The Six Core Strategies©: An Organizational Approach

An Evidence-Based Practice To Prevent Conflict, Violence, & Seclusion/Restraint Use

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Outline

• Overview & Development of 6CS
• Drivers of S/R Use
• Strategies Applied into Org. Pragmatics
• Key Elements of Sustained Practice Transformation
• Resources
Overview & Development
Andrew McClain, age 11
Died on March 22, 1998
Development of the 6CS©

- Hartford Courant (1998)
- HCFA, now CMS Emergency Rules (2001)
- NASMHPD Medical Directors Council (1999, 2001)
- HCFA, now CMS, Rule & COP changes (2003)
- NASMHPD funding leads to development of 6CS© Curriculum and training for all states.
Development of the 6CS© Curriculum

- **Ongoing Review of Literature**: (1960 - present)
- **6CS© Faculty**: Best practice information from individuals with personal and direct experiences in successful reduction projects across the country. Included Service Users (patients)
- **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 review
- **Core strategies emerged** in themes over time
The Six Core Strategies©

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
Independent Research Confirms Efficacy & Effective EBP (2004-2009)

- Research data gathered/analyzed by HSRI in Cambridge, MA (independent contract) x 5 years
- 8 states and 43 facilities participated
- 28 facilities completed the project
- Over 50% significantly reduced use of restraint by hours and individuals
- Over 70% significantly reduced use of seclusion by hours and individuals
- These findings were considered “robust” and led to these practices being accepted as a national (US) Evidence-Based Model (2012)
6CS© Adopted & Adapted

- Adopted in several countries: United Kingdom, Australia, New Zealand, Finland, Germany, United States, Canada, Japan
- Implemented in mental health/behavioral health settings: hospitals, residential programs, crisis centers, emergency departments, respite programs
- Implemented in general hospitals, schools, detention facilities, jails/prisons, nursing homes, head injury programs, developmental disability centers
6CS©: An Organizational Approach?

- “Top Down” Approach vs

**Integrated transformation approach**

**What?**

- **Dual objectives**
  - Major sustained performance improvement
  - Lasting cultural/behavioral change

- **Broad scope**
  - Multiple functions with varying performance objectives

**How?**

1. Top-down directional setting
2. Bottom-up performance-improvement problem solving
3. Core process redesign

Vision
A Creative Change Process?

- Sydney, AU ~ May, 2017
- Interpretation of 6CS Effort

Art Response from art Therapist
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The Essence of 6CS©: Culture Change

- A “systemic” practice change, such as reducing violence & use of S/R requires a **CULTURE CHANGE** 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 defining/implementing recovery, resiliency and transformation principles.

- Best practice core principles and strategies have been identified.
Core Foundational Principles for the 6CS Curriculum

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

The Public Health Prevention Model Applied to S/R Reduction

- **Primary Prevention** (*Universal Precautions*)
  - Interventions to prevent conflict from occurring by anticipating risk factors (e.g. great customer service, decontaminating past experiences, address needs)

- **Secondary Prevention** (*Selected Interventions*)
  - Early interventions to minimize and resolve 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)
Trauma-Informed Care

- Emerging science based on high prevalence of traumatic life experiences in people we serve.
  
  *(Muesar et al, 1998; SAMHSA, 2014)*

- 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; SAMHSA, 2014; BBI, 2014)*

- 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)*

Play & Joy

(Panksepp, 1998)
Trauma: Lifelong Impact

(Panksepp, 1998)
Being Trauma Informed is Not Enough

- Dr. Laurie Leitch
  - ACES/Trauma over-focus on negative events to the neglect of protective and positive factors
  - Social Resilience Model
  - Trauma information → Trauma action
  - Promote neurogenesis/neural plasticity
    - Self-directed attention practices (yoga, medication)
  - Pragmatic Resilience Skills
    - self care & self control

- Trauma Responsive
- Trauma Effective
Drivers of S/R Use & S/R Prevention
History: Deep Roots

- S/R used for centuries
- *Quid Pro Quo* doctrine (1740s)
- S/R prevention soon followed
  - Before Pinel: William Tuke
  - Tea & coffee merchant
  - 1796 opened the Retreat at York
Roles, Power, & Others
Influence Decision Making

- Milgram’s Behavioral Study of Obedience (1963)
- Zimbardo’s Stanford Experiment (1971)
- Rosenhan’s Pseudopatient Experiment (1973)
- Morrison’s “Nursing Toughness” Study (1990)

Role and power differential can influence judgement and decision making and absolve a person from feeling responsible for their actions, particularly if they perceive they are working at the direction of another.

Power itself does not corrupt; it heightens pre-existing moral and ethical tendencies.

“Nearly all men can stand adversity, but if you want to test a man’s character, give him power.” Abraham Lincoln
Our Own Thinking & Behavior: Learned Helplessness, Attribution (causality) & Reinforcement

- Seligman (1967): *Inability to control stressful stimuli leads to passive acceptance of it*

- Weiner (1986): Judgement/thinking is compromised:
  - global attribution & specific attribution
  - stable attribution & unstable attribution
  - external attribution & internal attribution

- Learning Theory: staff behavior can reinforce and maintain aggression, violence and S/R use

  (Daffern, Howells, & Ogloff, 2007)
THE CORE STRATEGIES® & ORGANIZATIONAL PRAGMATICS
6CS #1: Leadership

Organization leaders must take the lead: How?

- **Own it.**
  - This work is leadership’s responsibility. Not line staff. Assure the work gets done!

- **Be present.**
  - Be on site. Lead and participate in the process

- **Translate the vision.**
  - Shape policies/procedures/practice/budget ( $ / £ ) and connect to agency philosophy/values/mission

- **Focus. Make the change happen.**
  - Ignore the “whirlwind” we walk into every day at work…

(McChesney, Covey & Huling, 2015)
Organization leaders must **use data in real-time to analyze events**: *How?*

- Use data every morning/day: senior-level ‘flash meeting’
- Use data at implementation team meetings/debriefings/crisis plan reviews/staff performance reviews
- Reinforce *near misses* at change of shift/staff meetings
- Post/distribute/share the data – make it visible and simple
- Drill for detail:
  - S/R event #s, duration (hrs.), invol. meds & all injuries
  - Unit/day/shift/time of day
  - Age/gender/race/disability
  - Date of admission/diagnosis
  - Trends and patterns of staff, including ordering staff, involved in events
  - Precipitating events, in clear/specific language.
  - Safety issues justifying S/R was the only response and why
6CS #3: WORKFORCE DEVELOPMENT

Organization leaders must prepare and mentor staff well: How?

- Hire to expectation and support thru preceptorship
- Shape scope of role based on competency attainment
- Teach judiciously: separate hands-on and teach with CPR not as part of the continuum from verbal to physical procedures
- Involve staff in the process and grow staff leaders/educators
- Continually educate on:
  - Customer Service
  - Prevention Model
  - Aggression/Violence Risk
  - Trauma
  - Medical/Physical Risk
Organization leaders, staff & persons-served must all know what to do to **prevent / disrupt the cycle of aggression/violence** and teach to a new skill set: *How?*

- Identify what activates problematic behavior
- Identify the specific problematic behavior to be addressed
- Identify **and practice** calming strategies (**positive practice**) in non-emergent situations
- Learn what does not help
- Use sensory based strategies to connect the mind and the body
- Use interventions that can be implemented at home/community
6CS #5: USE THE POWER OF PERSONS-SERVED & FAMILIES

Organization leaders must invite and integrate persons-served and family choice into the service at every opportunity: How?

- Just ask …

- Create opportunities proactively
  - Treatment planning; Consumer Councils; Consumer Surveys; Consumer Roles (formal & informal); Staff education & reviews

- Include consumers and accelerate culture change through:
  - Service delivery systems reform
  - Policy development & revision
  - Program design/re-design
  - Environment & physical design changes
Organization leaders must be **relentlessly curious** about learning and continually reviewing what happened and what can done differently to prevent recurrence and mitigate harm: *How?*

- Get accurate information: *freeze the scene*
- Teach staff how to facilitate effective debriefing
- Build in multi-phase/step review process
- Make this a sacred time with persons-served to repair harm / relationships: *apologize and build a new plan together*
- Connect the debriefing information with objective data and integrate into QI/leadership meetings/staff development & supervision
Key Elements for Sustainability
To Guarantee Success

To ensure successful implementation and sustained positive results:

- Start with input from persons-served and staff.
- Build and re-build the implementation team.
- Be clear about the goal and develop a written plan.
- Publicly commit in writing. Back yourself into a corner
- Own it. Hold it. Do not let go or delegate down. Be relentless.
- Tell your story: write/publish/promote.
- Actively include persons-served and staff.
To Guarantee Success

To ensure successful implementation and sustained positive results:

• Raise the bar with new practice expectations & standards.
• Listen! Continually check in with staff and persons-served and assess what is working.
• Teach, train, educate, support & celebrate successes and predict and embrace mistakes – they will happen a lot.
• Prepare for the long haul. This is a marathon for culture change - not a race to zero.
“It is not the strongest or the most intelligent who will survive, but those who can best manage change”

~ Charles Darwin
**RESOURCES**

REsTRAIN Yourself Toolkit: UK Adaptation of 6CS

Six Core Strategies Checklist: New Zealand Adaptation from Te Pou
RESOURCES

- Six Core Strategies© Snapshot: [https://www.nasmhpd.org/content/six-core-strategies-reduce-seclusion-and-restraint-use](https://www.nasmhpd.org/content/six-core-strategies-reduce-seclusion-and-restraint-use)

- Articles:
RESOURCES

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Contact Information and Any Questions!

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