

*PREVENTING VIOLENCE, TRAUMA AND THE
USE OF SECLUSION AND RESTRAINT
IN MENTAL HEALTH SETTINGS*

**An Evidence-Based Practice to
Prevent Conflict and Violence in
Inpatient and Residential
Settings.**

Kevin Ann Huckshorn PhD, RN, CADC

CPI Conference 2015

Restraint Reduction Network

Conference Aston

Birmingham

WHAT WE KNOW NOW RE: PREVENTING/REDUCING S/R?

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

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

FRAMING THE ISSUE

- A “systemic” practice change, such as reducing violence & use of S/R requires a **CULTURE CHANGE** in behavioral health treatment settings that results in far more than just reducing S/R.
(Huckshorn, 2006; 2013)
- This “*Culture Change*” includes taking a look at how staff interact with clients, what skills your staff have, and recovery, resiliency and transformation principles
- Best practice core strategies have been identified
- However, this kind of systemic organizational change is often difficult... for many reasons...

DEVELOPMENT OF THE 6CS© CURRICULUM TO REDUCE THE USE OF S/R

- Ongoing Review of Literature (1960 to present)
- Faculty: Best practice information emerged from individuals with personal and direct experiences in successful reduction projects across the country.
- Service Users/Staff: Personal experiences describe what these events feel like, both *to be restrained* or participate, as staff, in these events.
- 3 Focus Groups held in 2001-2002 plus literature.
- Core strategies emerged in themes over time.

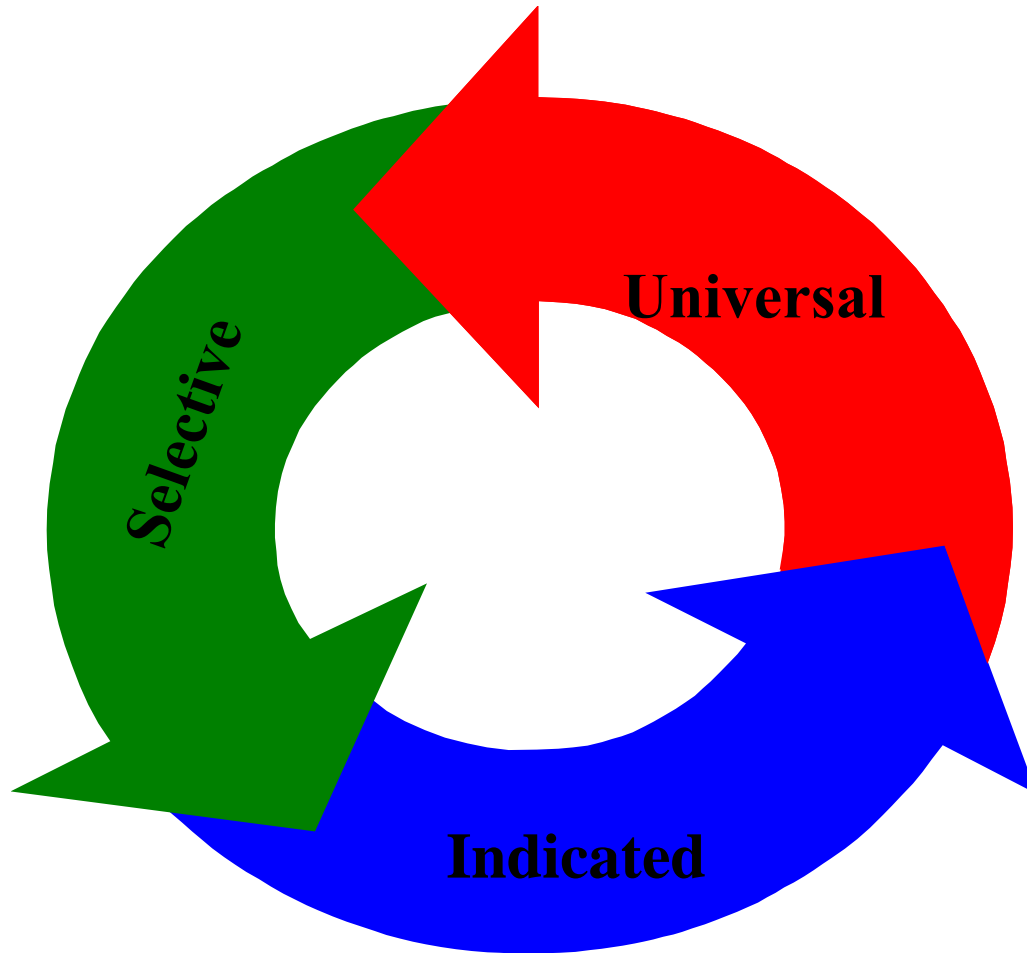
CORE BELIEFS PROVIDE THE FOUNDATION FOR THE 6CS CURRICULUM (THEORETICAL MODEL)

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

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

2. Public Health

Prevention Model (Nat. Academies Press, 2009)



THE PUBLIC HEALTH PREVENTION MODEL

- The Public Health approach is a model of disease prevention and health promotion and is a logical fit with a practice issue such as reducing use of S/R or using TIC in practice.
- This approach, designed to keep large populations well, identifies contributing factors and creates remedies to prevent, minimize and/or mitigate the problem if it occurs.
- Re “Violence and S/R use” it refocuses us on prevention while maintaining safe use

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

THE PUBLIC HEALTH PREVENTION MODEL APPLIED TO HEALTH PROMOTION

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

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. great customer service at admission, decontaminate past experiences, address needs)
- Secondary Prevention (Selected Interventions)
 - Early interventions to minimize and resolve specific risk factors when they occur to prevent conflict (use of trauma assessment/safety plans, immediate staff response to needs, engagement strategies with hard to reach clients)
- Tertiary Prevention (Indicated Interventions)
 - Post S/R interventions designed to mitigate effects, analyze events, take corrective actions, and avoid reoccurrences (e.g. gathering non-jargon info on events; posting data monthly on use and DEBRIEFING events rigorously)

5. TRAUMA-INFORMED CARE

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

(Muesar et al, 1998)

- Says that traumatic life experiences cause mental health or other problems or seriously complicate these, including treatment resistance. *(Huckshorn, 2013; IOM, 2005; Felitti et al, 1998)*

- Systems of care that are trauma-informed recognize that coercive or violent interventions cause trauma and are to be avoided. *(6CS, 2015, SAMHSA TIP 57, 2014)*

- Universal precautions required *(NASMHPD Med Dir, 1999, SAMHSA TIP, 2014, 6CS, 2015)*

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) Full inclusion of *service users (Peers)and families in all activities*
- 6) Make *Debriefing* rigorous

NEW RESEARCH ON VIOLENCE CAUSALITY AND ROLE OF THE ENVIRONMENT

- Violence in mental health settings has been blamed on the “patient” for years.
- Hundreds of studies done on patient demographics and characteristics.
- Findings were variable and inconclusive.
- More recently, studies have looked at the role of the environment in violence, including staff interaction patterns. All population health issues are complex.
- So is violence in behavioral health settings.

(Duxbury, 2002; Richter & Whittington, 2006; Johnstone & Cooke, 2007; Huckshorn, 2013; National Academies Press [prevention] 2009)

6CS #1: LEADERSHIP SETS CLEAR GOALS BASED ON A VISION OR POLICY GOALS

○ These Goals:

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

(<http://nrepp.samhsa.gov/ViewIntervention.aspx?id=278>)

6 CS #1: FUNDAMENTAL PRINCIPLE FOR LEADERS: *CREATING A VISION*

- 1) **The essence of Effective Leadership is the ability to motivate one's staff to action around a shared vision. In this case:**
 - Toward “preventing” conflict, coercion and violence that results in the use of seclusion/restraint
 - Creating non-violent and non-coercive treatment cultures.
 - Implementing a trauma-informed systems of care that feel safe and welcoming to customers.

(Anthony & Huckshorn, 2008; Huckshorn, 2013)



6CS #1: PRINCIPLES OF LEADERS

LIVING CORE VALUES

Effective Leaders use a Core Values Template to make decisions and guide practices:

- Is not enough to just change the words you use (recovery, trauma informed, person-centered)
- Need to go through P and Ps and check for congruence.
- Agency practices need to be compared to values template and changed when needed.

(Anthony & Huckshorn, 2008; Huckshorn, 2013)

6CS #1: PRINCIPLES OF LEADERS

VALUING EXEMPLARY PERFORMANCE

Effective Leaders build their organization around exemplary performers:

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

(Anthony & Huckshorn, 2008; Huckshorn, 2013)

6 CS #1: EFFECTIVE LEADERS DEVELOP A FORMAL PLAN AND APPROACH TO REDUCING S/R

- This work needs to start under a clear and documented “Prevention of Conflict *Umbrella*”
- Needs to include Performance Improvement Principles (CQI) where constant work is occurring to analyze events and attempt to eliminate these triggers/risk factors.
- Needs to create a Facility/Unit Accountable Team.
- Needs to be inclusive of persons/families served.
- ❖ The harm that is being perpetrated on people in inpatient behavioral health facilities is still widely pervasive.

(Anthony & Huckshorn, 2008; 6CS, 2015)

6 CS #2: USING DATA TO INFORM PRACTICE

- Providers need Data to identify & analyze events by daily review of:
 - SR Event #s, SR Duration (hrs), Invol Meds use for escalating behavior, and, all injuries related to conflict.
 - Unit/Day/Shift/Time of day.
 - Age/Gender/Race.
 - Date of admission/Diagnosis.
 - Pattern of individual staff, including ordering staff, involved in events.
 - Precipitating events, in clear/specific language.
 - Safety issues justifying that seclusion/restraint was the only response and why.

6 CS #2: USING DATA TO INFORM PRACTICE

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

(NASMHPD, 2012)

6 CS # 3: WORKFORCE DEVELOPMENT

- Staff need to get training on the following important topics and be mentored.

- **Prevention Model:** Work focus on primary/secondary strategies

- **Aggression & Violence Risk:**

Identify risks for aggression or violence in order to prevent the use of seclusion or restraint (S/R)

- Individual, environmental, & situational risk factors

- **Medical/Physical Risk:**

Assess and understand medical risks when S/R is used to reduce the possibility of serious injury and/or death (asthma, obesity...)

- Prone restraint restrictions

6 CS # 3: WORKFORCE DEVELOPMENT

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

- 1) Patient characteristics (blame the patient...)
 - 2) Environmental factors e.g. “triggers”
 - 3) Situational: a combination of the above
- The situational model has been the most useful in understanding the conflicts that lead to S/R use.
 - Attention to only the “patient” or only “the setting” ignores this multi-dimensional relationship and the variables that inter-relate to lead to conflict

6 CS # 3: WORKFORCE DEVELOPMENT

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

PROMOTING RISK INTERVENTIONS BY SITUATIONAL MANAGEMENT *(JOHNSTONE & COOKE , 2007)*

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

6 CS # 4:

SPECIFIC PREVENTION STRATEGIES

Why Are They Used?

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

6CS #4 PREVENTION TOOLS

Essential Risk Assessments:

- **Risk for Violence**: symptoms; engagement;²⁵ past history; pain, SUD...
- **Trauma History**: Adverse life experiences including past exp. in MH settings
- **Treatment History**: Responses to treatment including medications; time to stabilize; relationships with staff



6CS #4 PREVENTION TOOLS

Essential Crisis Plan Components:

- Triggers (A= Antecedents)
- Early Warning Signs (B= Behaviors)
- Strategies (C = Calming Interventions)



6CS #4 PREVENTION TOOLS

Triggers

- A trigger is something that sets off an action, process, or series of events (such as fear, panic, upset, agitation)
- Also referred to as a “threat cue” such as:
 - Bedtime
 - room checks
 - large men
 - yelling
 - people too close
 - Not being listened to
 - Disrespect
 - noise
 - being afraid
 - lack of privacy



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


ARE THEY...

Hungry?

Angry?

Lonely?

Tired? **T**hirsty?



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

6CS #4: PREVENTION TOOLS

**Second, Identify Early
Warning Signs**



EARLY WARNING SIGNS

WHAT MIGHT YOU OR OTHERS NOTICE OR WHAT YOU MIGHT FEEL JUST BEFORE LOSING CONTROL?

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

6CS #4: PREVENTION TOOLS

Third, Identify Strategies



6CS #4: PREVENTION TOOLS

CALMING STRATEGIES

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



COMMON ATTRIBUTES OF EACH CRISIS PREVENTION PLAN

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



Sensing A Change

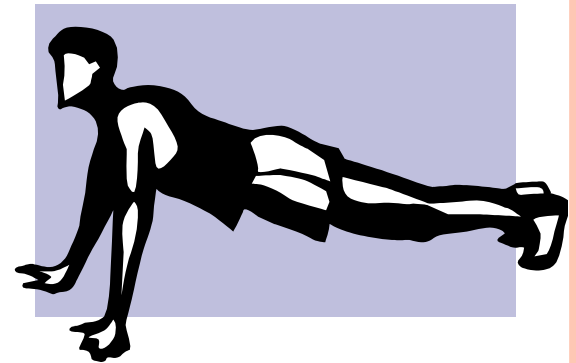
- Understand sensory experience, modulation & integration
 - Incorporate knowledge of sensory input and expertise of Occupational Therapy
 - Assess the *sensory diet* of each person-served
 - Identify *sensory-seeking & sensory-avoiding* behaviors
- Adapt the physical environment & develop sensory rooms/spaces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

(Champagne, 2003)

6CS #4: PREVENTION TOOLS

SENSORY-BASED APPROACHES

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



6CS #4: PREVENTION TOOLS

SENSORY-BASED APPROACHES

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

WESTERN STATE HOSPITAL

TACOMA, WA



6 CS # 5: FULL INCLUSION OF PEERS AND FAMILIES IN CHANGE PROCESSES

New Freedom Commission

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

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

6 CS # 5: FULL INCLUSION PEERS/FAMILIES CONSUMER ROLES IN MENTAL HEALTH SETTINGS:

- ✓ Integrate consumer choices at every opportunity
- ✓ **Create opportunities proactively!**
Treatment planning (obvious); Consumer Councils;
Consumer Surveys
- ✓ **Promote cultural change through inclusion** (not so obvious)
 - Service delivery systems reform
 - Policy development & revision
 - Program design/re-design
 - Environment & physical design changes



6 CS # 5: FULL INCLUSION OF PEERS/FAMILIES

CONSUMER ROLES IN MENTAL HEALTH SETTINGS

- Peers are working in many capacities; as advocates, counselors, educators, and evaluators in both private and public agencies



- But it is important that all staff understand these roles and their significance, their worth.

- Peers are critical in reducing conflicts, changing policies and practices, providing feedback on what works, etc. ●

6 CS # 6: RIGOROUS DEBRIEFING

DEFINITION OF DEBRIEFING

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

(Scholtes et al, 1998)

DEBRIEFING QUESTIONS

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

(Cook et al, 2002; Hardenstine, 2001)



DEBRIEFING GOALS

- 1) To reverse or minimize the negative effects of the use of seclusion and restraint.
- 2) To prevent future use of seclusion and restraint
- 3) To address organizational problems (rules, attitudes, practices, training, environment of care) and make appropriate changes.

And Finally...

MARTIN LUTHER KING, JR. SAID:

“Violence is the language of the unheard...”

The people we serve are the “unheard.” Just like so many of the disenfranchised minorities in our countries who use violence to be heard.

We need to learn to listen to/observe the people we serve and meet needs quickly! That is great customer service.

CONTACT INFORMATION AND ANY QUESTIONS!

Kevin Ann Huckshorn PhD, MSN,
RN, CADC

302-281-4550 (Office)

302-824-1218 (Mobile)

Kevin Huckshorn & Associates. Inc.

Kevin@kahassociates.com