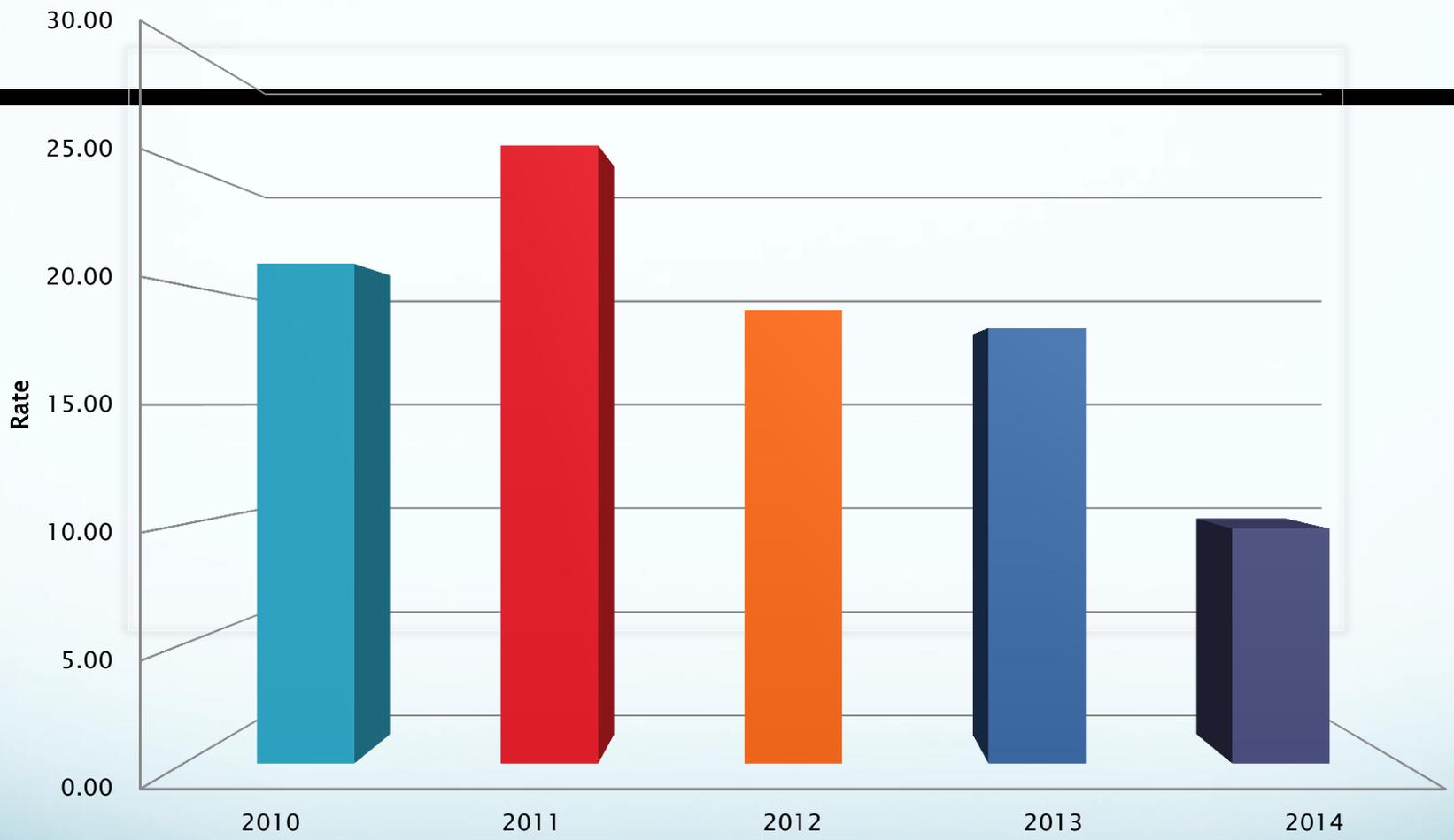
# Delaware Psychiatric Center

## Manual Hold Rates Per 1000 Client Days: 2012 – YTD 2014



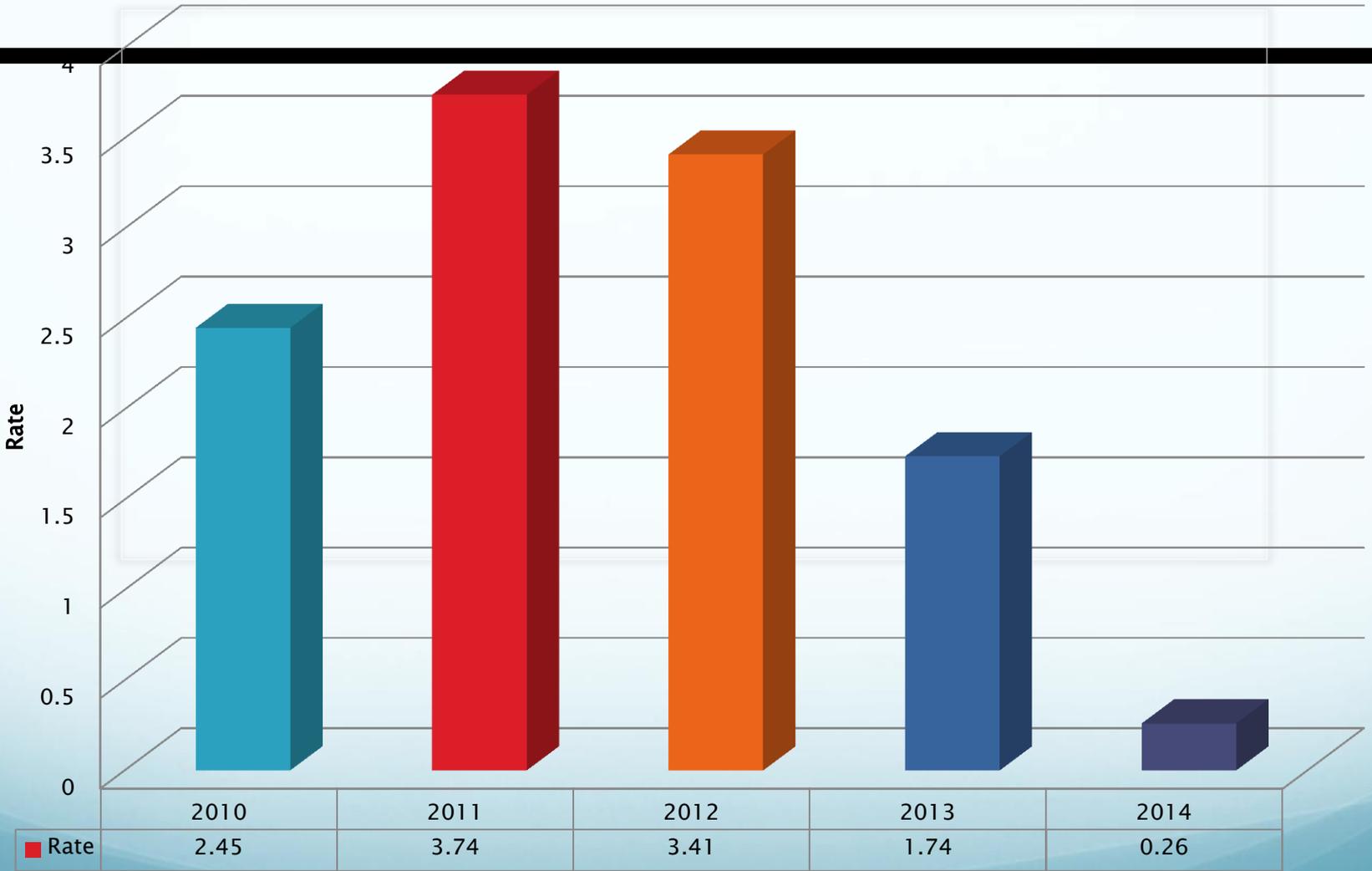
# Delaware Psychiatric Center

## Aggression Incident Rates per 1000 Client Days: 2010 – YTD 2014



	2010	2011	2012	2013	2014
■ Rate	20.89	25.85	18.96	18.2	9.82

# Delaware Psychiatric Center Injury Rates Per 1000 Client Days: 2010 – YTD 2014



# Specific S/R

## Leadership Strategies used at DPC

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- Revised DPC Mission and Values to include Trauma-informed and Recovery Principles including respect, choice, voice, and accountability.
- Developed a Strategic Plan, a living document, including goals, time frames and resp. persons.
- Transitioned treatment planning to Recovery Planning; Focus changed to individual's needs & getting people back to natural communities.

# Specific S/R

## Data Strategy used at DPC

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- Assigned Data Gathering procedures to specific hospital departments
- Assured for hire of Peer Support Specialists, from none to 14 now.
- Reduced hours that doctors could order SR from 4 to 2 hours.
- All Adverse Events get rigorous analysis.
- Started to recognize Best Practices of individual staff.
- **Implemented Debriefing and RCAs for serious events to inform practice changes.**

# Specific S/R

## Workforce Strategy used at DPC

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- Held DPC staff accountable for new values/basic competencies. This was new. (is ongoing)
- Made clear that a basic competency for all staff is compassion and respect. Required a lot of attention but was eventually adopted by most.
- Lots of training and meetings on new values, including new language.
- Re-allocation of current resources to expand PI, Risk Management and Advocacy in inpatient settings.

# Specific S/R

## Inclusion Strategy used at DPC

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- Other than Leadership work, this was the most important strategy we used.
- In 2010 we brought in a nationally recognized Peer Leader to develop a peer workforce for DE.
- From 1 peer in 2009 we now have 150 trained Peer Support Specialists in DE who work at the hospital, on ACT teams, and in 90% of our community provider programs.
- These staff have FOREVER changed our DE SOC toward client directed care processes.

# Lessons Learned

- Work to reduce SR (at DPC) was more difficult to do than any facility I had ever encountered. Staff felt besieged and demoralized by the media and changes required.
- In 2010-11 many staff remained oppositional to best practices here. We made progress but not in a way that was “real.” \*\*\* Most progress due to video cams, and constant reporting.
- But once we got more staff champions and Peers on board it started to come together. And it has now.
- The work continues... Thanks for your time today.

# Delaware Psychiatric Center

## Key Contact

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