Welcome to the National Executive Training Institute for Creating Violence Free and Coercive Free Mental Health Treatment Environments. My name is _____and I will be presenting this module, developed by the Kevin Huckshorn who is the Director of the National Technical Assistance Center (NTAC) at NASMHPD, also known as the National Association of State Mental Health Program Directors. NTAC also coordinates the National Technical Assistance Center for the Reduction of Seclusion and Restraint (S/R).

Any work used from this document should be referenced as follows:

"National Executive Training Institute (NETI). (2005). *Training curriculum for reduction of seclusion and restraint. Draft curriculum manual.* Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD), National Technical Assistance Center for State Mental Health Planning (NTAC)"

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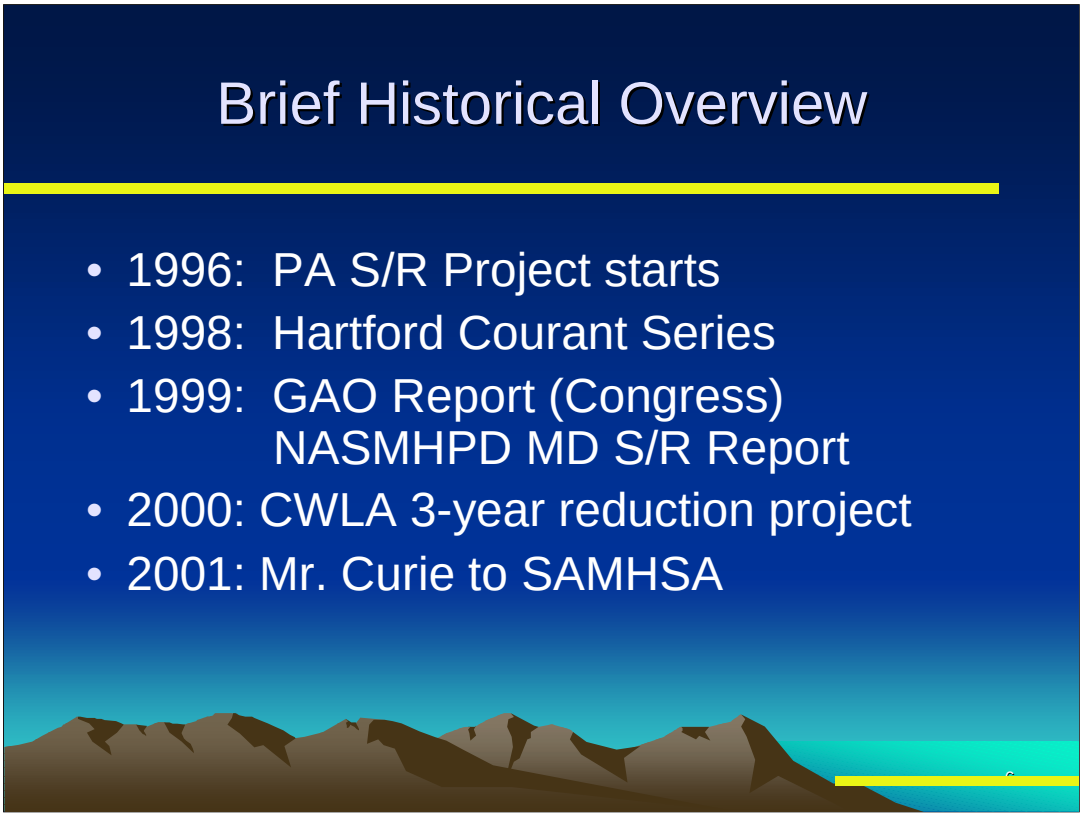
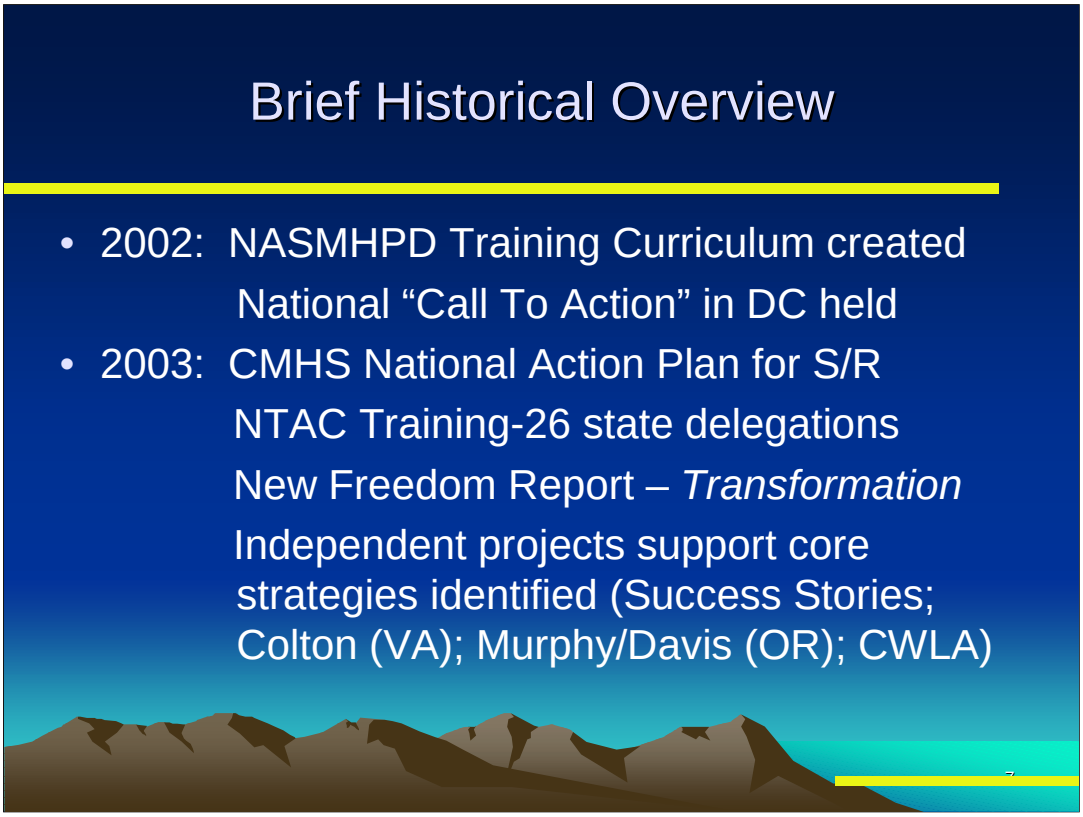
I will be providing an overview of the training modules that will be presented throughout this training and I would also like to acknowledge our sponsors that include the University of Missouri, St. Louis and the Center for Mental Health Services (CMHS). This training initiative has been generously funded through the Substance Abuse and Mental Health Services Administration, SAMHSA, CMHS, and Lilly Pharmaceuticals as part of their support of ongoing education that is unrelated to medications.

The training materials that you will have or you can order include the Training Curriculum, which includes your objectives, your references, your power point presentations and your outlines for each one of the modules. The Resource Manual that is generally sent to a facility, one book for a facility, includes adjunctive kinds of information, documents, policies and procedures, examples of assessment tools, technical papers, reports and other kinds of resources. All of these can be ordered from NTAC and our contact information is at the end of this particular training module.



I want to start out by giving you a brief overview of this issue of seclusion and restraint; in order words, why are we here. I wanted to talk, to begin with, about Pennsylvania and the really tremendous initiative that started back in 1996. The State of Pennsylvania, prior to the *Hartford Courant* ever occurring (the series of newspaper articles that came out in 1998 titled "Deadly Restraint", decided on their own to reduce the use of seclusion and restraint and they took this on as a state-wide initiative in their adult state institutions. PA was the first state to provide leadership in this area on a statewide and then national level. PA state office leadership went into their state adult hospitals, got together the executives and the senior leadership and made a decision that they were going to figure out how to reduce and eventually eliminate the use of seclusion and restraint. That project, as I said, started in 1996 when Charlie Curie was the Deputy Commissioner of Mental Health and under his leadership that project continued up to this day.

In 1998 the *Hartford Courant* released its series of newspaper reports. The *Hartford Courant* is a very small newspaper in Connecticut and followed the death of a local child by the name of Andrew McLain. The *Hartford Courant* dispatched four investigative reporters to go out and look at this issue of seclusion and restraint. About a year later they came back and wrote a series that caused public outrage and shock and dismay in the community at large in terms of the general population. This public outrage rapidly found its way to the US Congress. The *Hartford Courant* series which can be found on their website detailed the deadly use of restraint and the fact that use was very under-regulated. They noted that providers rarely talked much about restraint use outside of treatment settings that were treating people with serious mental illness and developmental disabilities and that this use had gone on for years and that injuries and deaths were occurring to both staff and consumers in care and again, were very unreported. Finally, the Courant noted that there was actually no national database that even showed how often these kinds of interventions were



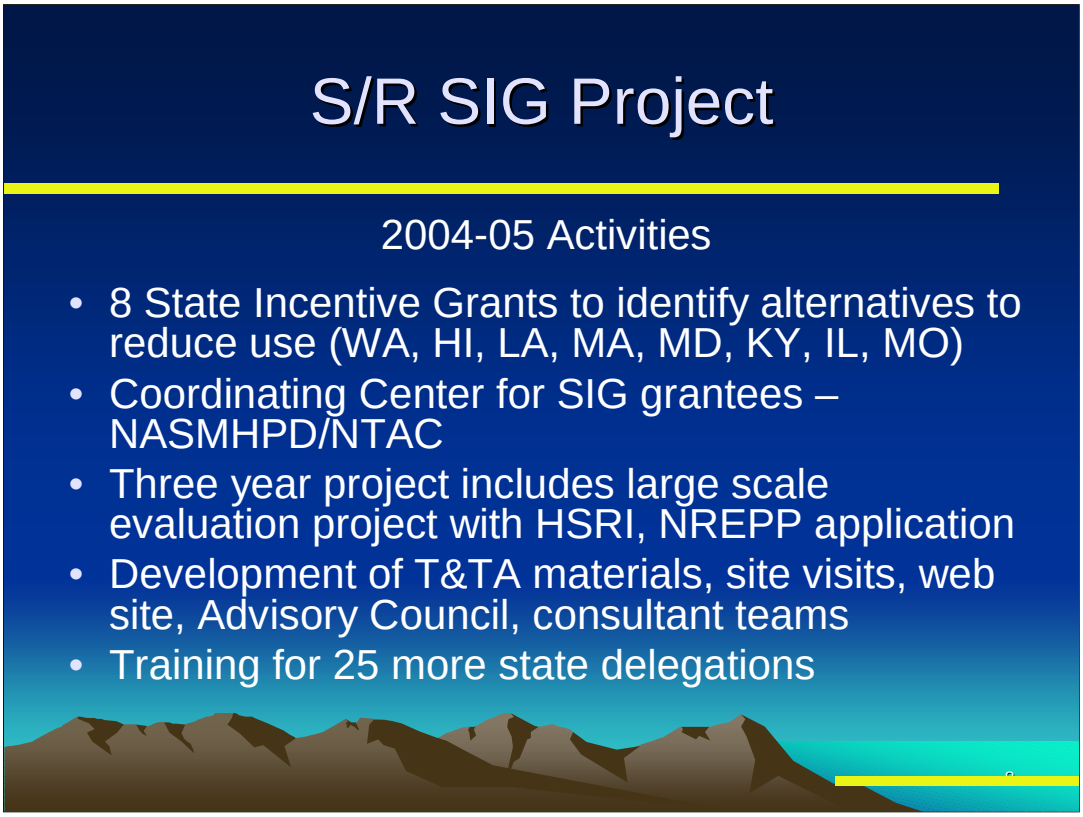
In 2002, NTAC and NASMHPD, who had already been involved in speaking with the commissioners in all 50 states and the five territories and the District of Columbia and had voted on unanimously a policy statement on reducing seclusion and restraint. NASMHPD then went back to CMHS and presented a proposal to develop a NTAC supported training curriculum on how to reduce S/R use and whether CMHS would help to fund these trainings. CMHS and SAMHSA agreed to fund the trainings, once the curriculum was developed and so in 2002, NTAC staff and faculty did a thorough review of the literature, spoke to many consumers and experts in the field who had successfully reduced use, and went on to create a curriculum training which is what you're seeing here today.

Also in 2002 SAMHSA launched a national "call to action" on this issue and it was held in the District of Columbia and about 300+ people came representing all parts of the mental health community in terms of stakeholders, policymakers, legislators, providers and consumers and family members.

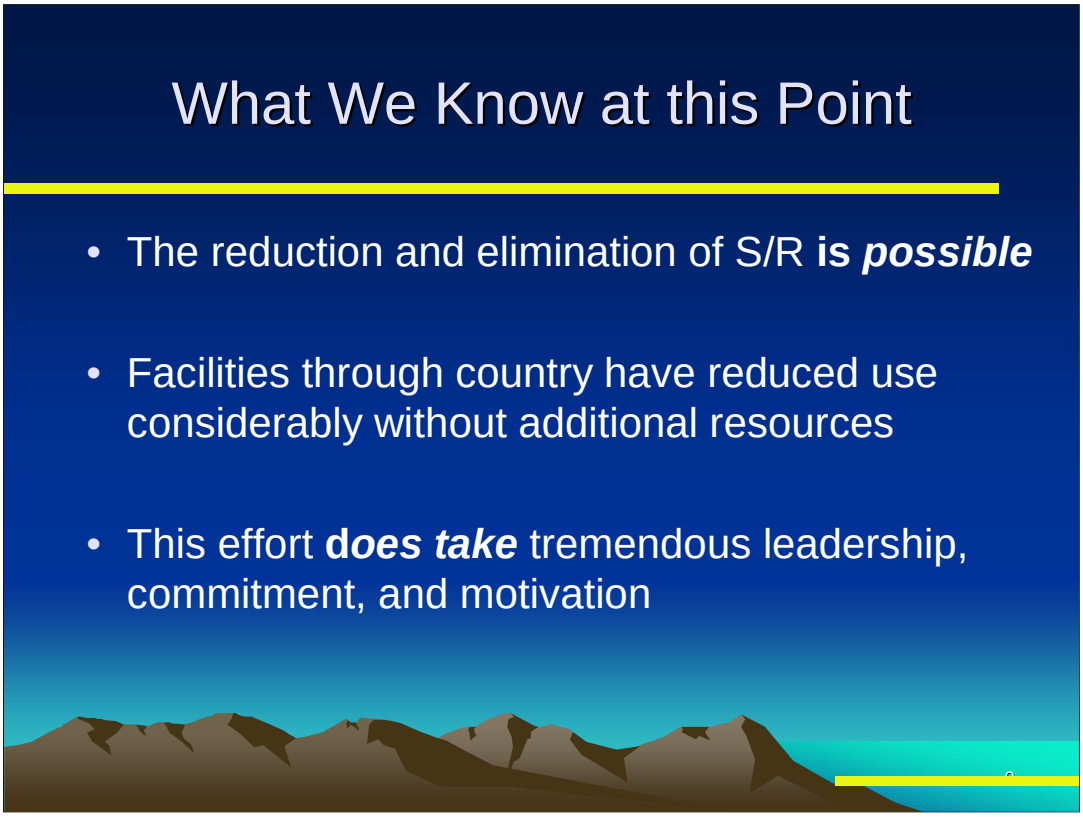
In 2003, NTAC, and their expert faculty trained 26 state delegations using these standardized training modules. Also in 2003 the New Freedom Commission Report was released and I will be talking about that a little bit later.

We continued to gather evidence about seclusion and restraint reduction throughout 2002 up until the present. Back in 2002 there was very little research on seclusion and restraint reduction, so because of that and because of the heightened interest on this issue, we kept combing the literature and inserting that literature in other kinds of references and resources as they became known.

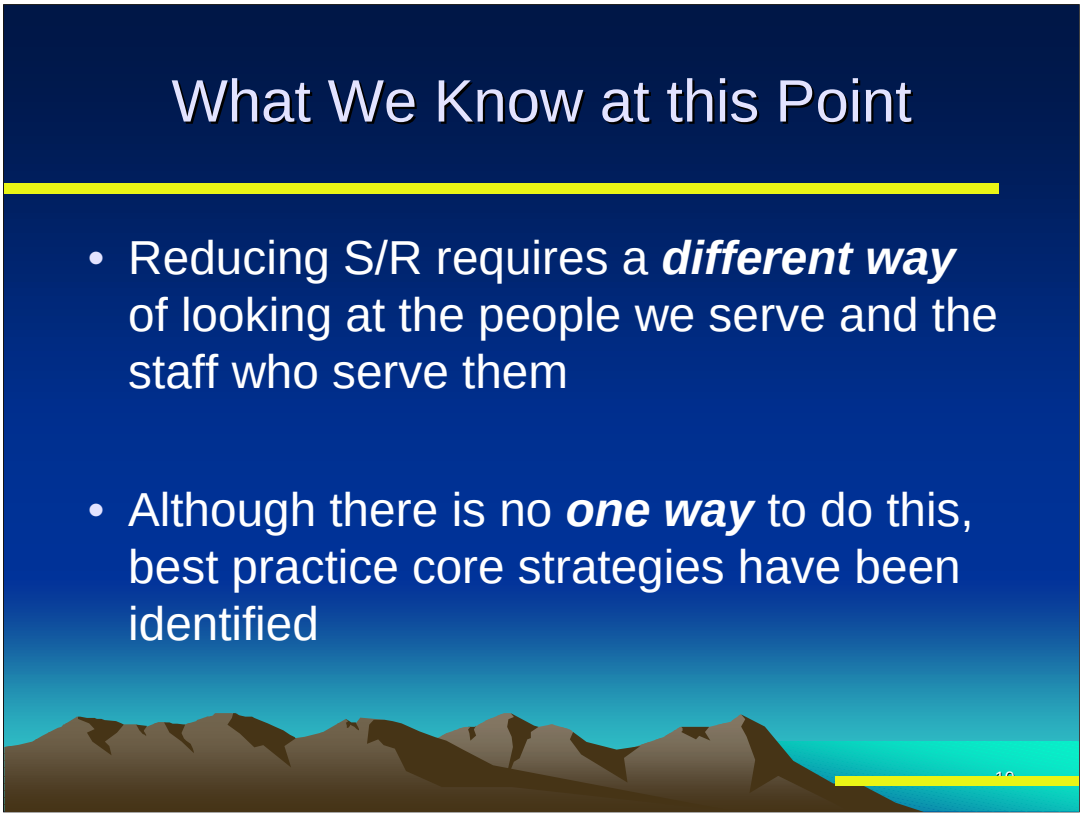
In 2003 several different documents were published: one was called *Success Stories* and was written by a partnership between the American Psychiatric Association, The American Psychiatric Nurses Association, the National Association for Psychiatric Health Systems and the American Hospital Association and they did a very large document that presented success stories and



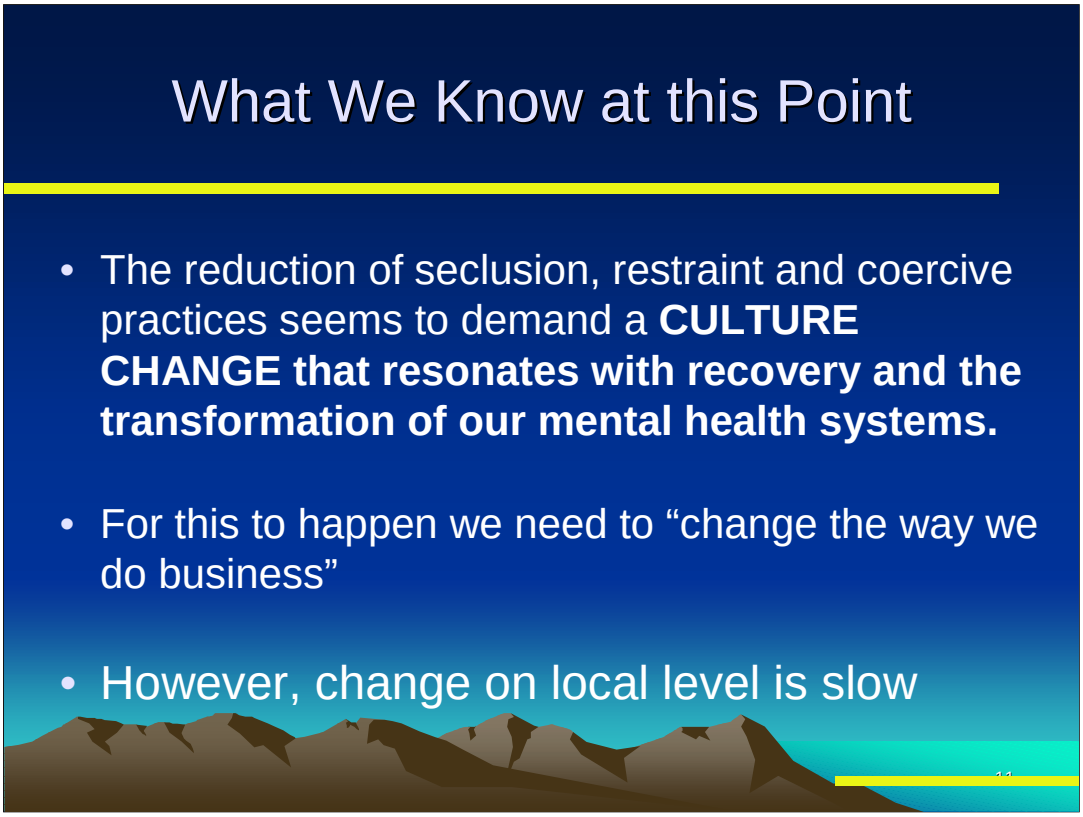
In 2004 – 2005 and now, SAMHSA has continued to strongly support this initiative and they launched another state incentive grant project. NTAC is now involved with an eight state, large research project that is focusing on 49 sites in a variety of settings. NTAC is now the coordinating center for reduction of seclusion and restraint and their role is to basically help develop training and technical assistance materials, do site visits, create a website and post as much of this information so it can be in the public domain, if possible.



What we know at this point is we know that reduction and elimination of seclusion and restraint is possible. We also know that facilities throughout the country have reduced use without additional resources. We also know that this effort does take considerable effort, leadership, commitment and motivation and that this goes on over a fairly long period of time.

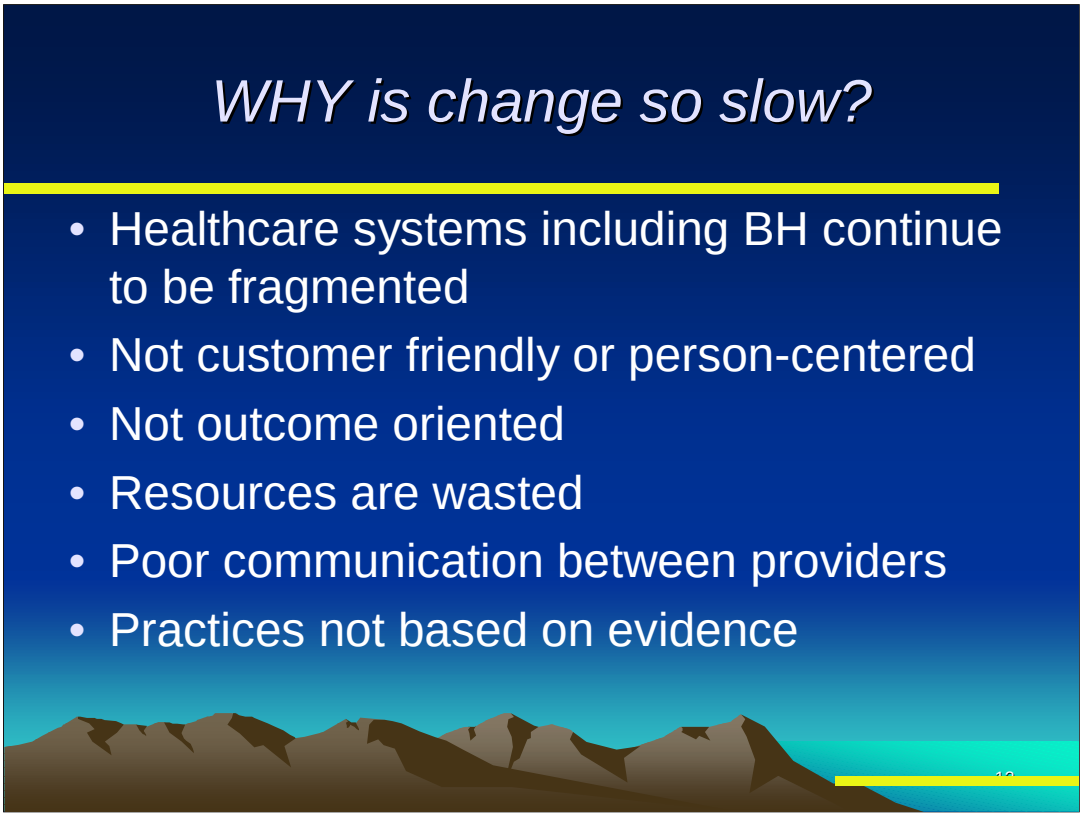


What we also know is that reducing seclusion and restraint requires a different way of looking at the people we serve and the staff who serve them. Although there is no one way that's been proved through evidence base research, one way that works; core strategies that have been proven to be successful have been identified and that's what we'll be talking to you about today.



We've also noted in our work that the reduction of seclusion and restraint and any other kind of coercive measures seems to demand a culture change that resonates with recovery and the transformation of our mental health systems of care. In other words, changing the way we do business now. The issue of transformation, which we'll talk about in a minute, is a critical one for the mental health system in 2006.

However we also recognize the change on the local level is very slow. The Surgeon General's Report in 1999 that was released identified the lag between knowledge, getting down to the practice level to be over 15 years. So this is partly, these presentations are focused on trying to narrow that gap because we can no longer wait 15 years to actually implement best practices. It's not fair to the people we serve, nor is it fair to the staff or to the public taxpayer dollars.



Other reasons that change is so slow in mental health is that we're following the exact kind of pattern that our general health care systems are demonstrating. Health care systems including behavioral health continue to be very fragmented systems of care. They are not seamless; they are not customer friendly or person-centered particularly. They're not outcome oriented. They're more focused on processes; how we get there rather than outcomes. We waste a lot of resources because of these things. Very poor communication between providers sometimes is just because no one has enough time; sometimes it has to do with confidentiality issues but be that as it may, providers don't necessarily talk to other providers and a consumer could have several providers that never even touch base when they're all trying to provide care for one person. Our practices are still not really based on evidence, although we're making some inroads in that.

The Institute of Medicine in 2001 and then again in 2005 released reports on the status of health care in America. The first one is called *Crossing the Quality Chasm* and addressed the state of the general health care system in America that the IOM identified as fragmented, not person-centered, and not outcome based. The IOM, in this report, envisioned 10 rules to redesign the way we provide care in our general health care systems.

Some of those goals or values were continuous healing relationships; that people would have actually relationships with their provider that went beyond 15-minute check in the doctor's office. That this care would be customized to each individual person so that care was no longer provided in kind of a global group or homogeneous way but really was tailored to what that person needed. Also that the customer had to be more involved and it was much more important that they have some feeling of control about what was happening to them and that that feeling of ownership would then be reflected in their adherence to what they agreed to do in terms of their treatment.

That information needed to become much more transparent so that multiple providers could actually join forces and work toward helping an individual or family get better. Also that we do a better job of anticipating risks and anticipating needs and not wait until the back end of the process where we're trying to be reactive and fix things that had already gone fairly far down a road of disease or a problem. And then we start to use best practices and that providers be expected to use best practices, even if that meant not using practices that they've used historically for years.

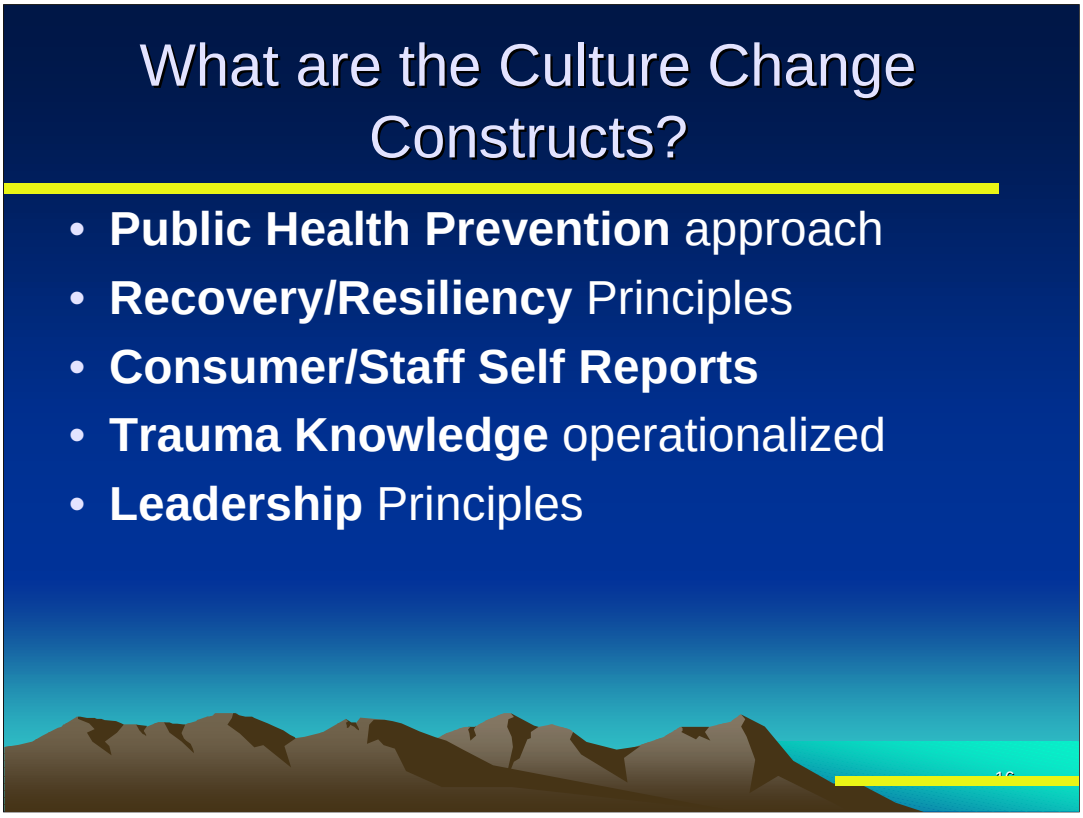
In 2003, the first President's Commission on Mental Health appointed since the Carter Commission in 1970, released its report. It was called "The New Freedom Commission Report on Mental Health Care" in America. This report called for total system transformation and that this kind of transformation was quite different as compared with doing some kind of band-aid approach where we fix a couple of parts of the system that weren't working. They recognized that the system was almost broken and that it wasn't providing the kind of care that most of us had envisioned or wanted to provide and that to get there we had to really transform and not just band-aid a few areas.

The New Freedom Commission Report called for mental health systems to adopt the goal of "Recovery for Everyone." This call to action legitimized the concept of recovery in a well-written and widely distributed publication, probably for the first time. The NF Commission expected that services and supports would need to be consumer centered and that the focus of care in mental health settings must be on helping an individual learn to manage their own ailments, so that they did not have to become dependent on the scientific community or the health care setting where they were getting services. That the point for every staff person and every provider working in the field was to help teach their service users how to manage their own illness and that that would be a big piece toward helping someone facilitate their own recovery.

Toward that end that individualized plans of care were critical and there was an acknowledgement that even though we call the treatment plans that we do nowadays and have for years, individual treatment plan, that they're most often not individually created or if they are they're often not referenced once they're written and that this was a critical piece that we really needed to focus on.

Then lastly, but certainly not least, is the consumers and family members must become full partners in their care and especially in mental health. We haven't done as well as other parts of our health care system and we've used reasons

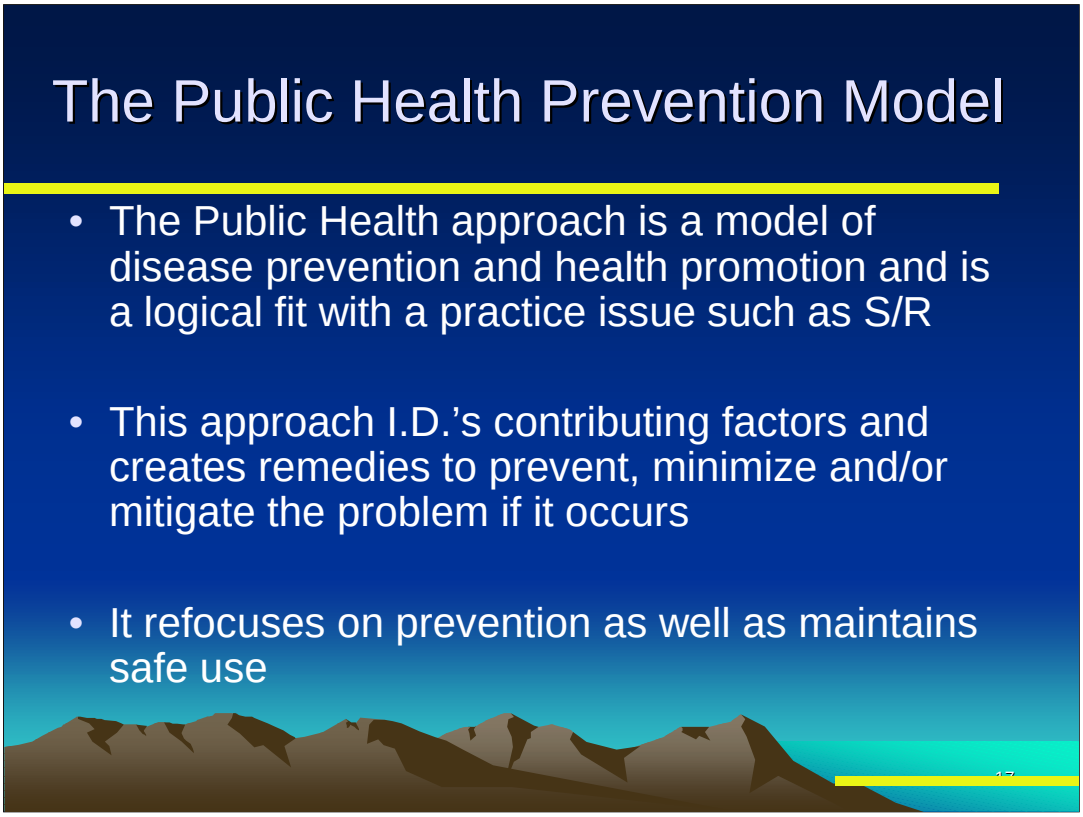
What we are finding is that in terms of seclusion and restraint that this is a critical cornerstone to creating a recovery-oriented system of care. It improves the safety for service recipients and staff. It teaches respect and negotiation skills. It helps us move the focus of our daily practices from control to one that looks more like partnership, negotiation, and empowerment. It means that staff don't always have to be in the win/win stance and that we can actually have situations where the consumer can win and that that's part of this negotiation of treatment outcomes and successful resolution of conflicts, if you will. That not using seclusion and restraint avoids re-traumatizing people and that using it, traumatizes people. That it creates more responsive environments for consumers and staff; that the environment of care becomes more like a sanctuary and more like a healing place than one to be feared. And that also reducing seclusion and restraint facilitates treatment and the therapeutic relationship is so important to successful treatment.



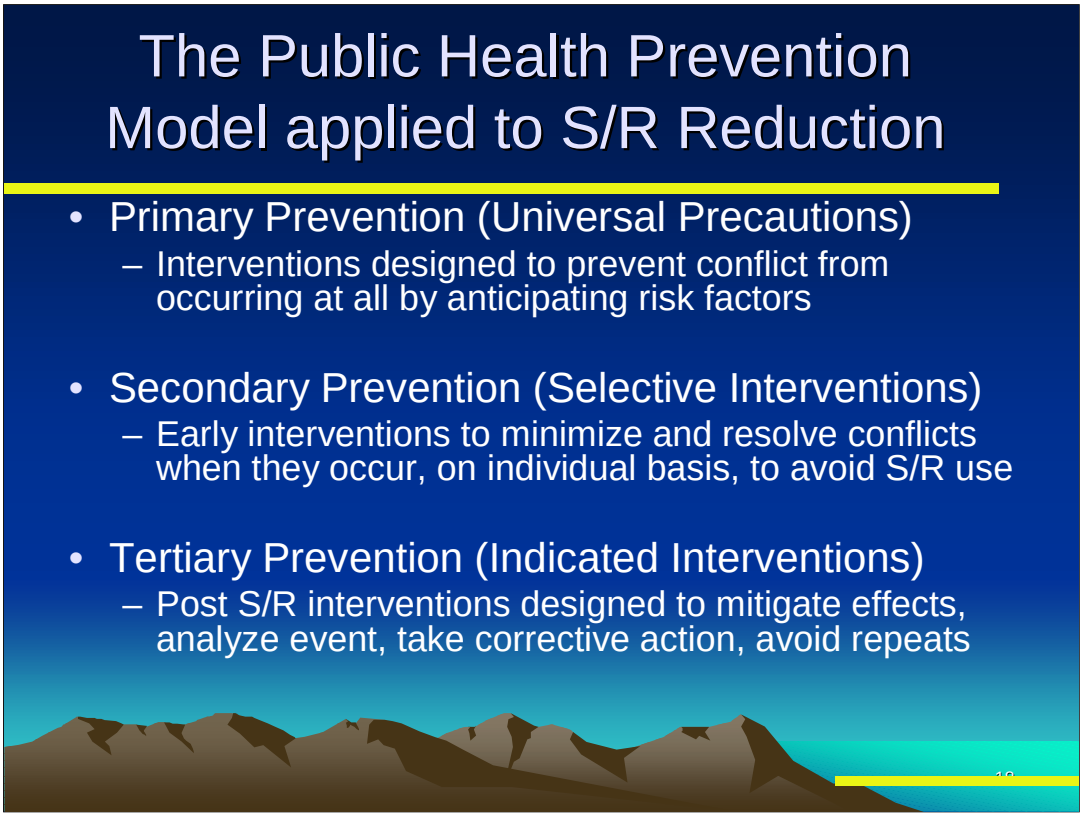
When NTAC and faculty went through the literature and spoke to consumers and experts in the field who had reduced seclusion and restraint, what they found was were some basic tenets that were critically important in this work. The first was the public health prevention approach. The second was the principles of recovery and resiliency as laid out by the New Freedom Commission and the other research that's been done. The third was the importance of valuing consumer and staff self reports; what the consumers and staff said when they talked about the use of seclusion and restraint, even though while possibly not evidence based in a rigorous way, very important because these are the people that are actually being most affected by the use of these interventions.

That the emerging science of trauma informed care was extremely important and critical both in supporting the reduction of seclusion and restraint and also really setting a challenge to the field that this was not only important, but it's almost a moral issue. That it is important for staff to know that research shows that the use of seclusion and restraint causes harm to people we serve, both emotionally and physically.

And finally it became clear that we needed to become much more knowledgeable about how effective leaders create successful organizational change in their facilities because reducing seclusion and restraint is really about successful organizational change.



I'm going to say a few words about some of those constructs or tenets because these provide the framework or foundation of the "Six Core Strategies to Reduce S/R" and what they rest on. Some of them I will not be covering now because they are their own modules and you'll hear about them later. The public health prevention model; most of you will recognize. It's the same model that we hear about when you go to work and you learn about universal hand washing precautions to avoid or manage to reduce infections. The public health prevention model is a model of disease prevention and health promotion and it is a very logical fit with the practice issue such as seclusion and restraint reduction. When we were putting together our expert groups at the beginning when we were working on developing the curriculum, the medical directors at NASMHPD who had already written a series of reports on this issue identified the public health prevention model was a critical piece and would really help us reframe the issue from doing seclusion and restraint better to preventing it from using it at all. So what this approach does is it helps us, as a provider agency, identify contributing factors that seem to lead to the use of seclusion and restraint and create remedies to help avoid using seclusion and restraint and if you have to use it to minimize the negative effects. Again, it focuses us on prevention; not the other end, which is reactive, after the fact, and tries to "fix things" after a seclusion and restraint event has already occurred. It also helps us reconcile prevention of use with safe use as long-term reduction strategy.

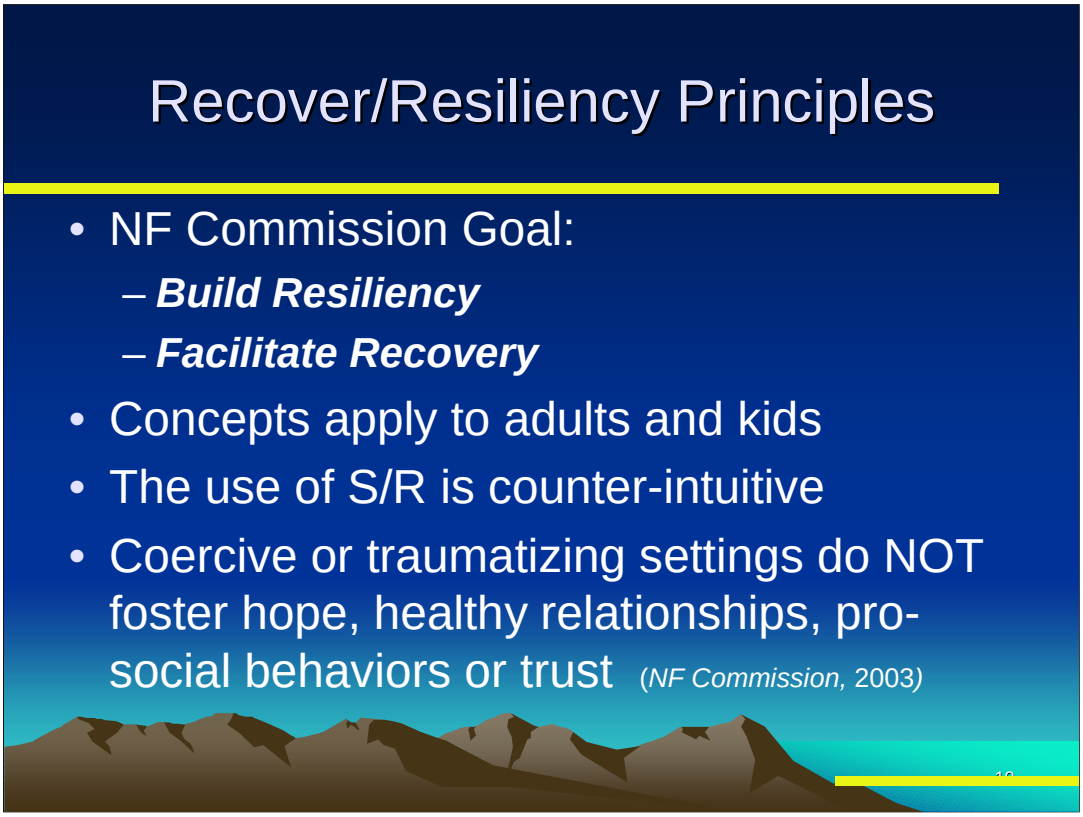


In terms of the public health prevention model in seclusion and restraint to be very specific, what you'll notice as you hear about the six core strategies is each one of them has been given a name, either primary prevention strategy; a secondary prevention strategy or tertiary prevention strategy and what that means even though there's some overlap is that that particular strategy is focused either on primary prevention, secondary or tertiary prevention.

They use three concepts: primary prevention means universal precautions taken to avoid a problem. A primary prevention intervention is generally used for the entire population based on the premise that you never quite know who is at high risk. So we basically use the approach that the entire population may be at risk, so what can we do to avoid this problem in the first place. So for instance; again, universal hand washing techniques to avoid transferring infectious diseases such as colds or the flu. Another universal precaution is the use of condoms for safe sex because you can never actually know your risk factors at any given time regarding your partner's exposure to STDs. So you use safe sex mechanisms to avoid these risks.

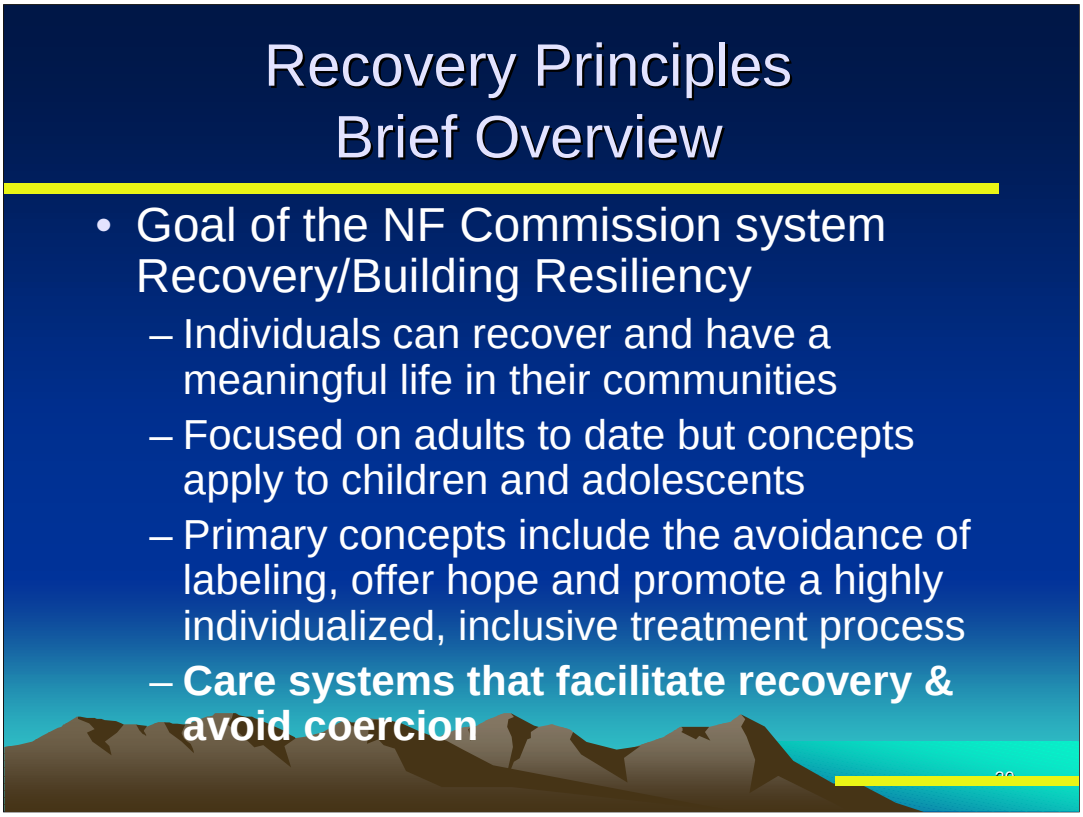
In terms of seclusion and restraint, primary prevention interventions would be those that are designed to prevent any kind of conflict or violence from occurring on your inpatient unit. Now that's going to sound to some of you like the utopian idea but that's really beside the point. Primary prevention interventions for seclusion and restraint are designed to help us create environments of care where we won't see conflict or violence. This goal is an important as preventing suicide or adverse medication events. We never would be "ok" with a "few" of these. The goal needs to be to avoid conflict and violence, no matter what. And there are interventions that can help you do just that.

In the public health model, secondary prevention activities are more selective interventions and what that means is now we know that we've got enough information that we can narrow down the population that we're going to focus



To move on to the other foundational constructs underlying this training, just a little bit about Recovery and Resiliency principles. The New Freedom Commission, noted that Recovery and building Resiliency was the goal for everyone in the MH system. These goals really focus the provider system to help our service users build the recovery and resiliency skills so they have a lot of successful coping strategies whenever they face all kinds of issues, problems, stress or adversity in their life. We're just now learning more and more about recovery all the time and there's just been a consensus statement on recovery issued to the SAMHSA website which identifies 10 key components of a system that would facilitate recovery and I really do suggest that you look at that when you get a moment; www.samhsa.gov.

In terms of seclusion and restraint, recovery and resiliency has some specific importance and that has to do with that the use of seclusion and restraint is counter-intuitive in a system that has facilitated recovery. Why? Because it creates a violent environment in a setting that was supposed to create sanctuary; people get hurt; and these events interrupt the therapeutic treatment milieu. It interrupts building therapeutic relationships. It also sometimes causes great harm to the staff and other service users. It also creates an environment where people do not feel safe. And all of those things are kind of mental health 101 to avoid. Since we now know ways to avoid using seclusion and restraint it's critically important for everybody to really get on the bandwagon here and to understand that again, the use of seclusion and restraint is counter-intuitive to creating or facilitating a system of care that helps people recover.

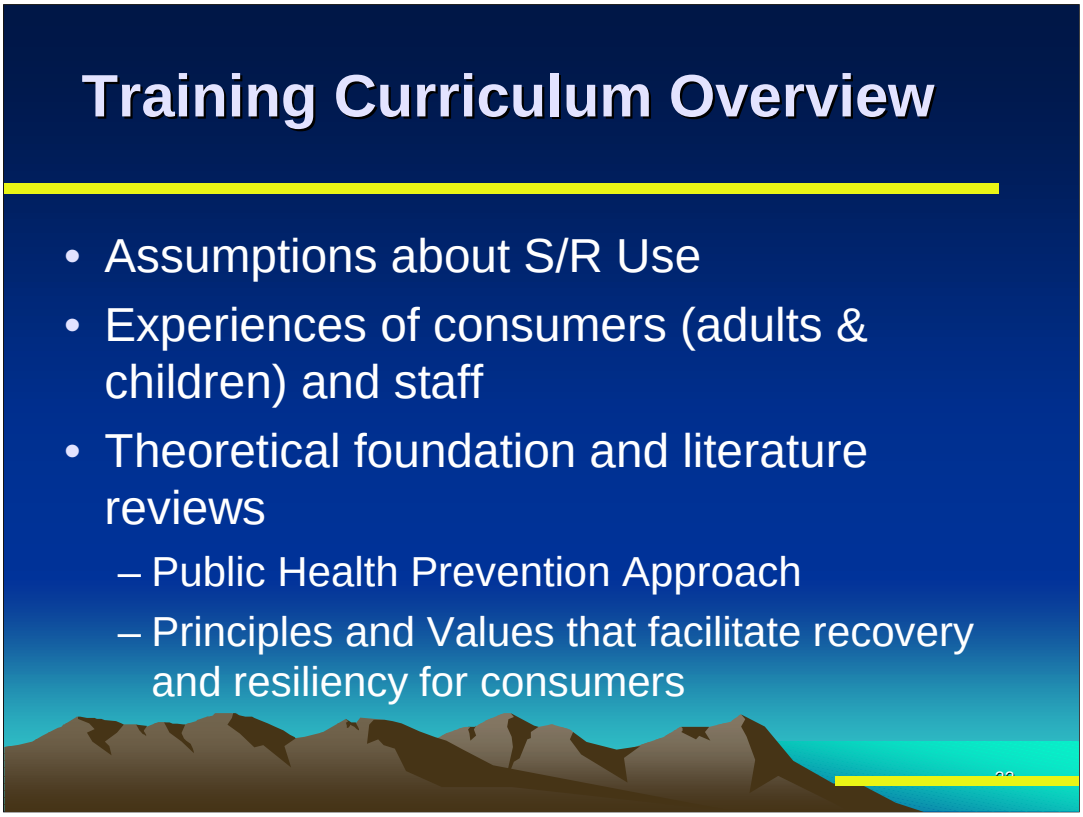


The goal of the New Freedom Commission was that individuals can recover and have a meaningful life in their communities. Most of the work that's been done in recovery to date is on adults, but all these concepts are applicable to children and youth and the primary concepts that underlie recovery systems include the avoidance of labeling; the ability to offer hope to people that have lost hope and to help motivate people to get better than they possibly lost their motivation and have become rather hopeless and powerless and dependent on their treatment system and to promote a higher individualized inclusive treatment process and you'll be hearing more about this in some of the following modules. Again, care systems that facilitate recovery also avoid coercion.

So how do we reduce seclusion and restraint? What we suggest in our training is that to start by developing a formal seclusion and restraint reduction action plan. Probably everyone that is listening to me now is an expert at creating treatment plans for the people you serve. That's exactly what we're talking about; an individualized seclusion and restraint reduction plan that is specific to your facility. This documented action plan needs to be individualized so that it will fit into where you are in that process and go where you want to go.

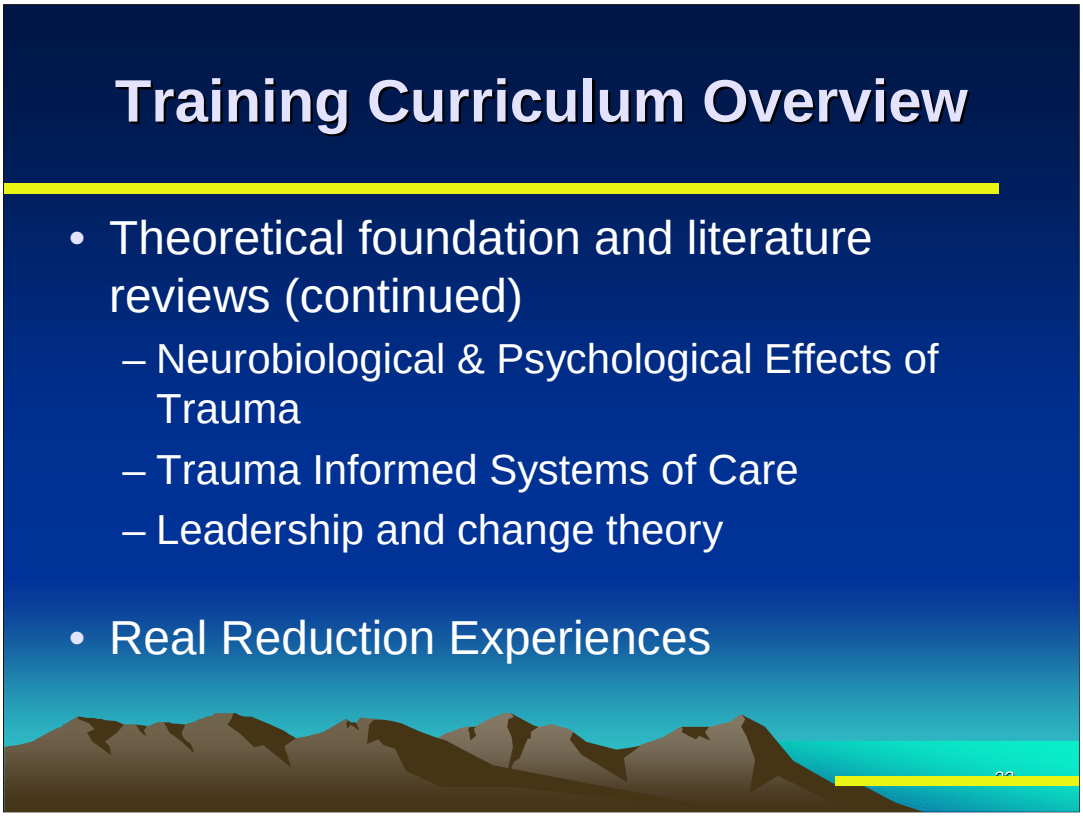
The essential framework for an S/R Action Plan is that you use a prevention based approach, like I just talked about. Don't focus on just how to do seclusion and restraint better because you won't get to where you want to go. It is important that you adopt and use continuous quality improvement principles and that's a real important piece because what that means essentially is that you're never going to get to your goal; you're only going to focus on the journey; you understand you're going to make mistakes as you go along; that staff need to be safe to make mistakes, and that you will learn from those mistakes, but they're not necessarily be mistakes that people get punished over. It is your staff who you're going to be expecting to take risks and to do things differently. They are going to need to feel safe to take those kinds of risks and to make those kinds of mistakes.

Also in terms of continuous quality improvement, this takes time. This process, this project takes time. Pennsylvania has been involved in it for over 10 years. Many other states like Massachusetts, New York have also been involved in this kind of work for many years. You'll make significant inroads and you'll see a lot of successes but you have to keep working on it.



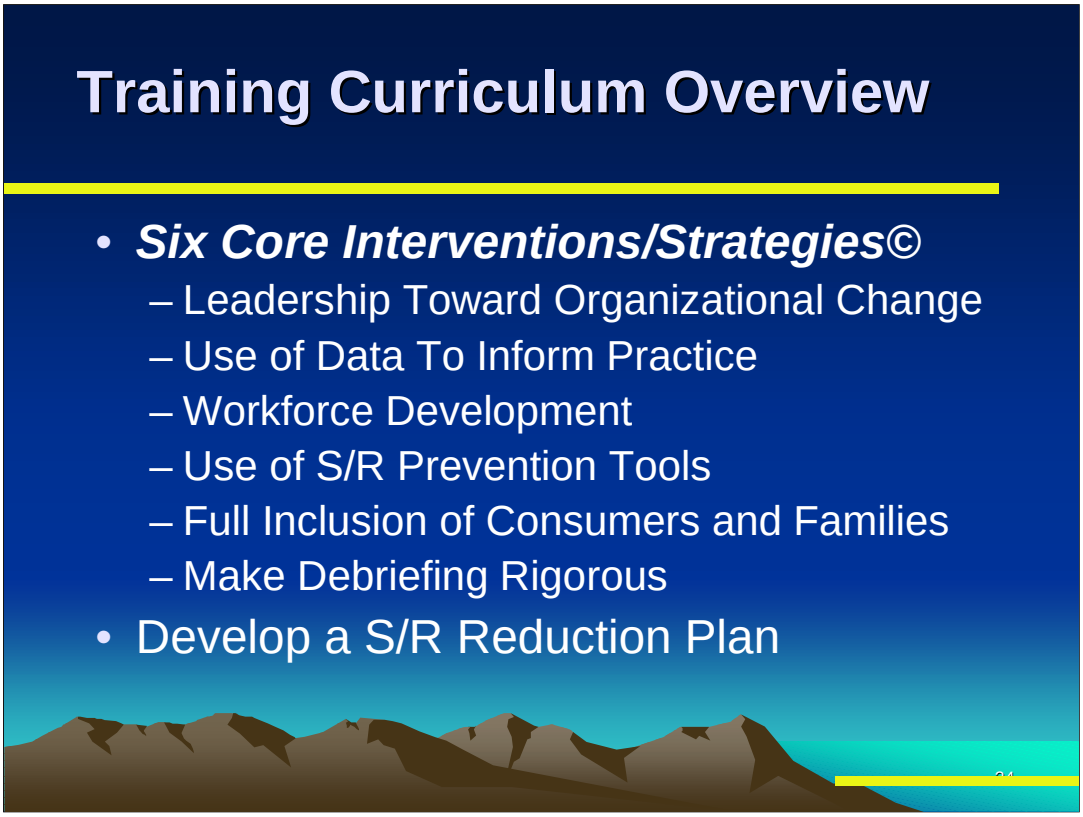
What you are going to be introduced to, in this training curriculum, will include the following:

1. Assumptions about seclusion and restraint use. Most of us grow up in the systems of care and we have certain assumptions that we have always believed about why we use seclusion and restraint.
2. We're also going to give you some vignettes from both service users and staff on their experiences in using, or experiencing being involved in a seclusion and restraint incident where you are the victim, if you will.
3. Lastly, we will also talk more about theoretical foundations and literature reviews. I talked to you about the public health prevention approach and recovery and resiliency principles which are embedded throughout the modules.

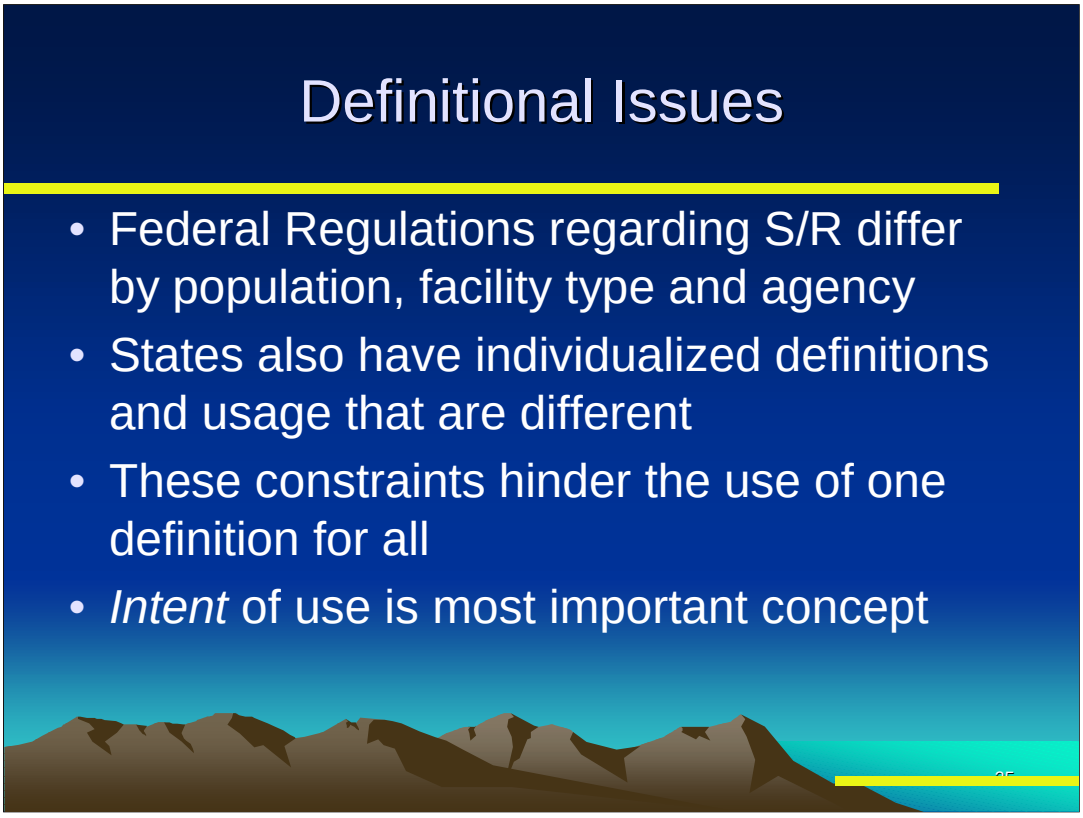


4. We're also going to talk about the neurobiological and psychological effects of trauma coming out of some of the newest research in the country. We're also going to introduce you to core principles to become trauma informed which is also known as trauma informed care and we want to introduce this to you because this is an emerging science and also fairly new research.
5. And then leadership and change theory. We have gone through the literature and gathered what we could on what appears to be the effective competencies of leaders in terms of creating successful culture change. This information base is growing and certainly not complete.

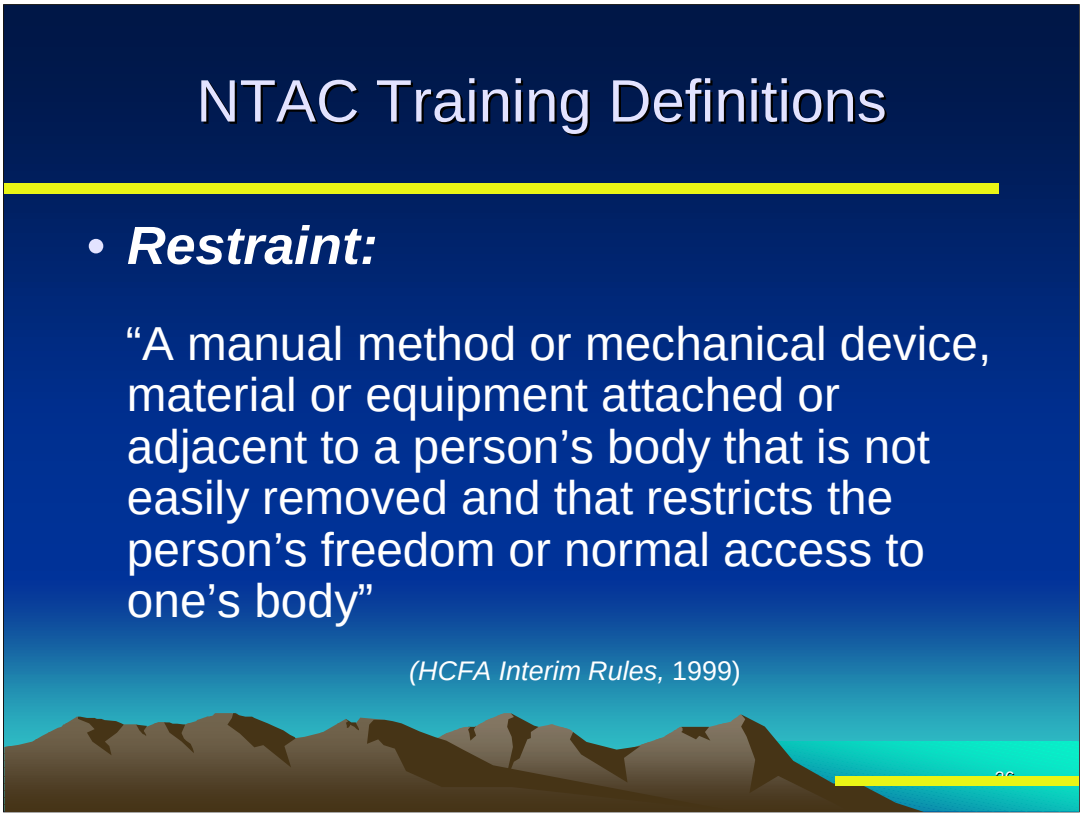
We're also going to provide you with what we call real reduction experiences. These are short presentations from facility's who have been successful in reducing seclusion and restraint and will cover what they did to get there.



We'll also present the NTAC Six Core Strategies© which include: Leadership toward organizational change; the use of Data to inform practice; developing your Workforce; the use of Prevention Tools to prevent the use of seclusion and restraint; the full Inclusion of Consumers and Families in your project; and how to make Debriefing rigorous. These strategies will lead to helping you create or develop an individualized seclusion and restraint reduction plan for your facility.

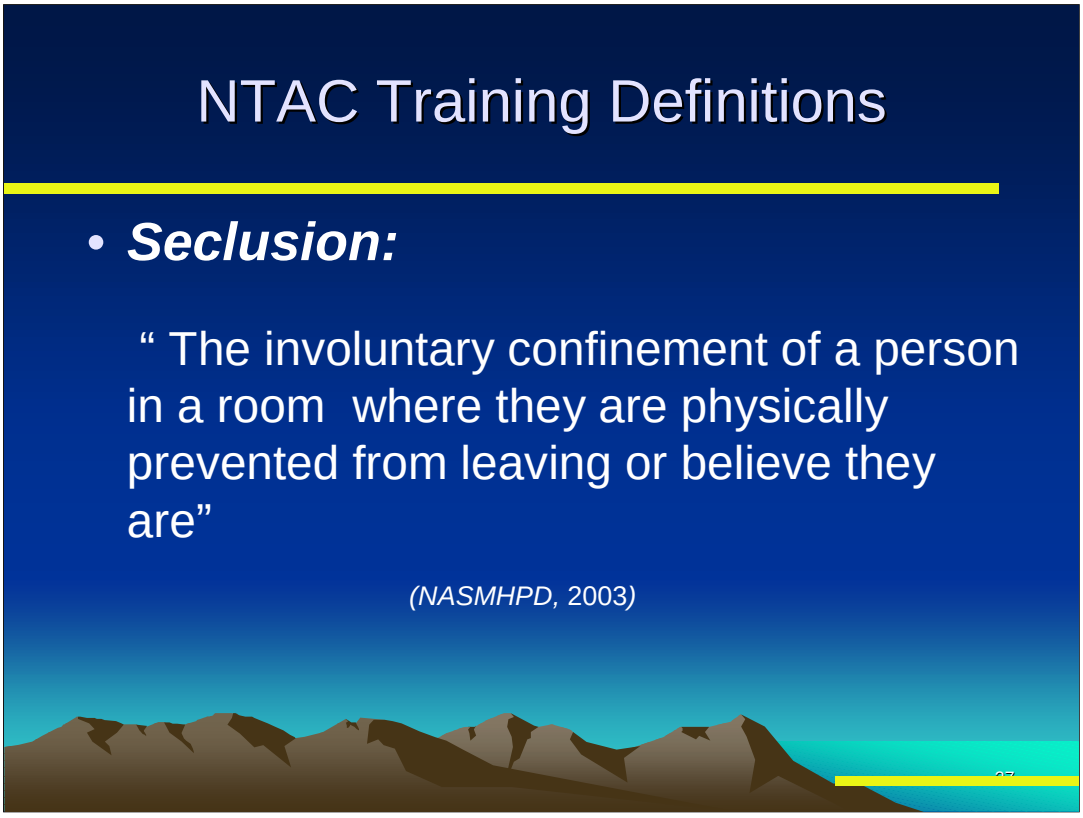


In terms of definitions, most of the providers in the audience will be under certain federal regulations and requirements by their accrediting bodies. Some of the definitions and the use of seclusion and restraint differ by facility, by population and by the agency. What is most important in terms of seclusion and restraint and understanding definitions is what is the intent of that particular intervention. The CMS guidelines pretty clearly describe the use of seclusion and restraint for behavioral reasons and I would draw your attention to those.

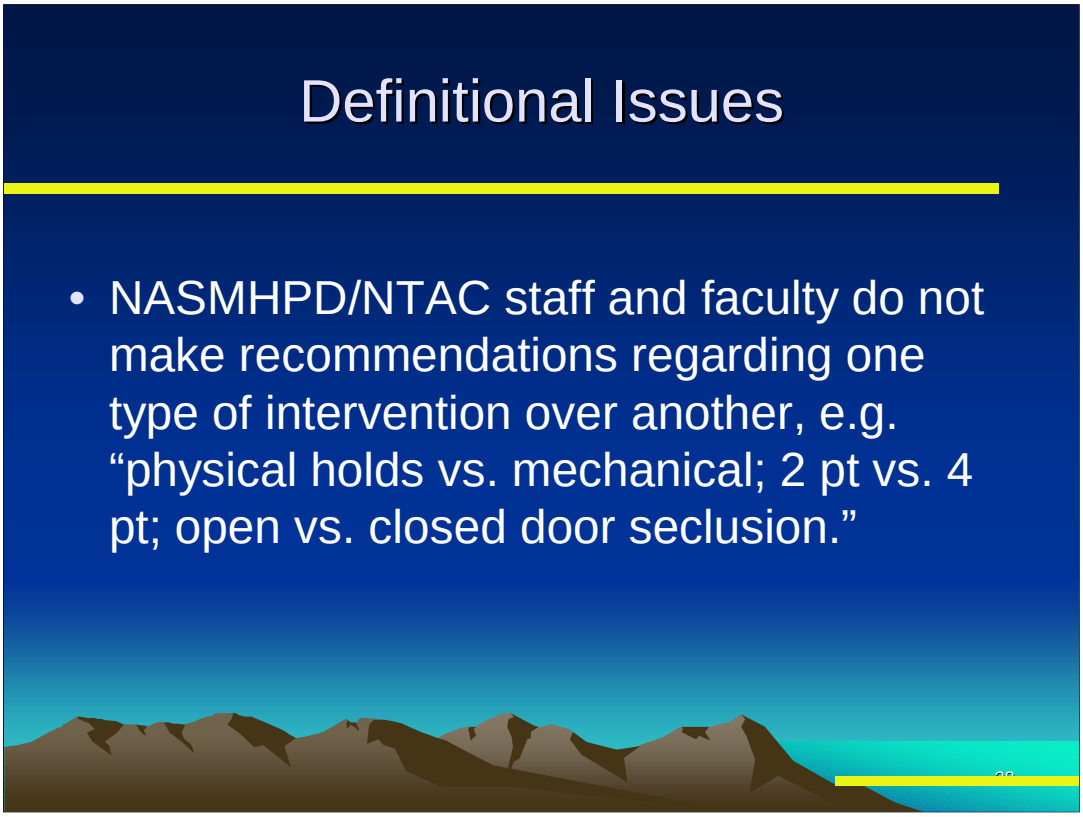


I would also draw your attention to the definitions that NTAC used throughout the development of this curriculum which are as follows:

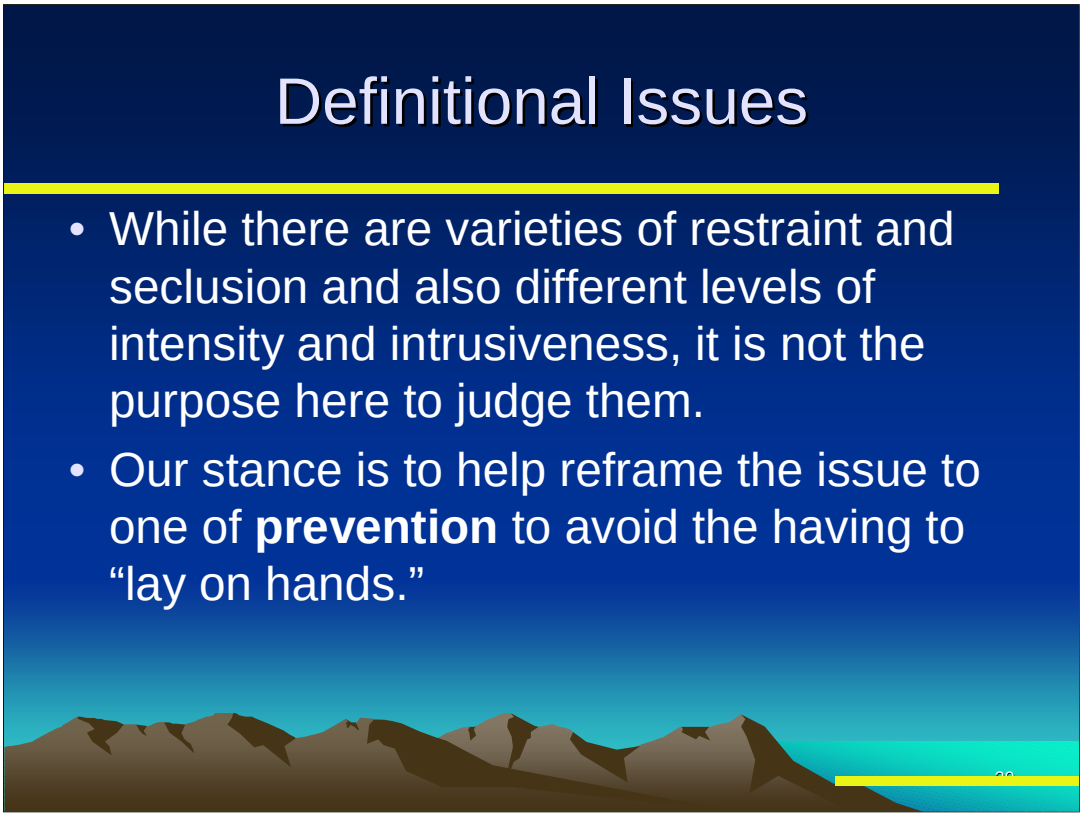
Restraint: a manual method or mechanical device material or equipment attached or adjacent to a person's body that is not easily removed and that restricts the person's freedom of movement or access to one's body.



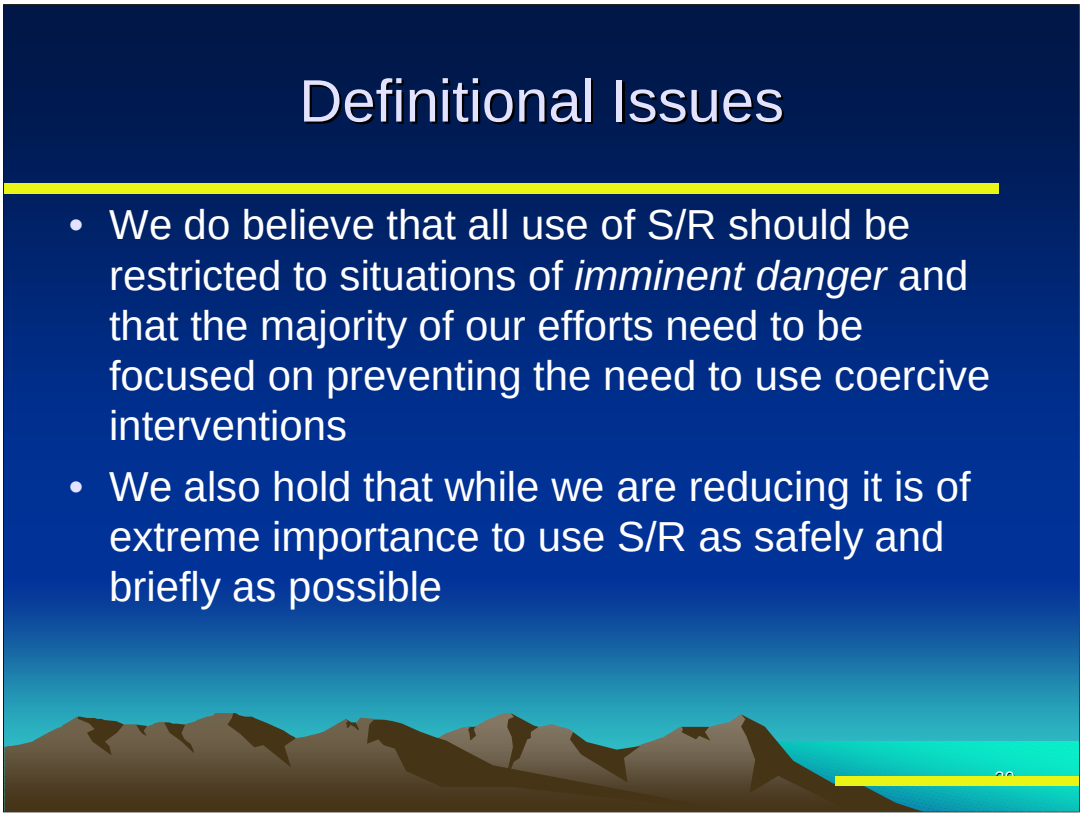
Seclusion: the involuntary confinement of a person in a room where they are physically prevented from leaving or believe they are. I will just note, in terms of the latter definition, that seclusion is in the eye of the person in it. I will just note that some facilities have started to use open door seclusion, that they do not count as seclusion; but when an adult or child is in an open door room and there's a large staff member standing in front of the door blocking their exit from that room and you interview the person and they do not think they can leave, that is to be considered a seclusion type of intervention.



NASMHPD and NTAC faculty and staff don’t make recommendations regarding one type of intervention over the other. In other words we don’t say 2- pt restraint is better than 4- pt restraint or physical holds are better than a mechanical restraint or mechanical restraint is worst than both; they have chosen to not make those kinds of judgments. We are really here to focus on the prevention of the need to use seclusion and restraint, stat medication or any other kind of measure. We really don’t get into judging which interventions are better or worse. In addition there’s absolutely no research that would be able to substantiate any such claims.

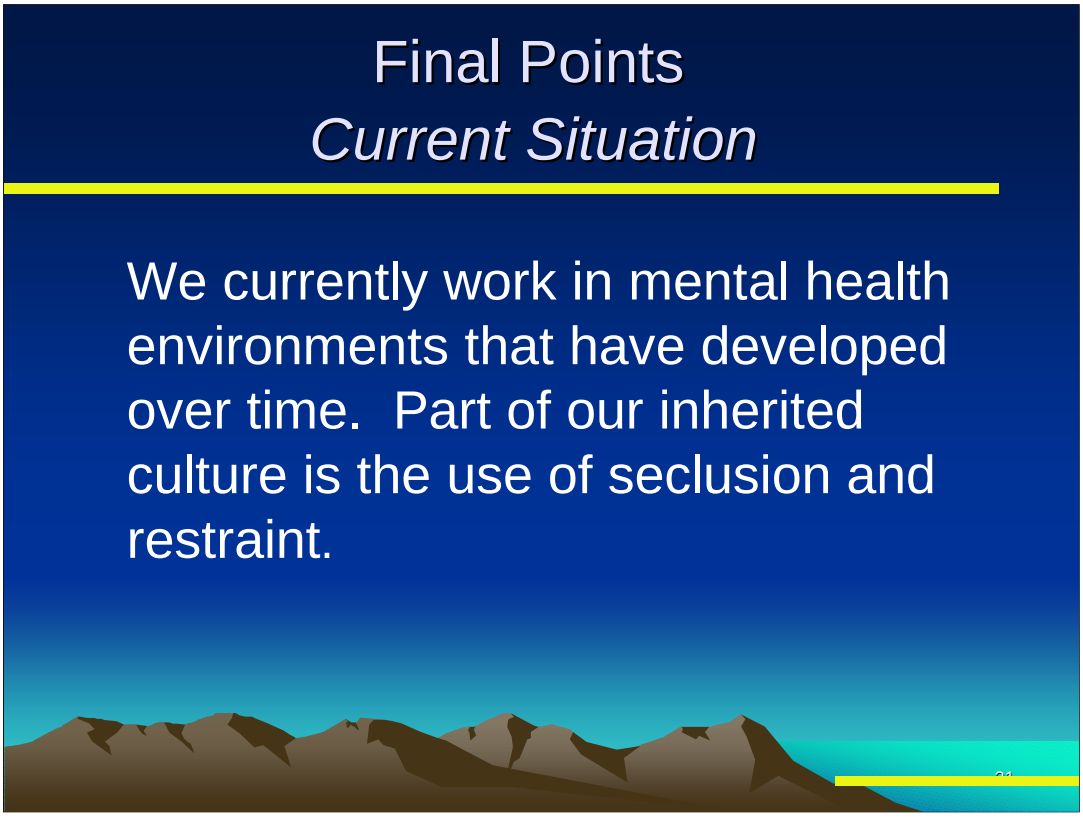


Our stance again is to reframe this issue for you, and to help you understand the difference between preventing the use of seclusion and restraint vs doing it better; doing it safer; monitoring it better; documenting it better. If you just leave with that understanding, prevention vs. managing an event, then this will have been a successful presentation.

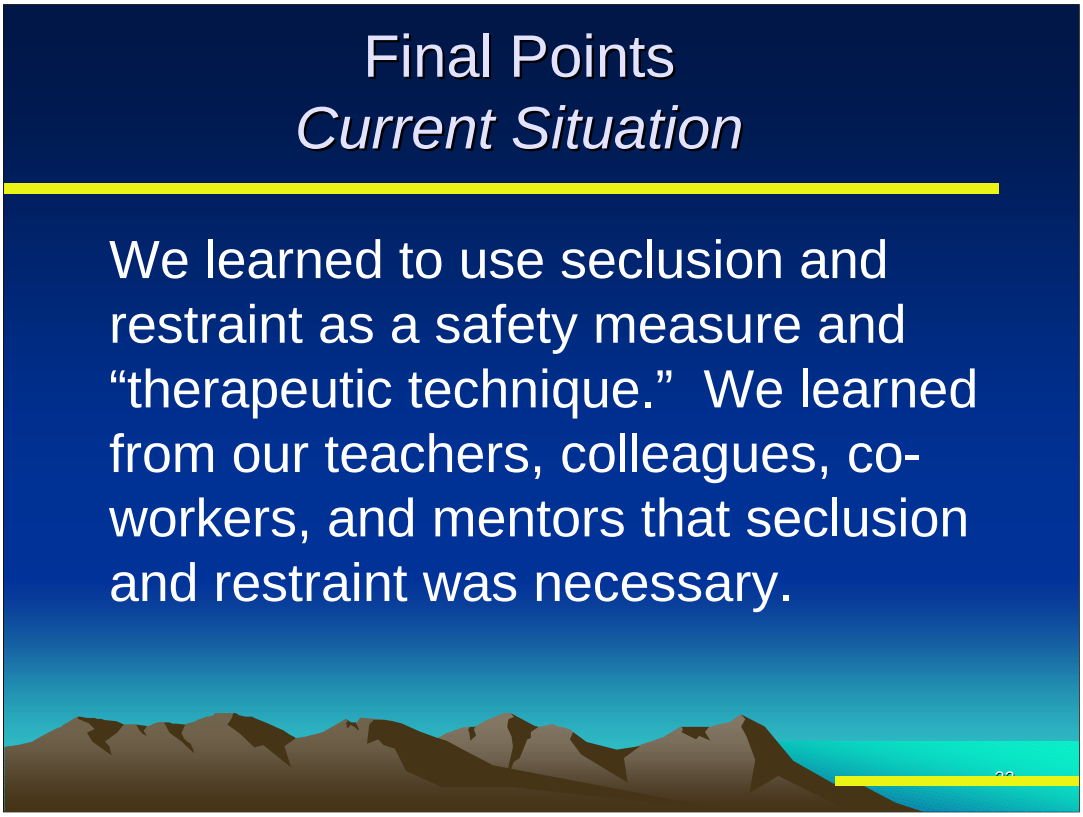


Some other definitional issues: NASMHPD believes that all use of seclusion and restraint should be restricted to situations of imminent danger and that the majority of our efforts need to be focused on prevention. Again, I comment on that because more and more of the literature and the research has begun to demonstrate a very clear pattern that our historical use of seclusion and restraint has probably most often not been in the face of imminent danger but instead in response to persons "breaking rules", as "consequences for verbal abuse" or other less than dangerous events. S/R should not be used as consequences for those kinds of behaviors that are troubling and problematic but that do not reach the threshold of imminent danger.

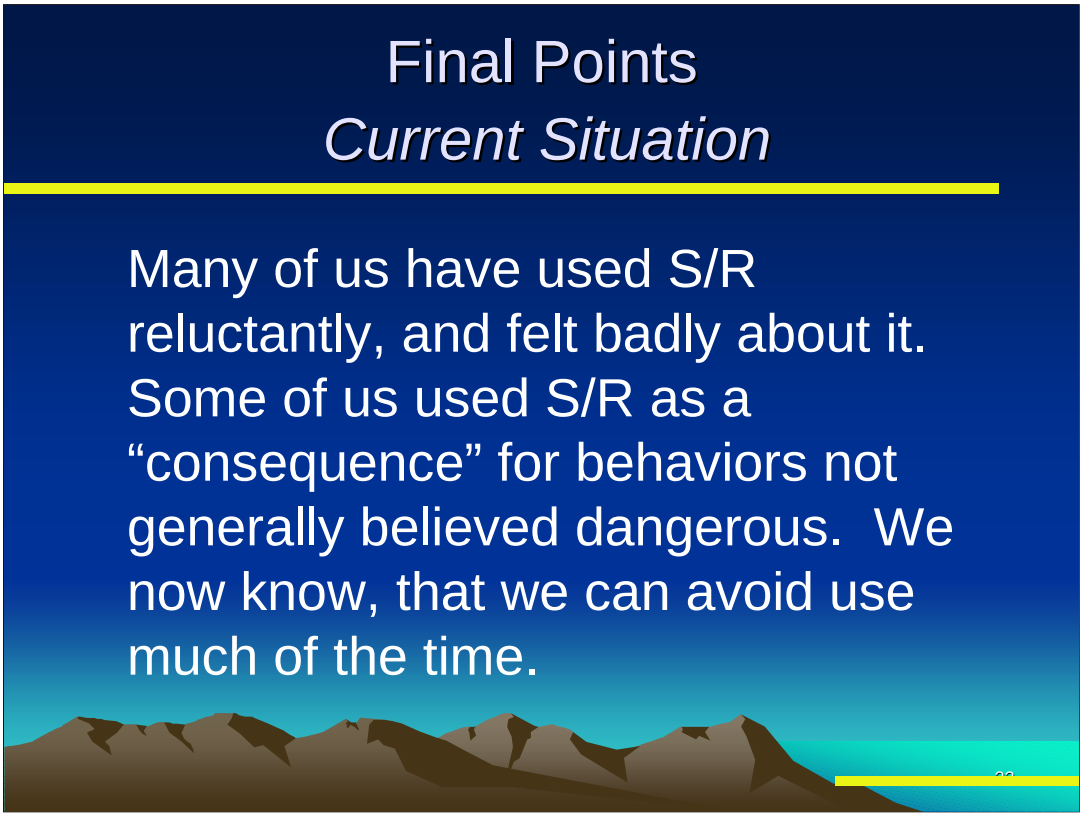
We also hold that while we are learning how to reduce the use of seclusion and restraint that if we really do have to use it, we use it as safely and briefly as possible.



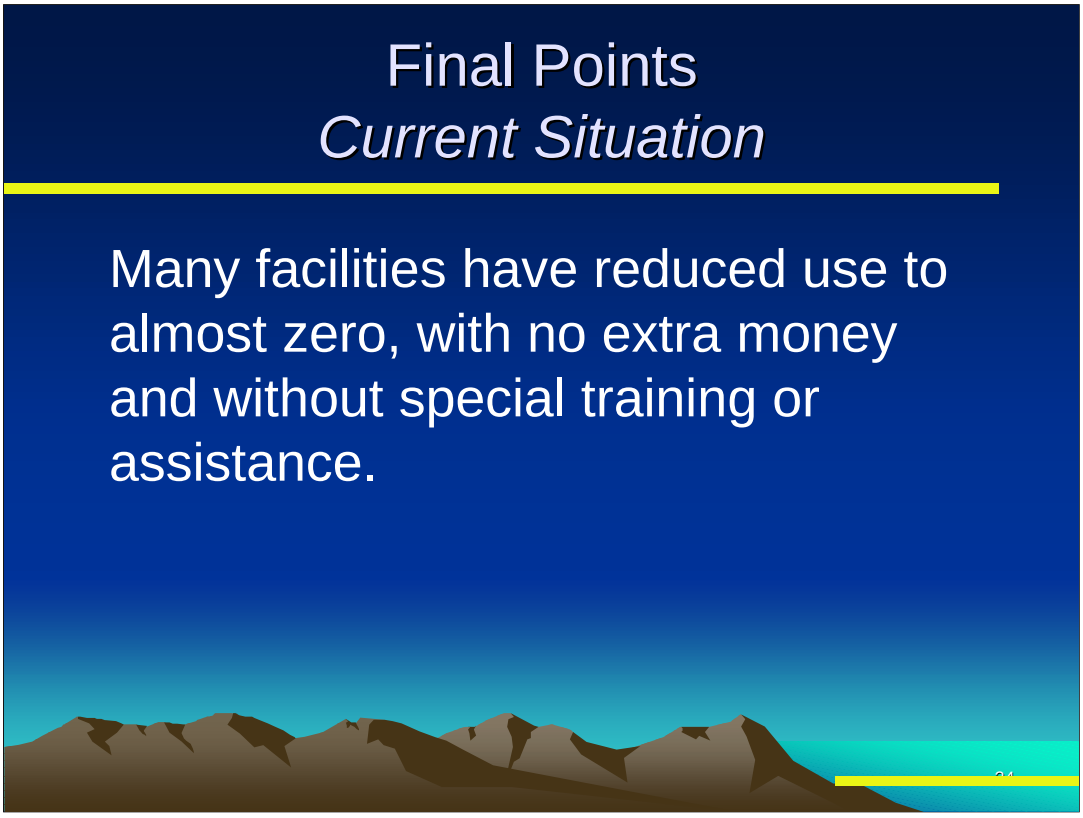
Final points: All of us currently work in mental health environments that are developed over time. Part of our inherited culture is the use of seclusion and restraint.



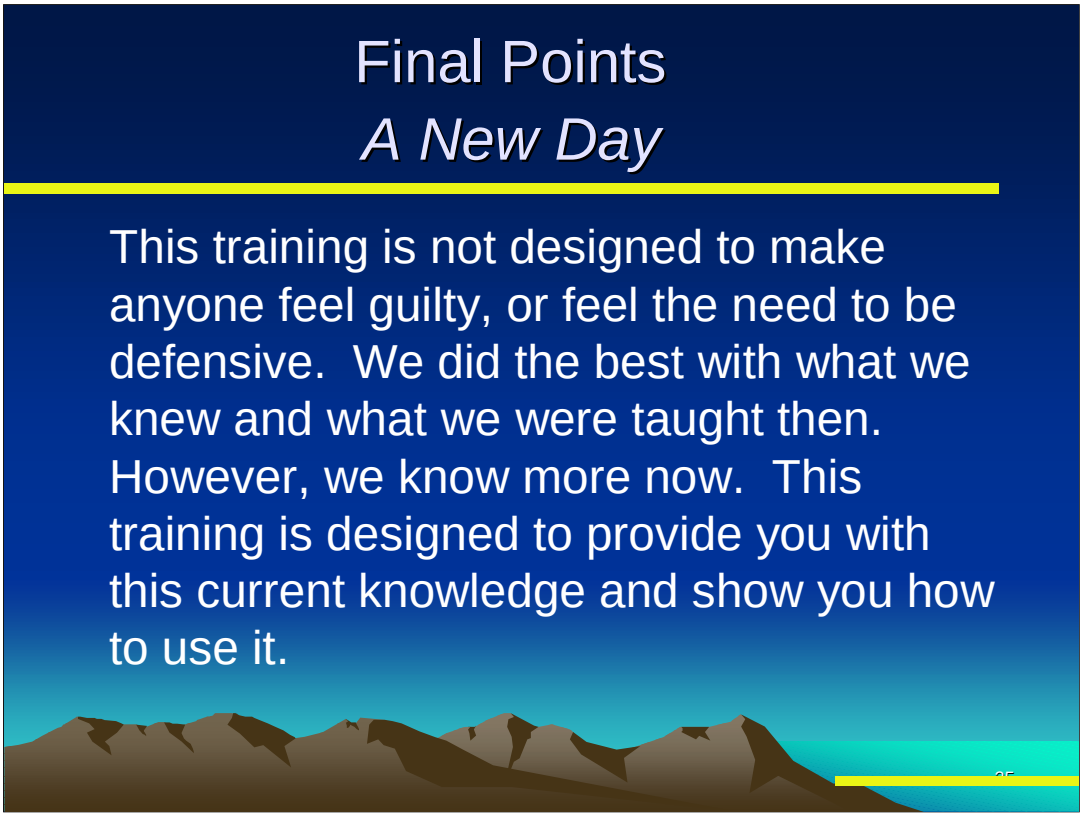
Most of us learn to use seclusion and restraint as a safety measure; some of us learn to use it as a therapeutic technique. We learned this from our teacher, our colleagues, our co-workers and our mentors. We learned that seclusion and restraint was necessary and it was a common and normal part of a daily routine of an inpatient unit.



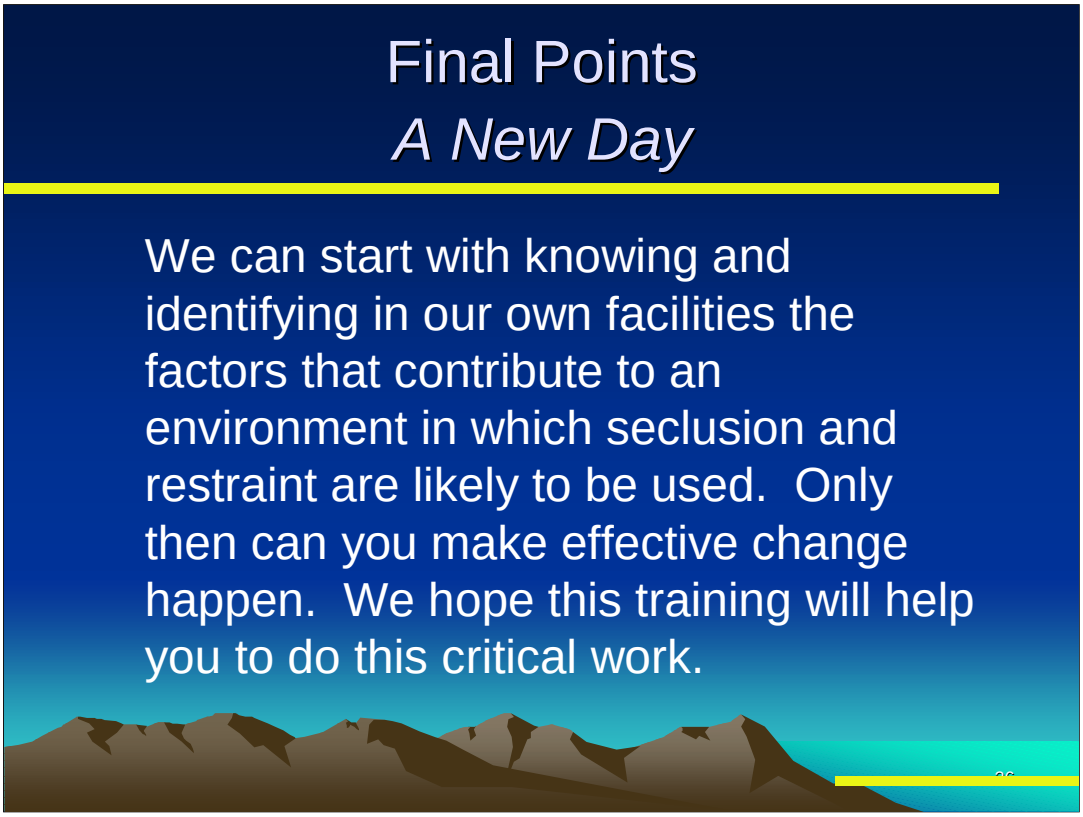
Some of us used S/R reluctantly. Some of us felt badly about using it. Some of us used it as a consequence for behavior when people didn't do what they were supposed to do. We now know that we can avoid this use much of the time.



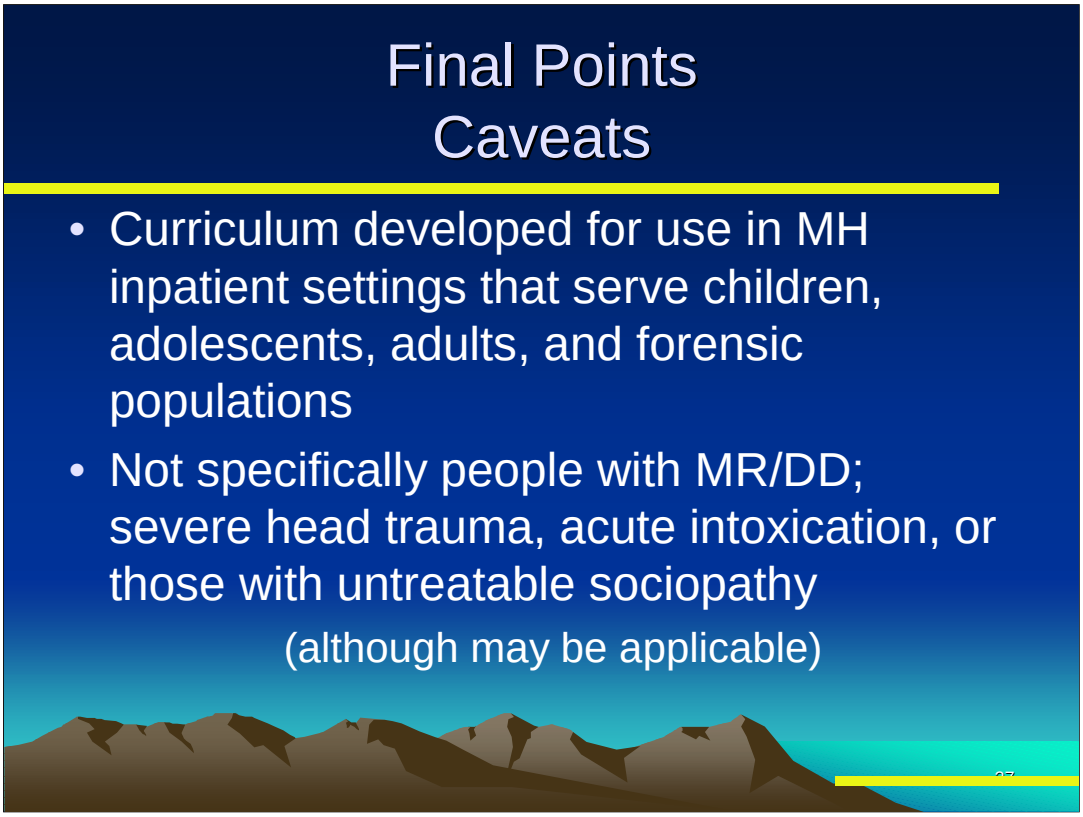
Many facilities have reduced use to almost zero with no extra money, no special consultants and no special kinds of training.



This training is not designed to make anyone feel guilty or feel the need to be defensive. It is really important that we try and keep an open mind and that we understand that we've done the best that we could; that our field has continued to grow like any other field in health care and, as such, practices change; clinical information changes and that we now know more. This training is designed to provide you with some of that new knowledge and provide you with the tools to make these changes, incorporate these into institutional practice. Again, nothing we present is meant to make anyone feel bad or feel guilty because we did the best we could with what we knew, then.

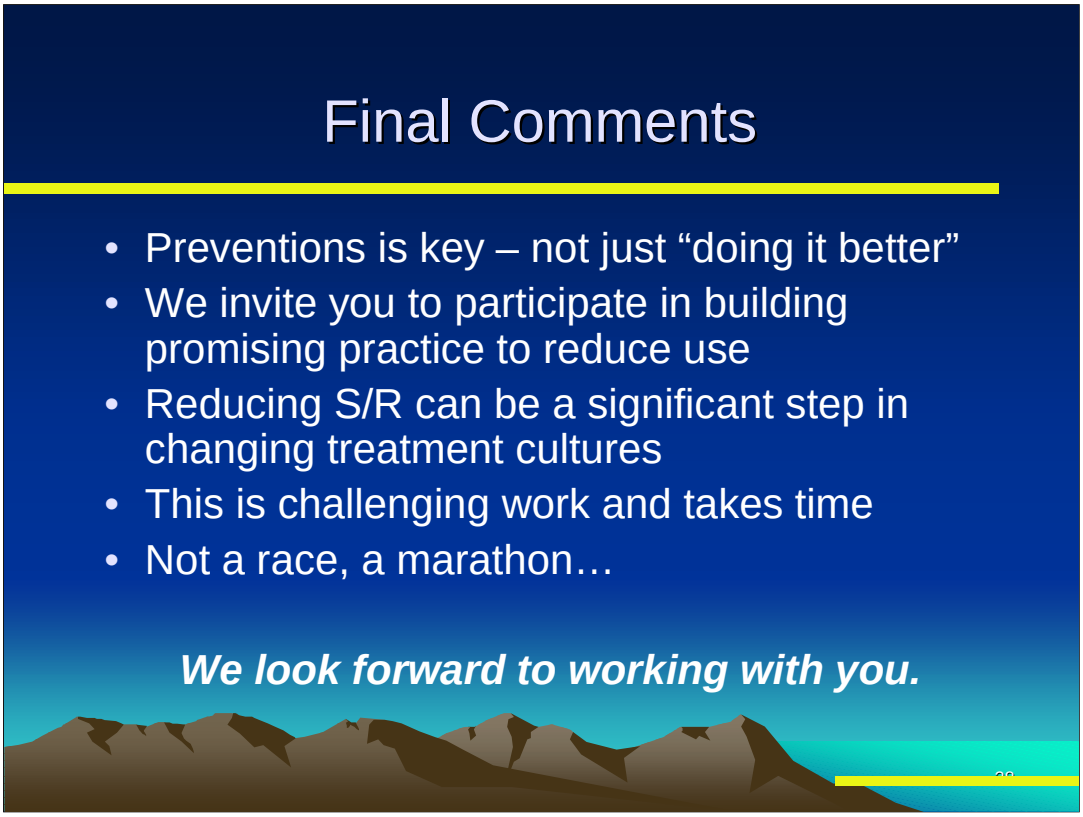


We can certainly start by identifying in our own facilities the factors that contribute to conflict and aggression and violence where seclusion and restraint are probably going to end up being used. Those factors in most cases very much under our control. Only after we identify these factors, can we actually make effective change happen to reduce these events. We hope this training will help you do this very critical work.



Some caveats: When we went to the literature and designed the curriculum there was not much about seclusion and restraint in the mental health literature. There is much more knowledge now and this training was developed based on literature, research and findings specific to mental health settings. There is still almost nothing in the literature regarding the use of S/R in setting that treat people with mental retardation, developmental disabilities, traumatic brain injury, intoxicated people with untreatable sociopathy. So when I say that this curriculum was developed specifically for people in mental health settings it was developed specifically for children, adolescents, adults and forensic populations in mental health facilities. But that does not mean that this information is not applicable.

We have over the last four years invited providers from these other systems of care to come in and listen to this training, to give us feedback and by and large, 9 out of 10 of those providers from these other systems of care said that this information was highly applicable and they are currently, in some cases, adapting it for their use. But I want it be make clear that it did not come from this literature outside of mental health.



Prevention is the key, not just doing it better. We invite you to participate in building promising practices to reduce use; this is cutting edge work and very exciting. Reducing seclusion and restraint can be a significant step in changing our treatment cultures and that again, this is a race (cannot hear the last few sentences)

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