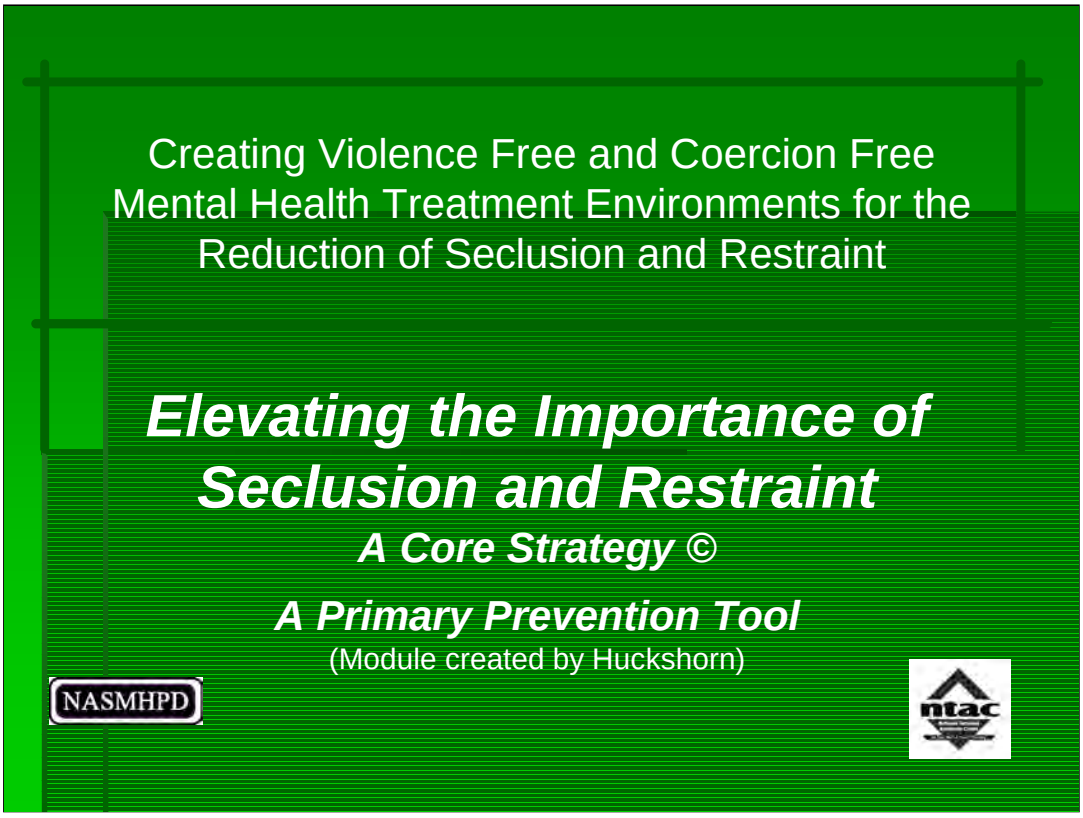


I would like to present now an interesting strategy or intervention called Witnessing, or elevating the importance of seclusion and restraint. This strategy used to be in the leadership module but it was too important, in the view of the NTAC faculty, so it has been separated into its own module.

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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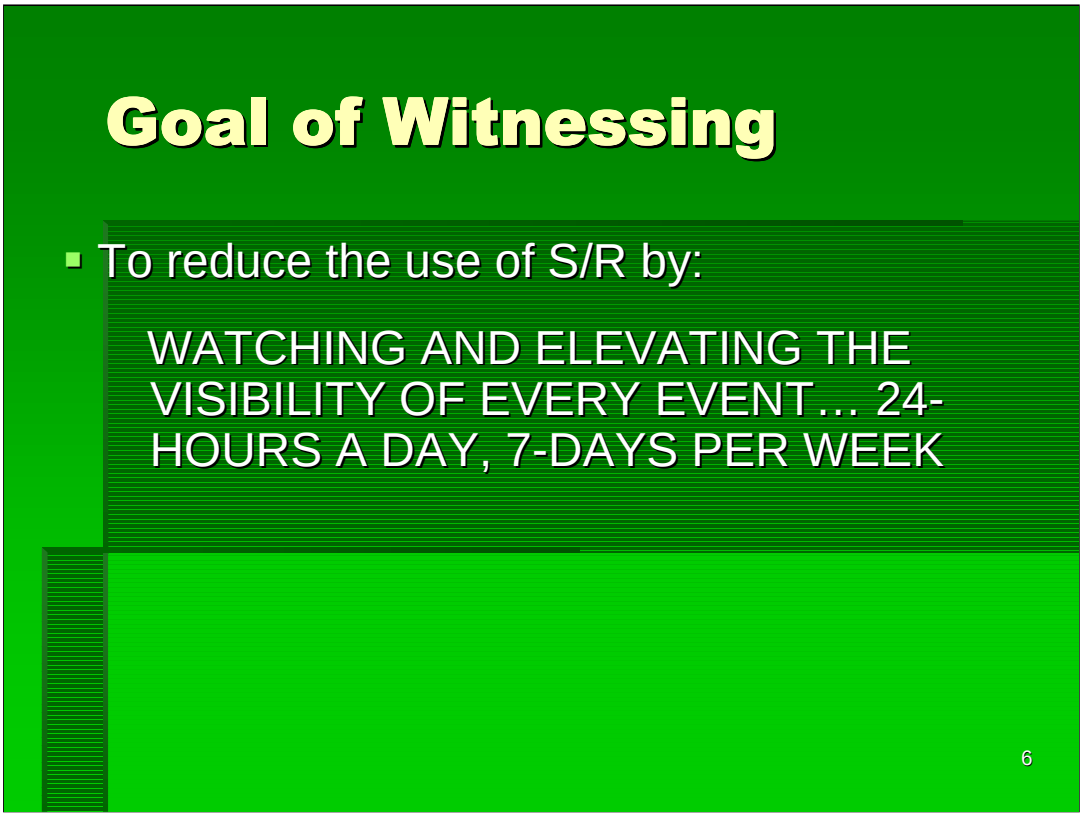
3

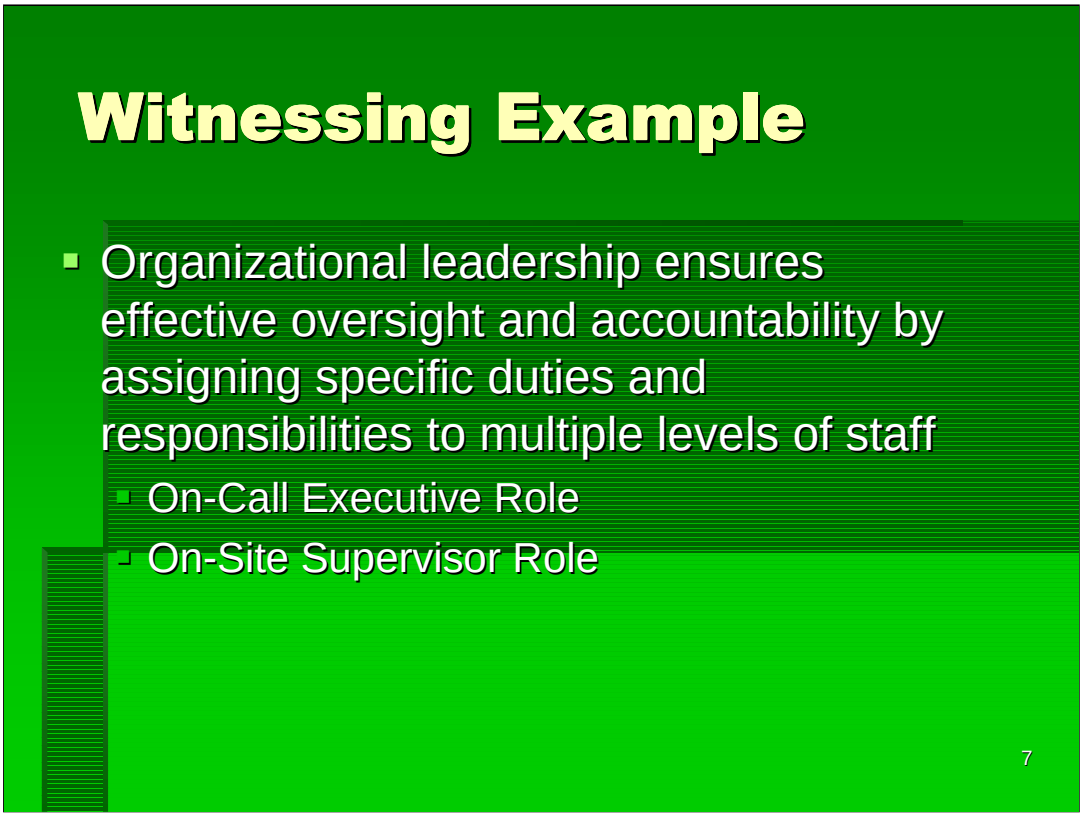

We see this as a very, very important strategy in terms of reducing seclusion and restraint for certain kinds of facilities. This particular module will include two sub-strategies under Elevating Oversight of Violent events. The first one is the witnessing piece and the second is the development of the workforce in elevating oversight.


"Witnessing" or elevating oversight, refers to the significant organizational changes in the level and importance of oversight, accountability, communication and the follow through that needs to occur after every event of seclusion and restraint.

I'm going to take a minute and mention, just because most of us have been in the field for a long time, that we need to relook at seclusion and restraint use as quite a significant issue. Our ability to use seclusion and restraint (which really means to deprive someone of their civil liberties) represents the HUGE power that we have in mental health settings. In the United States of America, it's probably the only time in our civilized society that someone can actually be deprived of their liberty without a police person present, a jury or a judge. So we, in mental health settings, hold an awful lot of power. And I think we need to think about that power when we think about seclusion and restraint.

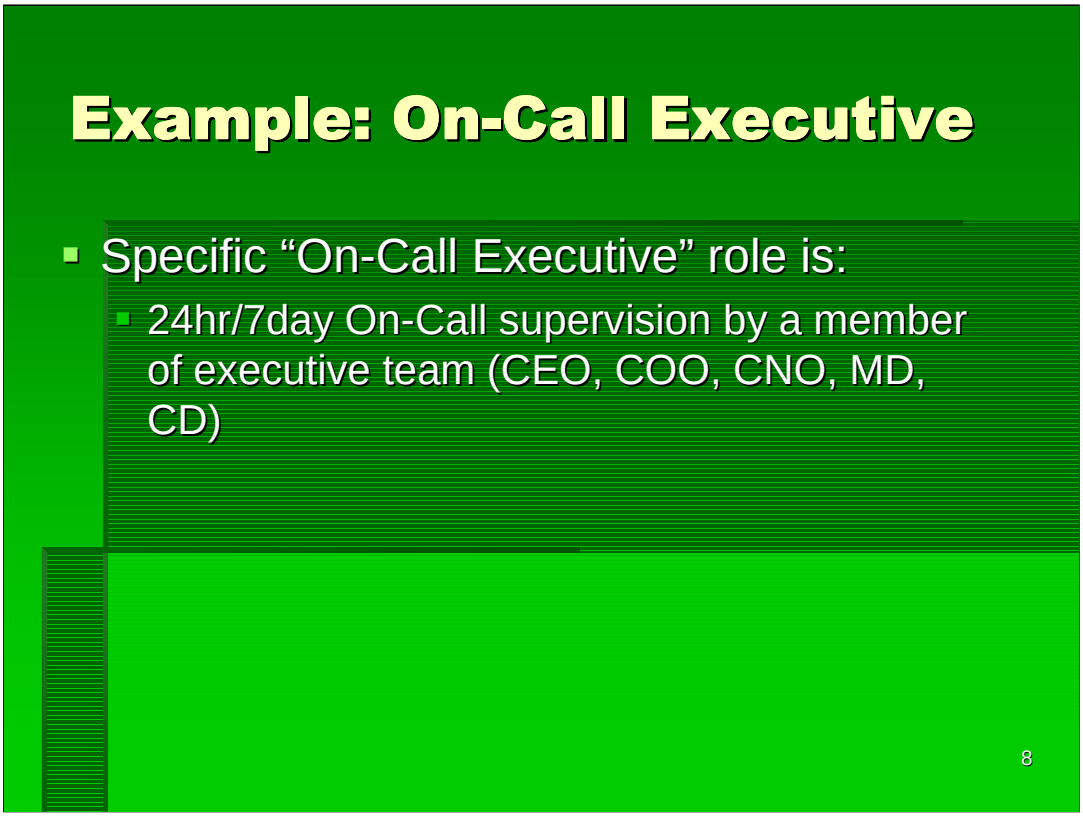



The goal of witnessing is to reduce the use of seclusion and restraint by watching and elevating the visibility of every event, 24 hours a day, 7 days a week. In the old days, if you will, these events would occur on different shifts and someone would write this event down, usually in an incident report. The incident report would be forwarded to administration; sometimes the event would be passed on in shift report, sometimes it wouldn't be. At some point that month or maybe every other month, or even every quarter, the quality improvement director would aggregate all the data and present it to the executive team or the PI committee. At this point in time the information would have become very homogenized and we would have lost all of the clinically significant and important facts that had surrounded each one of those events. We would no longer be able to be aware of the clinical issues or institutional issues that would have informed us about what had really happened and put a real human face on each and every event. This strategy changes that past historical practice.

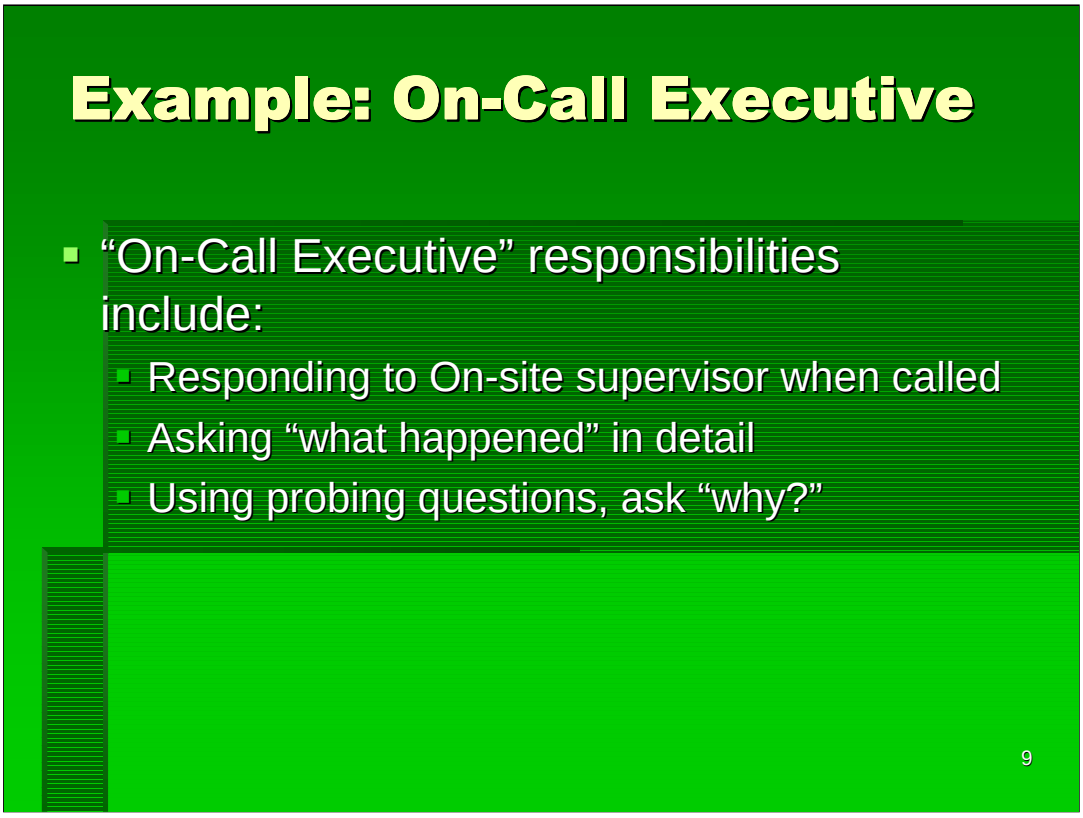



An example of what we mean by witnessing is that organizational leadership again, ensures that this occurs by assigning specific duties and responsibilities to multiple levels of staff throughout the organization. I'm going to talk most specifically today about the executive leadership role. Most organizations or facilities have an executive team, usually identified as the CEO, COO, the DON; sometimes the facility manager, the clinical director, the medical director and others. Facilities are very different, but most have an executive team who have overall responsibility for daily operations, policy, procedures, rules and staff accountability.

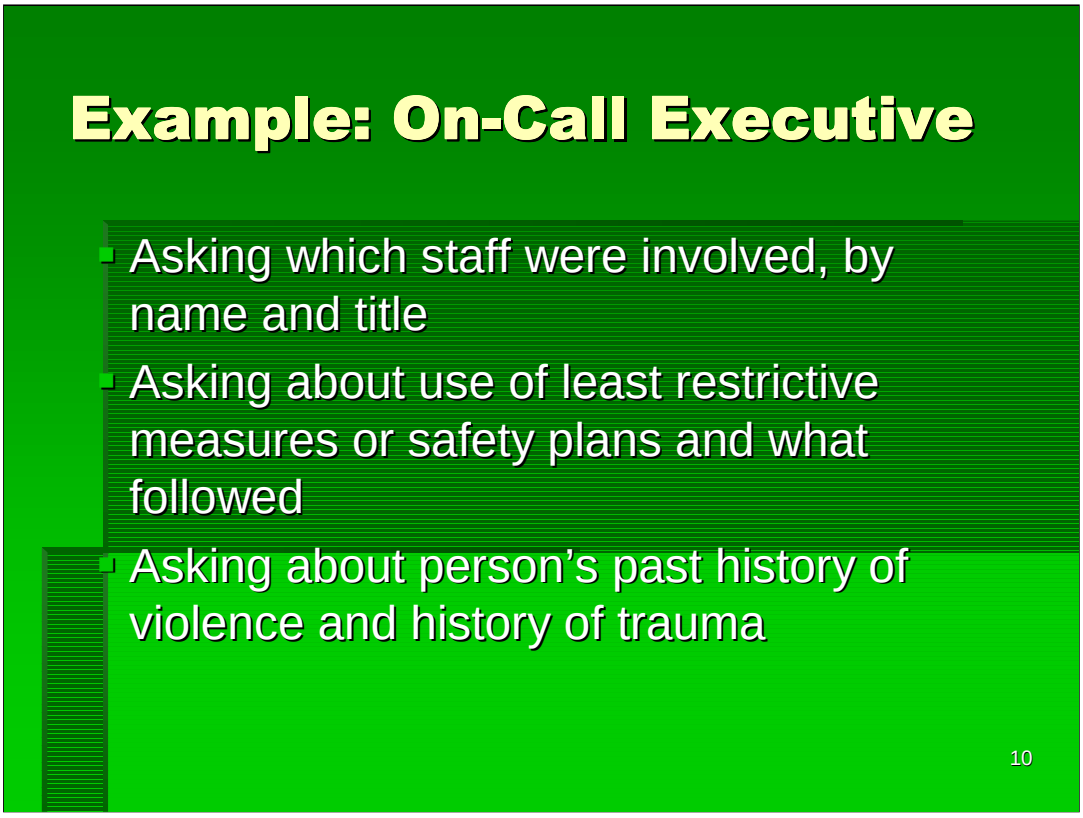
And this executive function includes the evening and night shift, on-site supervisors who are the people that run our hospitals/agencies for us on the off shifts, and on holidays and on weekends. And whether you're a hospital or a residential treatment facility or a group home, you usually have someone on site that's more senior than the rest and who's the person that's supposed to handle emergencies. So when I talk about on site supervisor role, that's the person we're talking about.



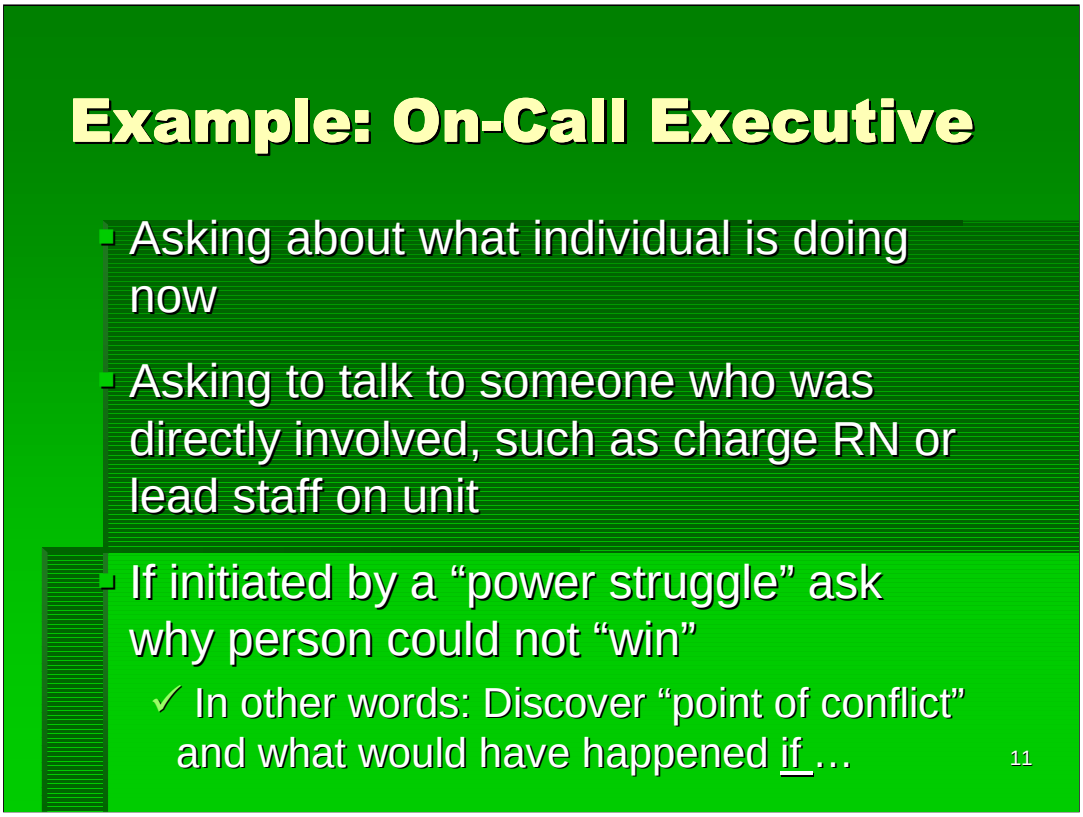

Specifically for the senior leadership team, we’re talking about assuring 24 hour, seven day a week oversight by a member of the executive team; an on-going, on-call list which we strongly suggest that you share with your colleagues, because if you give it to one person they will become exhausted in about four months. So it’s really helpful to have several people take turns, although you can do it in multiple ways.



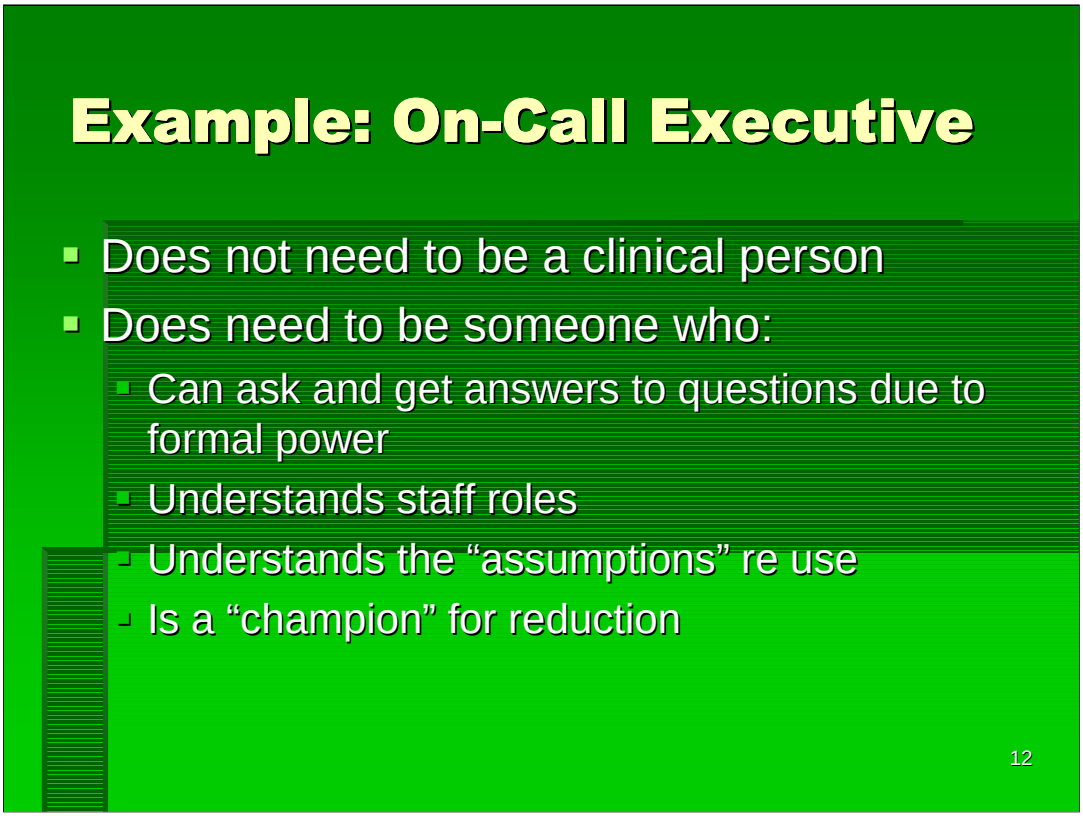

The responsibilities of this person is to be on-call and receive phone communications from the staff on the unit every time one of these S/R events occur, usually shortly after the fact. The responsibility of the on-call executive is to then ask the "why" questions to get the details of what occurred.




You will want to find out who was involved in each event by name and title. The reason I say that is again, you're wanting to identify what staff are constantly involved, what staff need training; what units are using these interventions more than others and you're starting to track for patterns of use. You want to find out if least restrictive methods were used and what these were. There have been several studies done to explore the understanding of non-licensed professional staff as to whether they really understand the term "least restrictive alternative." By and large, the findings have been that staff mostly understand least restrictive alternatives to be medication. So they may be lacking critical de-escalation tools and you need to find that out.

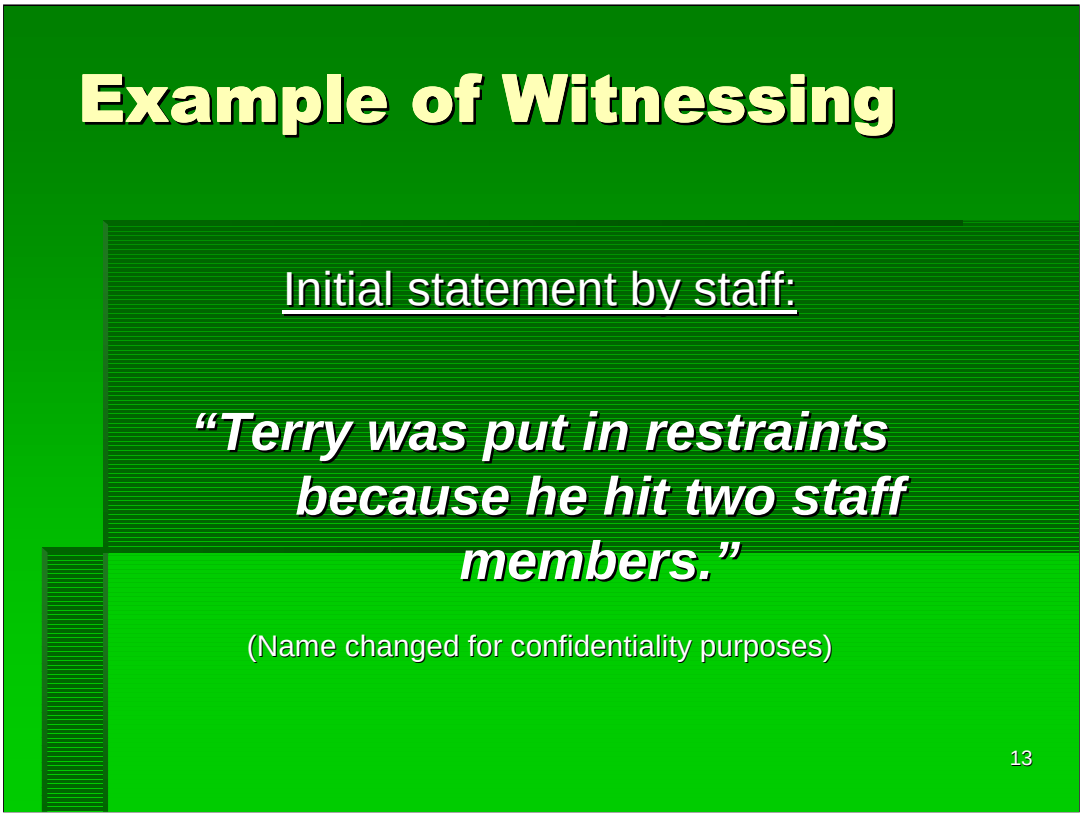



Also ask about the person who ended up in seclusion and restraint and if they had a past history of violence or other incidences of seclusion and restraint and was in the chart. Did they have a history of trauma? Ask what's happening with the person now and to obviously make sure that they're safe and also take steps to get them out of seclusion and restraint. Talk to whoever was in charge of the event. Find out what happened; if this particular conflict was part of a power struggle between staff and persons served and what was the point of conflict and as the executives start to think to yourself; could this resident have won? Could we have created a win/win situation here and what went wrong?

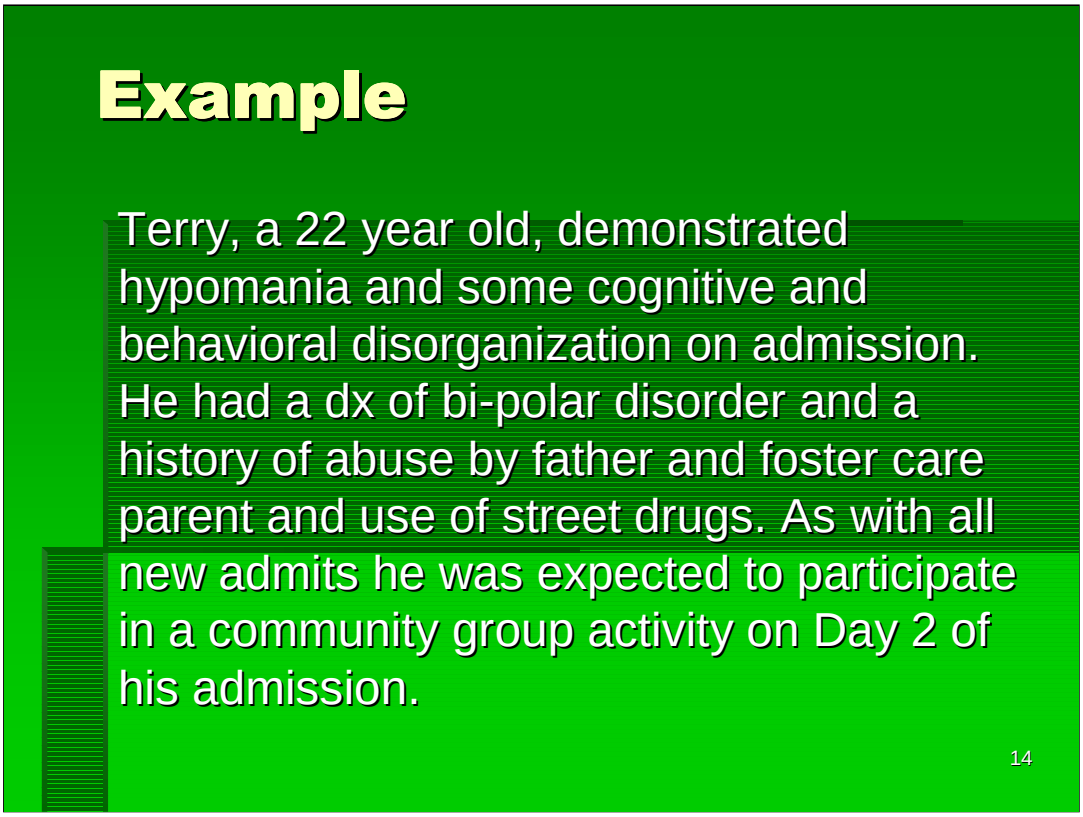



The on-call executive does not need to be a clinical person. In one facility, the person who had oversight over housekeeping and food services and grounds did an outstanding job because he approached this, not like a clinical person, but as a person with good common sense and he asked really good questions that a lot of us missed. It does need to be someone who is a champion of the initiative who really does see the importance of gathering this data in real time and how this can then speak to the policies at the facility and inform change.

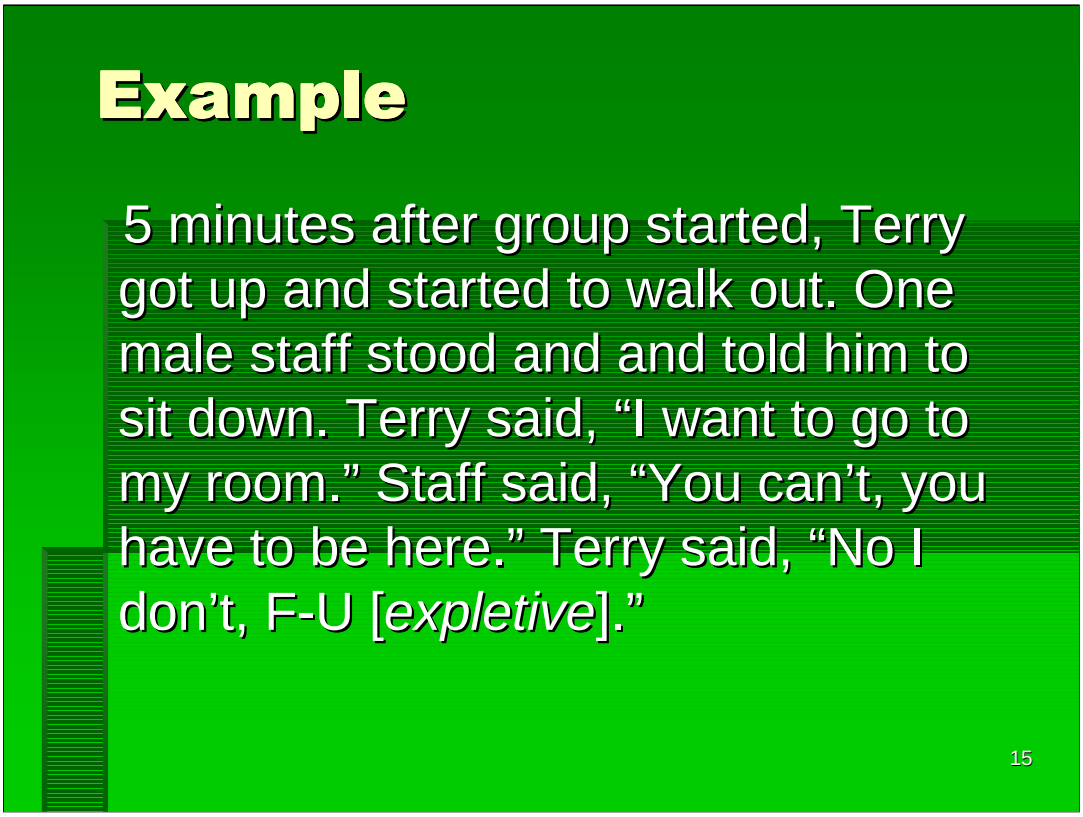
It also should be a person who understands all the assumptions that we have always labored under when we use seclusion and restraint and I’ll give you an example.



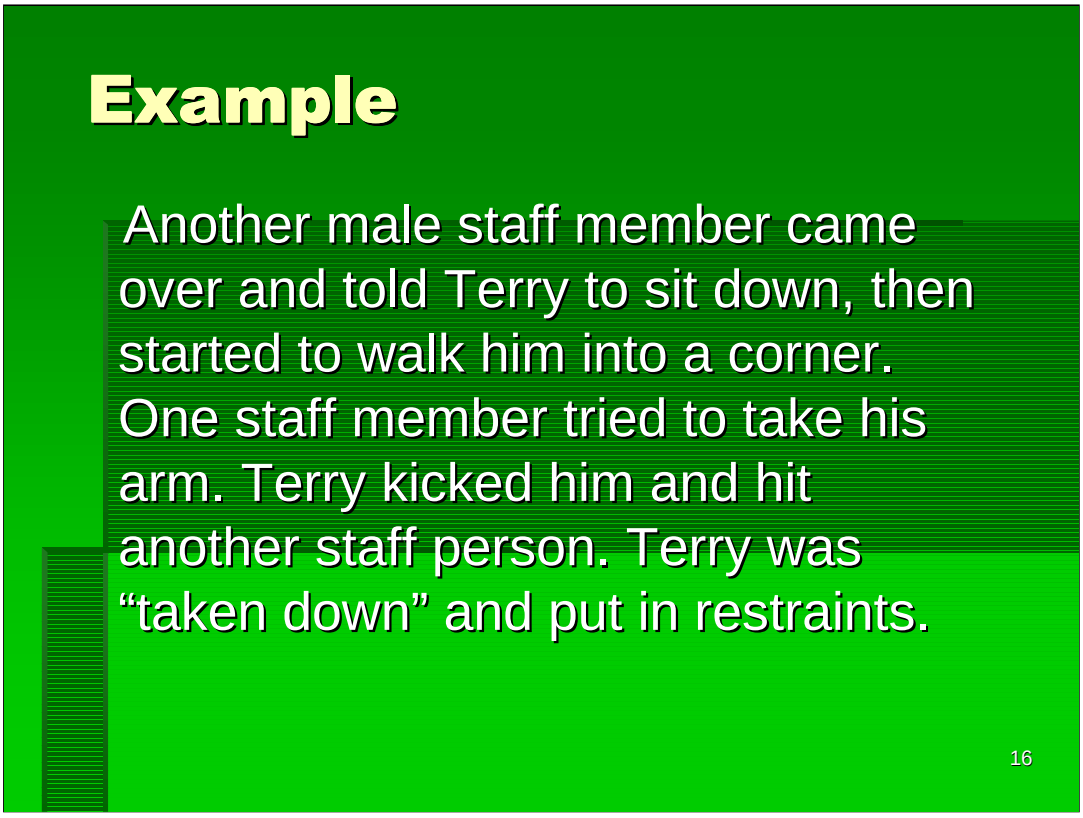

This particular example occurred in a real facility shortly after they started to use this particular intervention. The statement that was given to the executive on call was "We put Terry in restraints because he hit two staff members." That's a pretty common phrase; you'll see it on incident reports and you'll see it in medical records; that so and so did something and they hit, kicked, bit, threw and they ended up in restraints and often that's where our investigation stops.



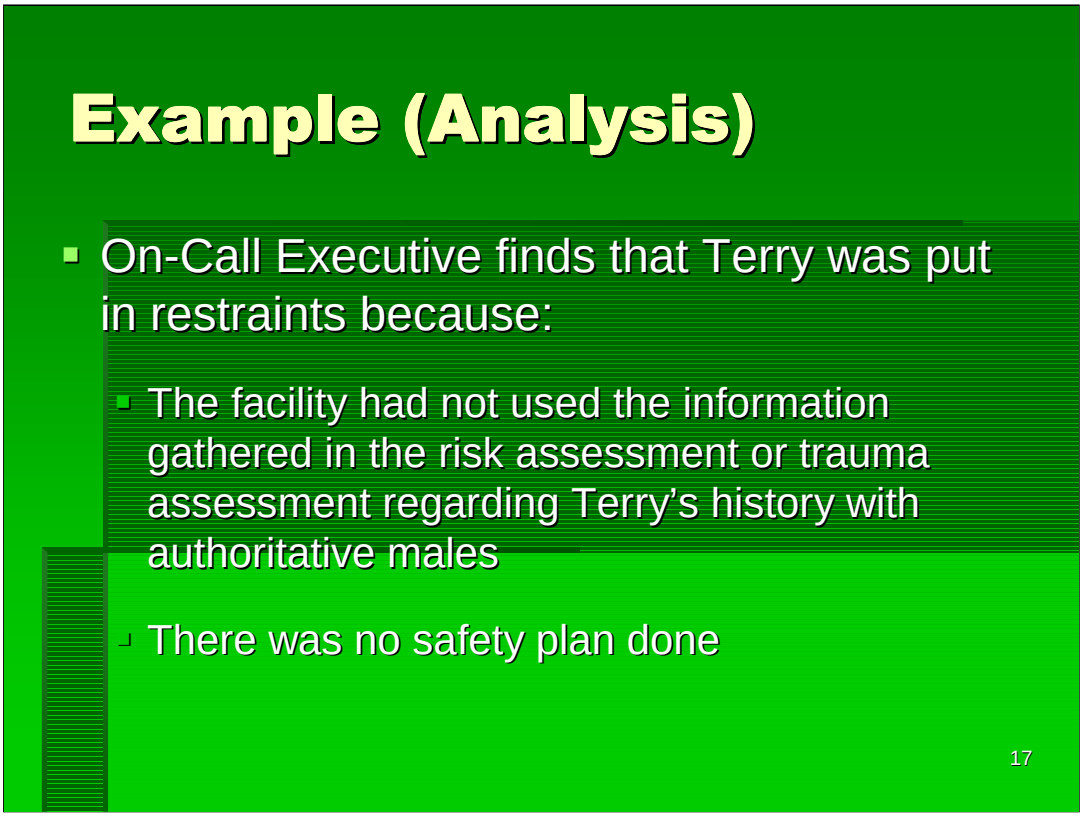

In this particular example, Terry was a 22 year old male, had just come in two days ago demonstrating some behaviors that looked hypomanic; he had been off his medication; he had some cognitive and behavioral disorganization, and by that I mean he had some signs and symptoms of psychosis. He had a history of bi-polar disorder and a history of abuse by his father and foster care parent (father). He also had some use of street drugs in his history. As with all new admissions in this particular facility, he was expected to attend and participate in a community group on the second day of his admission; it was the morning routine, everybody went to community group.



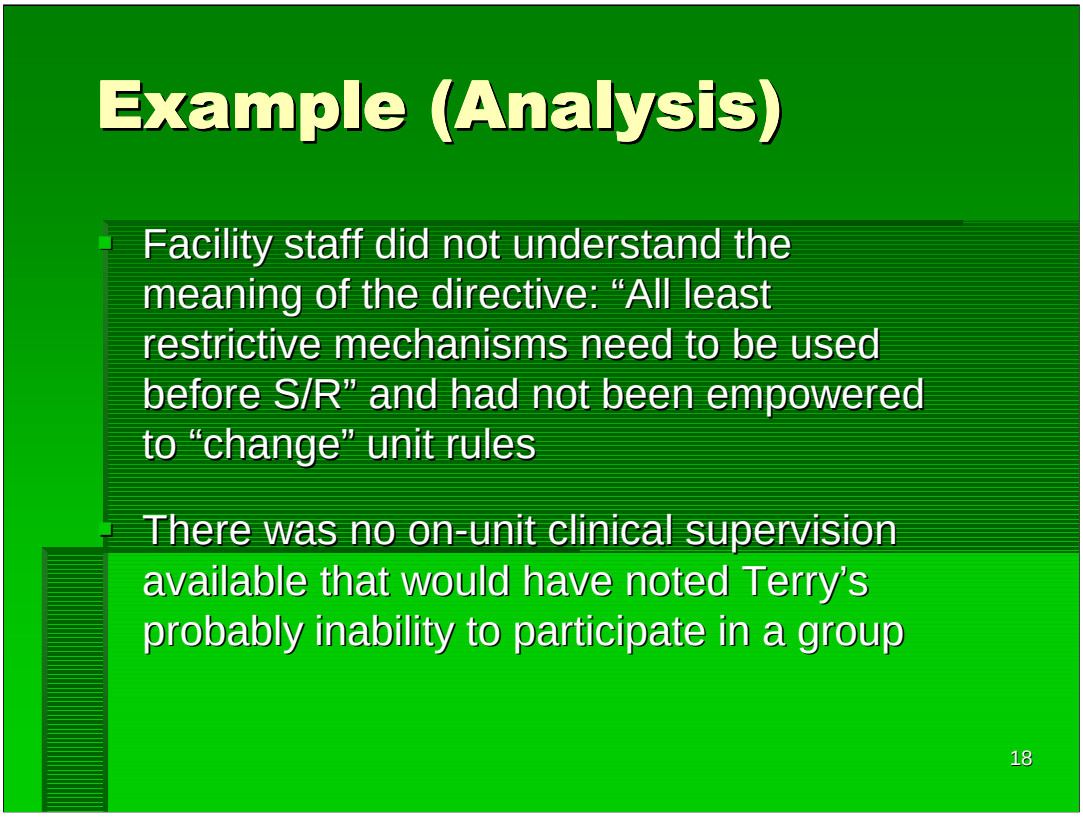

When he went to the group that day, five minutes after the group started he, of course, got up and started to leave and he told staff that he wanted to go watch TV and he didn’t want to be there. One of the male mental health workers, as they had been told, said “No, you can’t, everybody goes to group. The bedroom doors are locked; you have to stay in this room.” Terry said “No way, Jose” and a couple of other words and continued to try and leave the room.




At that point another male staff and another male staff stood up and started to back Terry into a corner. Terry struck out; kicked somebody, hit somebody; he was taken down and put into restraints.



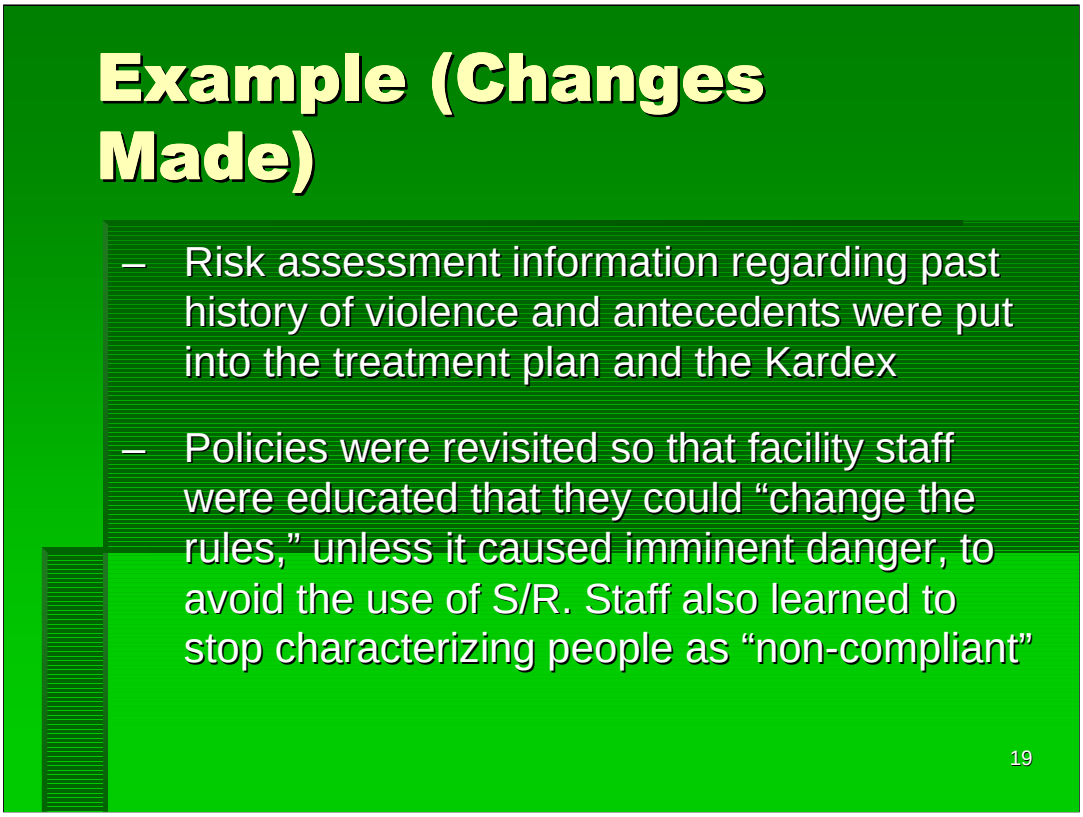

What the exec on call found, when the nurse called and made the report, was that we had in his history that Terry had a lot of problems with male authority figures. The executive team also found out that the safety plan that staff were supposed to be doing had not gotten done so staff had no idea about triggers that Terry could have identified and his family could have identified from past events just like this; in other words, shows of force by male staff.




This facility also found out that the direct care staff had absolutely no idea what we meant by this phrase “all least restrictive alternatives need to be used before you use seclusion and restraint”. It had become kind of a buzz word and therefore meaningless because the administration had never really concretized that particular phrase to have any meaning for the staff on the units.

Staff also had not been empowered to change any rules, so the staff were doing exactly what they thought admin expected of them. “This is the community group; this is the schedule of the day; these are the rules, no one can leave group because what in the world would we do if people started leaving group because then there will “chaos”. So staff did exactly what they had been told to do.

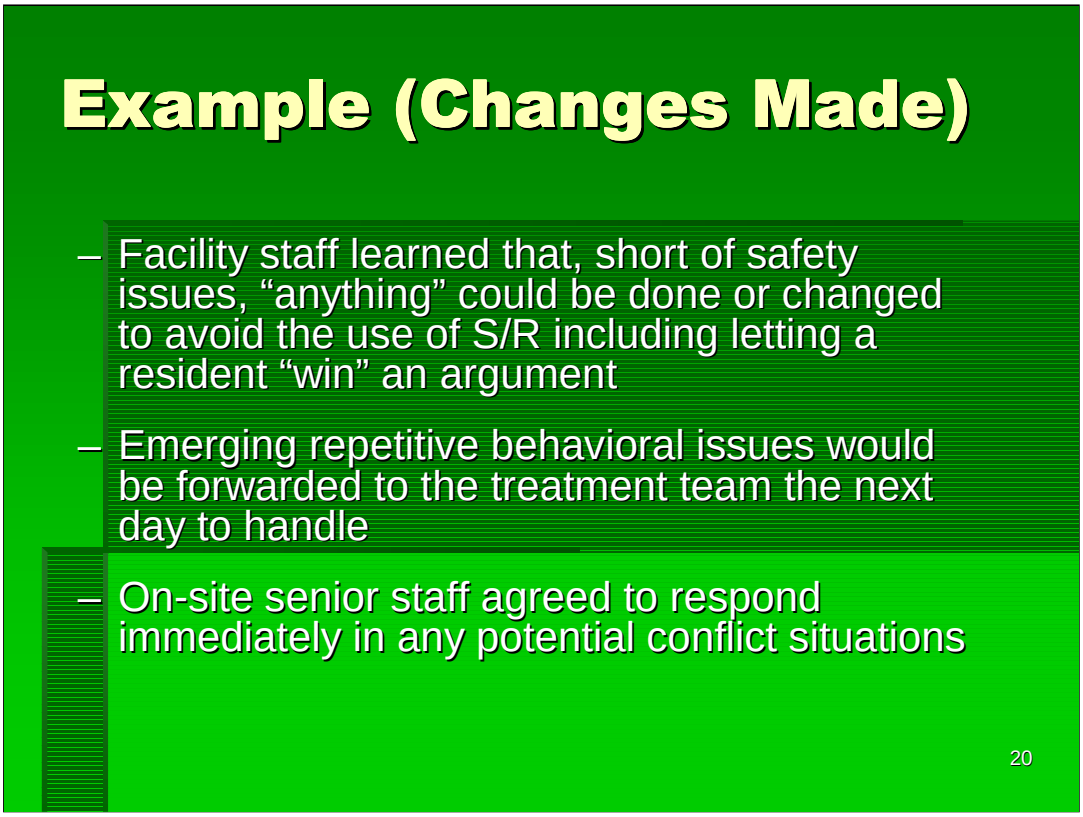
This facility also had not assured for an on-unit clinical supervision person that could have said to the unit staff, “Terry cannot possibly sit in a 30 minute group. He is experiencing symptoms of bi-polar disorder and hypomania and he just can’t. He’s demonstrating symptoms of mental illness and needs to have individualized approaches for the next few days.”




What this facility did, as directed by the exec on call was to make changes in organizational policy. To assure that the risk assessment information, gathered on admission, was not "just in the chart" but it made it out to the Kardex and, for certain high risk individuals, passed on in report, especially the first four to six days of their admission because they found that that's when a lot of their seclusion and restraint events occurred.

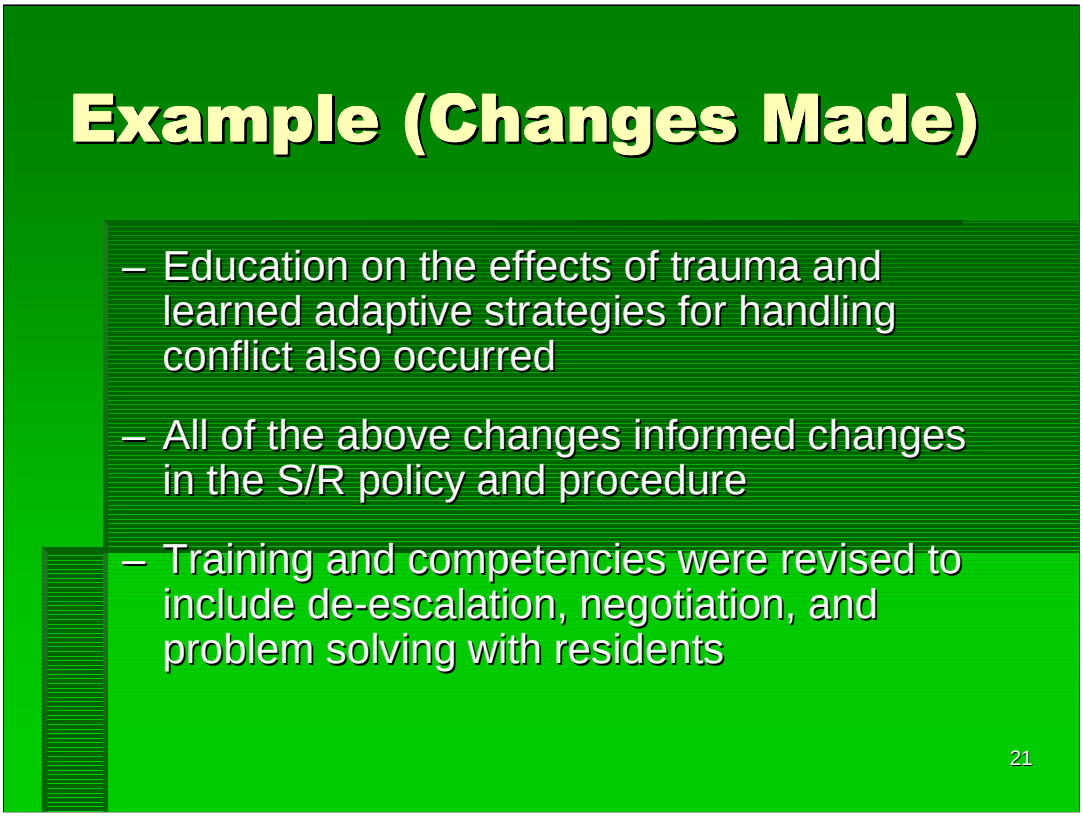
This executive team also revised their policies to assure that direct care staff were educated to negotiate and even change the rules if this would avoid S/R events unless it was an issue of eminent danger. Admin said "safety first, but within that let's get a little creative and if you think taking Terry out for a walk on the grounds because he can't sit in group, take Terry out for a walk. Let Terry go and watch some TV with you."

This executive team also noted that language was a potential issue. They started working on language because they noted, after some months, that a lot of folks were being characterized as "non-compliant."



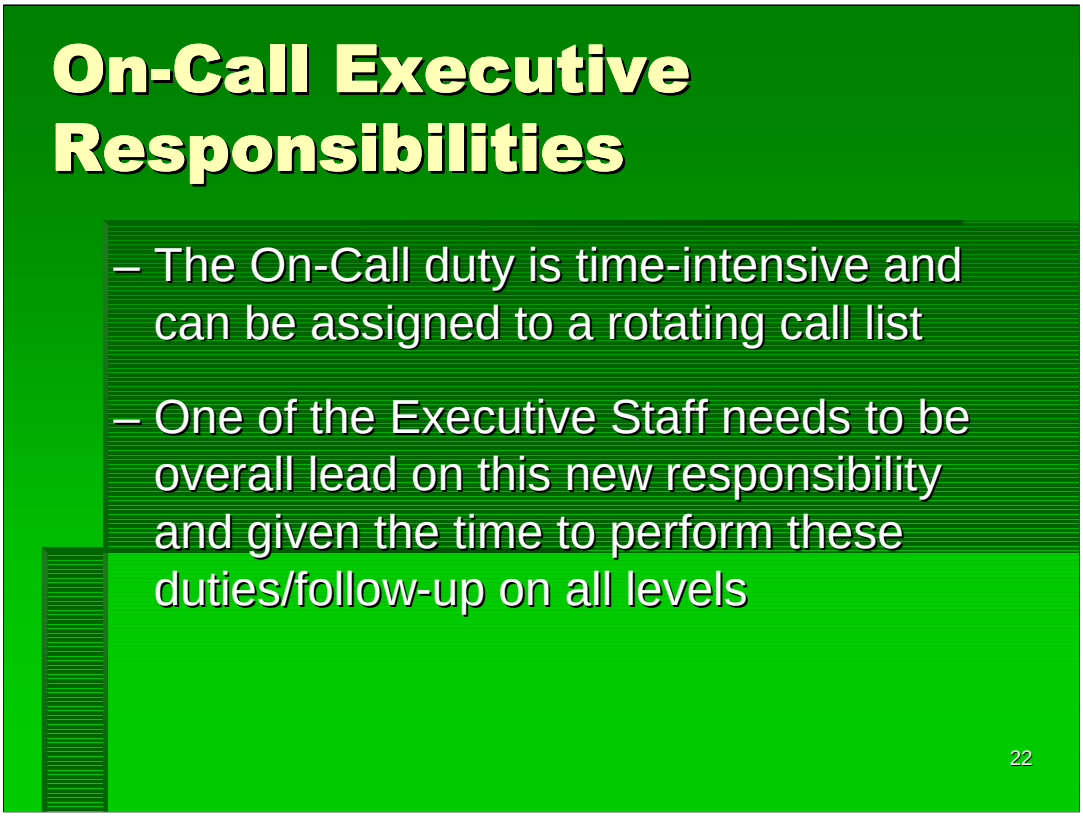

Facility staff also learned that short of safety issues, anything could be done or changed to avoid the use of seclusion and restraint including letting a resident win an argument. And herein lies another more covert phenomena and that is the fact that , somehow in some facilities, we have supported the belief in our staff that they “must win arguments.” That if they don’t, chaos will reign. When facilities started having rap sessions with direct care staff, they heard the following: “Oh my gosh, well if we do it for one person, the whole place is going to fall apart because everybody is going to start testing the rules.” So some facilities took this issue further and said, “Okay, let’s practice it, one unit at a time and if chaos starts to happen let’s address it.” What has been reported, to date in that everybody didn’t become oppositional and everybody didn’t become rule breakers. Everybody didn’t figure out that they could have a cigarette if they pretended they want to act out enough to be in seclusion and restraint. There were a few people that started some of that pattern; these issues were addressed in treatment team meetings and it worked out fine for those particular facilities.

Also important is to get your senior clinical staff who are on-site on the off hours to respond to all events. Usually you will have someone who is a senior clinical person but, often they do not necessarily respond to S/R events. Instead of just listening to the code over the intercom and calling sometime later to see if everybody was okay, we suggest raising all events of this nature to a response expected in the event of a cardiac arrest or a seizure. Frankly, S/R takedowns are very dangerous and you will never be able to predict who may have a very negative, physical reaction. So expecting everyone on site, especially the senior person on-site person to respond is risk prevention and very smart to do.




Facilities need to spend a lot of time on educating direct care staff on the signs and symptoms of mental illness and this kind of training needs to be memorialized in policy early in a staff person's hiring. Also important is to educate staff as to the effects of trauma and how resident behavior can replicate those experiences, based on their past lives. The kind of changes and activities, detailed above, were able to happen because an executive who was on call had the formal power, personal interest and incentive, and ability to change operational policy and procedures.

Staff training, by the agency, revisited required competencies and were revised to include attitude changes, and skills in negotiation, de-escalation, and win-win problem solving with residents.




Witnessing (or elevating oversight) is a very time intensive, staff intensive role. Sometimes we just suggest that you take it on for six months. Just be sure that you identify one executive staff person to do this and one who is very knowledgeable about staff roles on units. It may not work for you and it may not be nearly as valuable in your facility as it has been in other facilities. Some facilities mainly are taking care of kids and have a multiplicity of hold events. Depending on the size of your facility, say you have 20 or 30 events a week, you can't do this for every one of those. So prioritize the events that seem to be most significant; the child that has a hold six times in a week; any holds that result in injury or particularly violent, if you will. So prioritize them so you're really making this a meaningful activity.

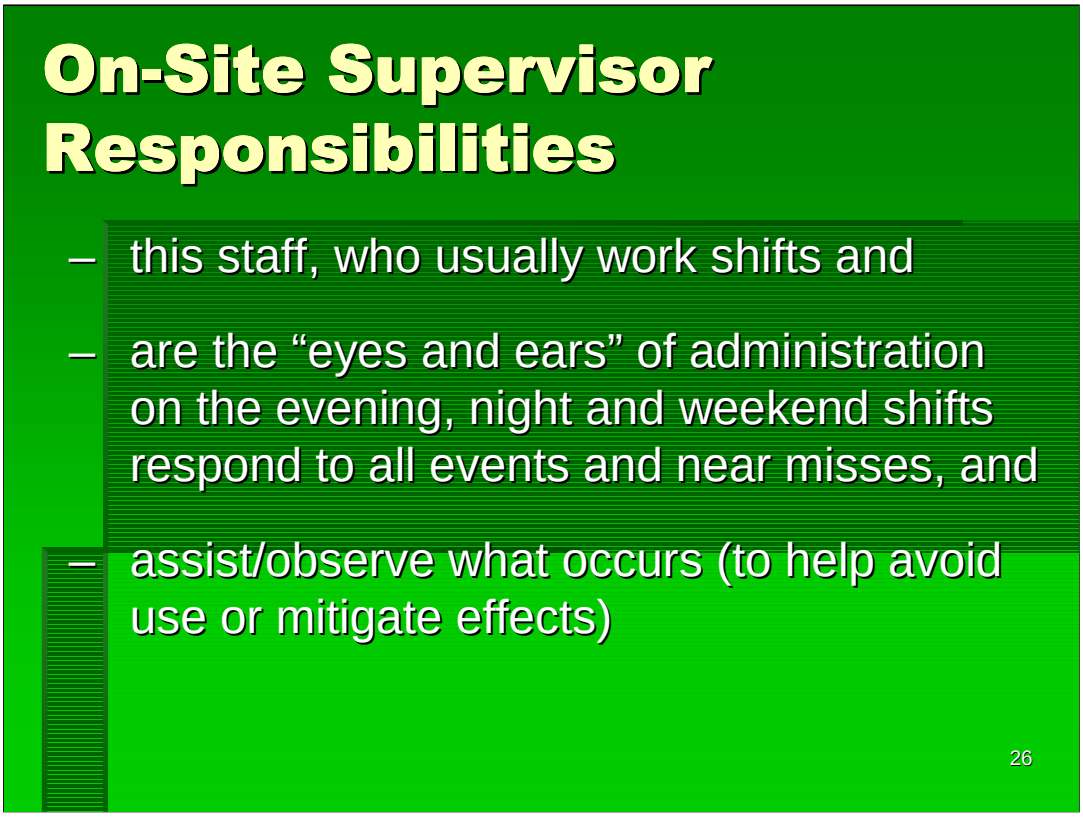

Unless grievous misconduct occurs,  and I'm talking overt staff abuse that at least in my experience has been relatively rare, these event reviews need to be handled in a non-punitive way and as a learning process.  Again, your staff will watch you because if you do this and they hear you're going to do this, folks immediately become very nervous and they think you're kind of trying to look over their shoulder. Instead the message need to be that you, as the administrator on call, is saying " I know we're trying to work on this project; I want to participate in this project.  I don't want to be an administrator who just directs you all to go do this and let me know how it's going.  I want to know what's happening.  I want to be there to support you and I want to basically have you give me feedback in real time ways."

I'm sure you all know this; you've been in management positions for years. However, emerging patterns of behavior for sometimes a very few staff in your facility need to be dealt with the way you decide when that reaches that threshold.


Also important, we need to reward staff for best practices and “near misses.” We do not do this kind of reward behavior enough. Rewarding staff for best practice, by awarding a certificate for their file, giving a free lunch or lunch with the CEO goes far to encourage staff to get on board.

Seclusion and restraint also needs to become a standing agenda item wherever you have a meeting. Whenever you have your typical staff meetings; town hall meetings; unit meetings or the meetings that the after hours staff may have, talk about this, get it on the agenda even if it’s just a few words.


Now I’m going to go to the next level which is the on-site supervisor responsibilities and again, that could be a nurse; senior clinician, or senior unit manager on some of our residential treatment programs. These staff are expected, by you, to respond to all conflictual events like it is a cardiac arrest or other medical emergency.



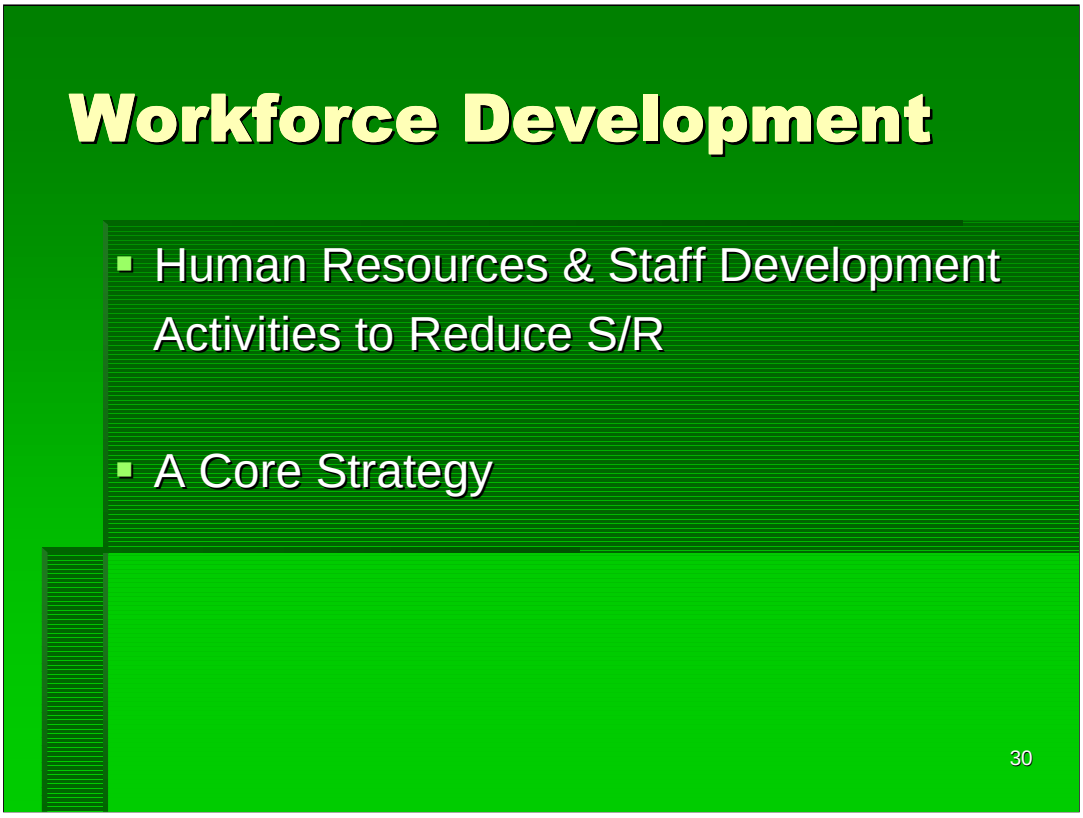

Again, these staff need to become a big part of this process, because they are going to respond to this event on site and in real time. You are asking them to be the eyes and ears of administration. These staff usually work shifts; the people you leave in charge on weekends, evenings, nights and holidays. They need to respond and be there to assist in takedown events and observe what has happened to both return the milieu to pre-crisis and also to be sure that everybody is safe.


Specific responsibilities for on-site supervisors include leading the post-event or post-acute informal debriefing. This can be done in a variety of ways where if I’m the nurse going up to the unit, I’m going to come in; I’m going to try to touch base with everybody that was involved, staff and the person served and the person who is in seclusion and restraint, make sure they’re safe, gather that information, make sure your documentation requirements are being met and make a good attempt to interview the adult or child involved.


I am also, in this role, going to review the Kardex (if there is one), review the treatment plan to see if triggers or safety interventions are listed, look at risk factors and generally gather information about the event with the goal to avoid any more events.

Also these supervisors need to be alert for post-event feelings of shame, anger, fear which sometimes staff try and cover up that are definitely experiencing and often sometimes the people that we see are event absorbers


The on-site supervisor must report to the on-call executive (to close this loop) and also passes this off in shift report. Facilities need to create a process so that shift report goes right back up to administration on the following day. Some facilities have implemented a daily debrief if any seclusion and restraint events occurred in the morning for 15-30 minutes, just to make sure someone is following up on that, and this is the function of the CEO, to make sure this occurs.

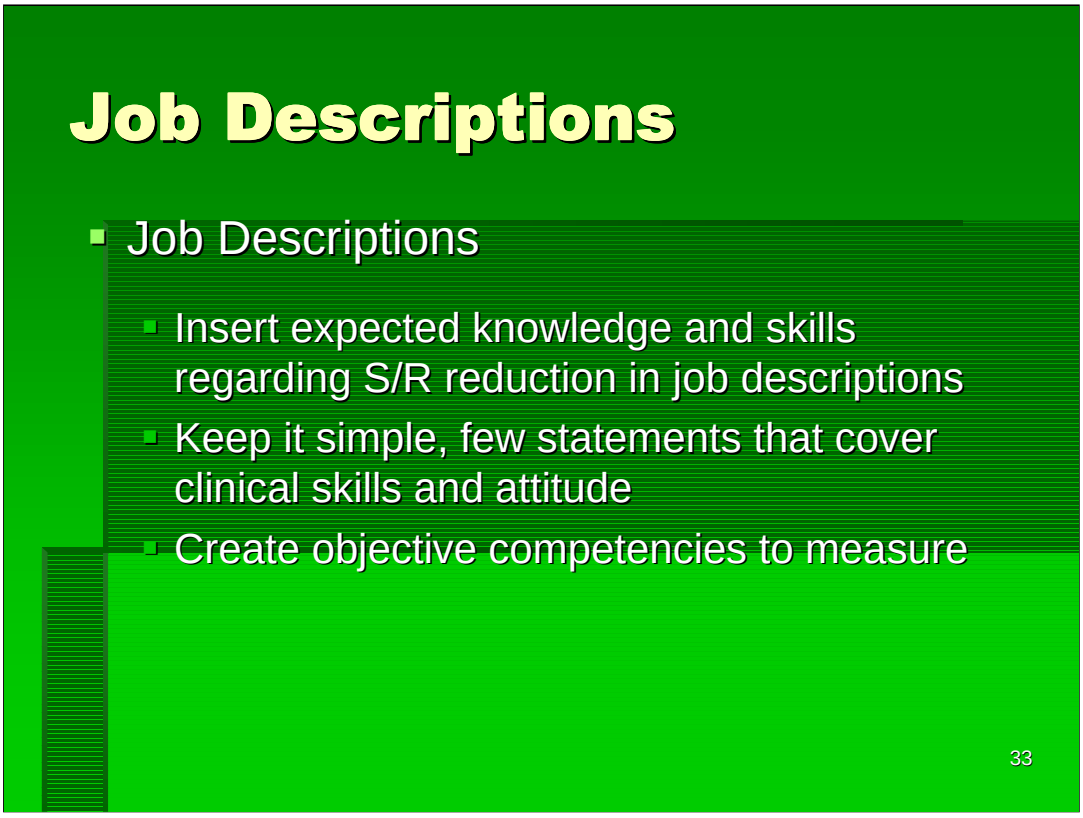



**Part Two of Elevating Oversight: Workforce Development**

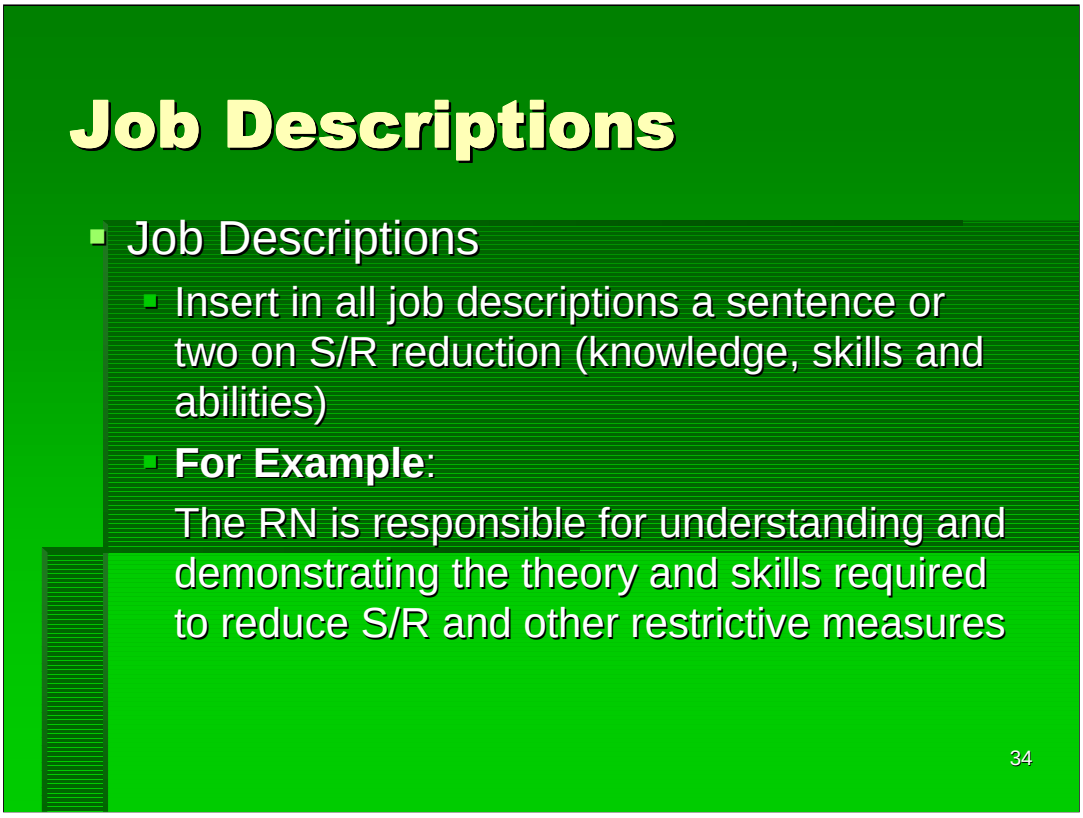
For this part, write PART II as it is not in this slide. PART II of this particular module, all having to do with elevating the oversight of seclusion and restraint, has to do very specifically with workforce development. This is the first module of two that we're going to have that's very specific on workforce development.


What we suggest here is the involvement of your Human Resource Department and/or your Staff Development Department to participate in helping to actively reduce the use of seclusion and restraint. This strategy talks about how we integrate seclusion and restraint reduction by very specifically and thoughtfully working with HRD to insert this particular expectation into new hire procedures; job descriptions; competency evaluations; performance evaluations and new employee orientation.

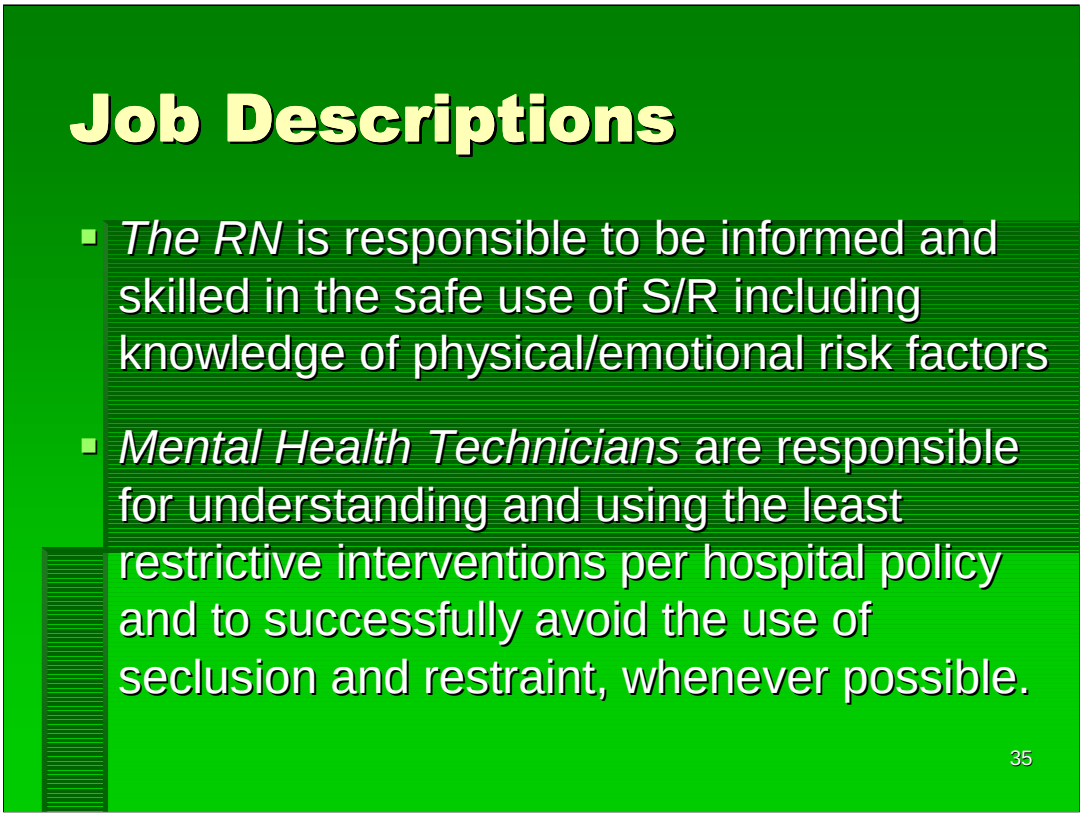

For instance, in the new hire interview, when potential applicants come in, take a minute and talk to a perspective applicant. Ask them about their past use and training in using seclusion and restraint. Find out which other settings they've come from because all of our people are coming from other settings and they've learned very different values; that sometimes they're coming from criminal justice or the prison system. Sometimes they're just coming from very different places and we need to find out what they know about this issue. We need to basically talk to them about if they're willing to work in a facility that's actively trying to reduce seclusion and restraint. You usually know pretty quickly if there's a fairly good fit.




In job descriptions, insert a few lines that communicate to staff, in the job description (which is their kind of contract to do work for you), what knowledge and skills you expect from them regarding seclusion and restraint reduction; a few statements and then create some competencies to measure that. Make this simple and clear regarding the facility's expectation that all skills be used by staff to avoid S/R and that any suggestions are welcome.

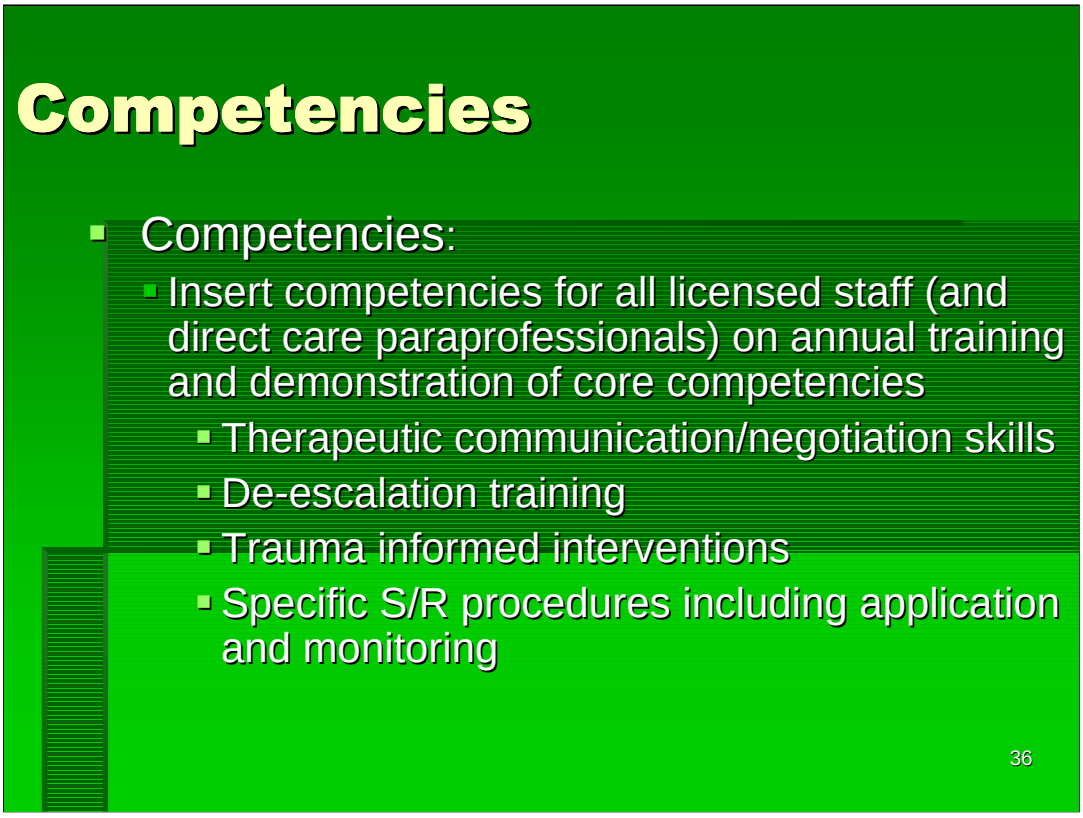



In job descriptions specifically talk about RN and mental health tech expectations, whatever staff that you have in your particular facilities, you can adapt to this. We talk about, for instance, the knowledge, skills and abilities that a registered nurse would need to help this initiative be successful. So for example, the RN is responsible for understanding and demonstrating the theory and skills required to reduce seclusion and restraint and other restrictive measures.

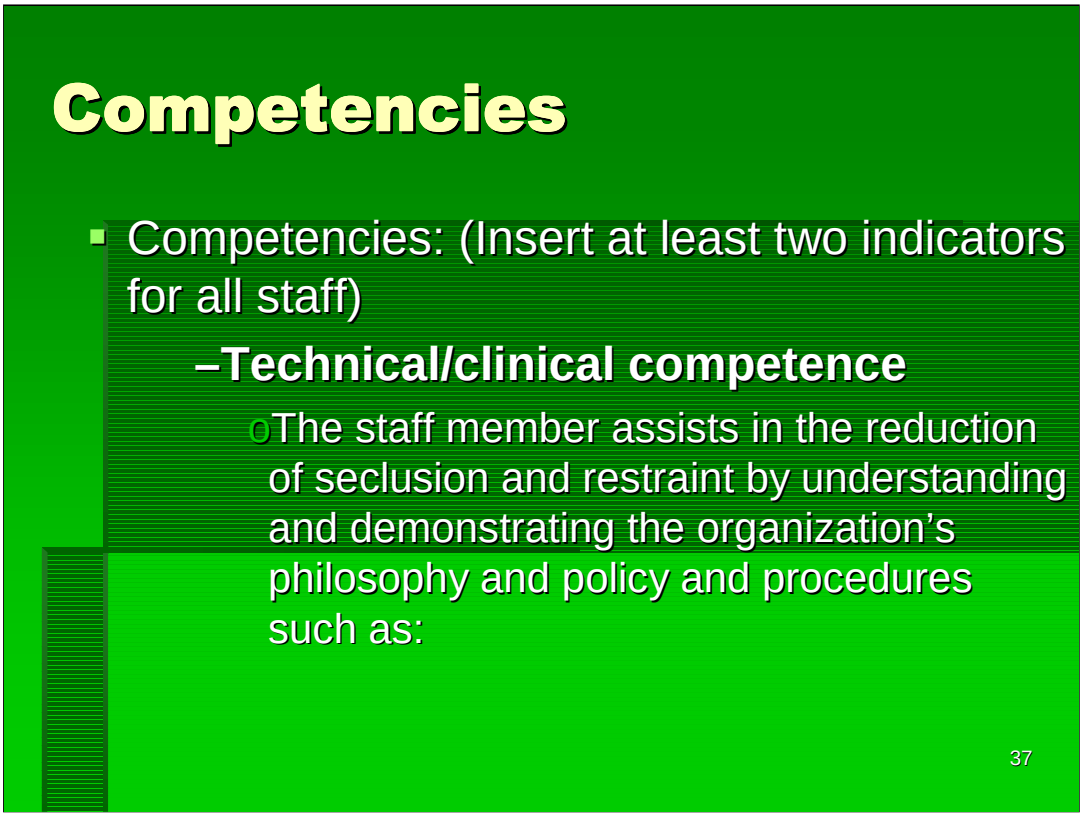



Another example is that the RN "is responsible to be informed and skilled in safe use of seclusion and restraint, including the knowledge of physical and emotional risk factors." Mental health technicians "are responsible for understanding and using least restrictive alternatives per hospital policy to avoid the use of seclusion and restraint."

Typical kinds of statements you find in job descriptions. We've seen this work in facilities that have a lot of union involvement, as well as the facilities that don't, and there are sometimes ways around this. If your job descriptions are mandated through the state and you're not allowed to change them, you can do this as an addendum, a workforce agreement that everybody signs.




Then basically follow that up, those job description expectations, with some measurable competencies. When we talk about competencies, I pretty much talk about things like that are demonstrable; such as the ability to role play or demonstrate communication and negotiation skills; de-escalation skills; what are trauma informed inventions, things like the overt wearing of clanking custodial key rings; the way language is used in the facility; the noise level, how people talk to one another and you can start this very slowly and not be real sophisticated about it; just start the process.




When we talk about competencies also I like to make the point that we talk about two types of competencies with regard to seclusion and restraint. One is technical/clinical competence and there are some examples here.

# Competencies

- **Technical/clinical competence(Cont.)**
  - Stating that “The use of S/R demonstrates treatment failure”
  - The development and use of safety plans
  - Demonstrate crisis communication skills
  - Use trauma assessment info
  - Knowledge and use of risk factors
  - Creative use of less restrictive alternatives

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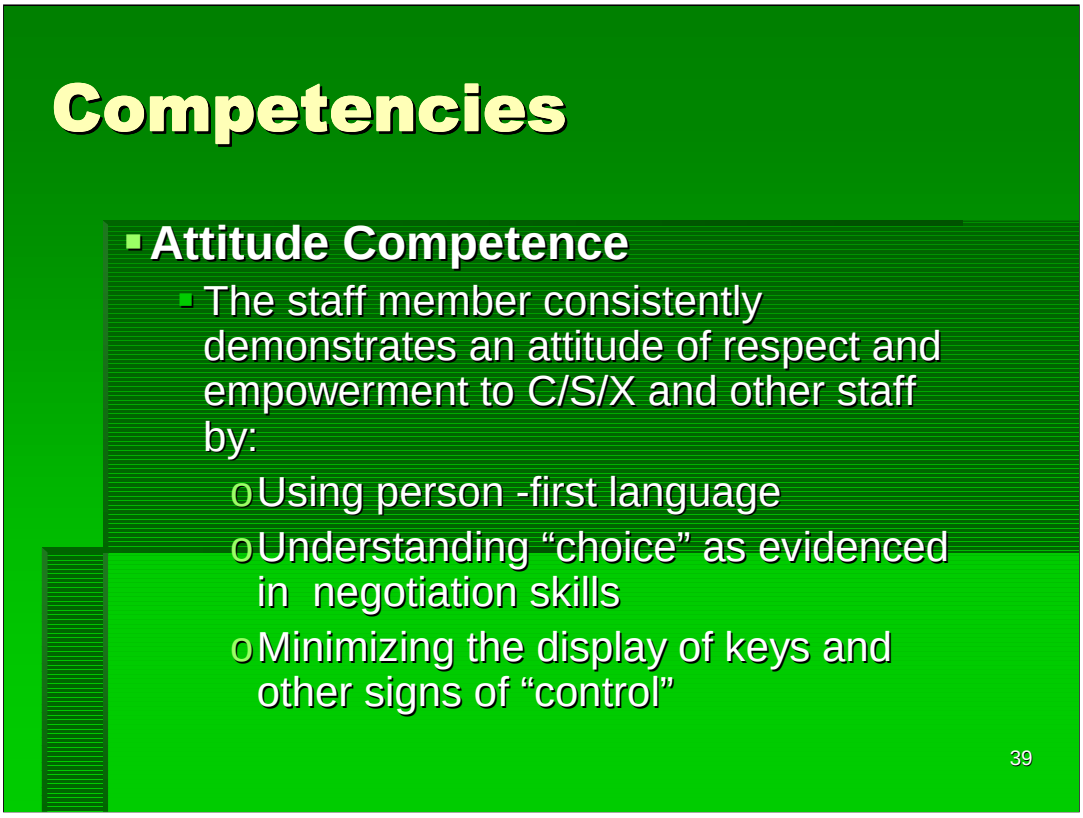
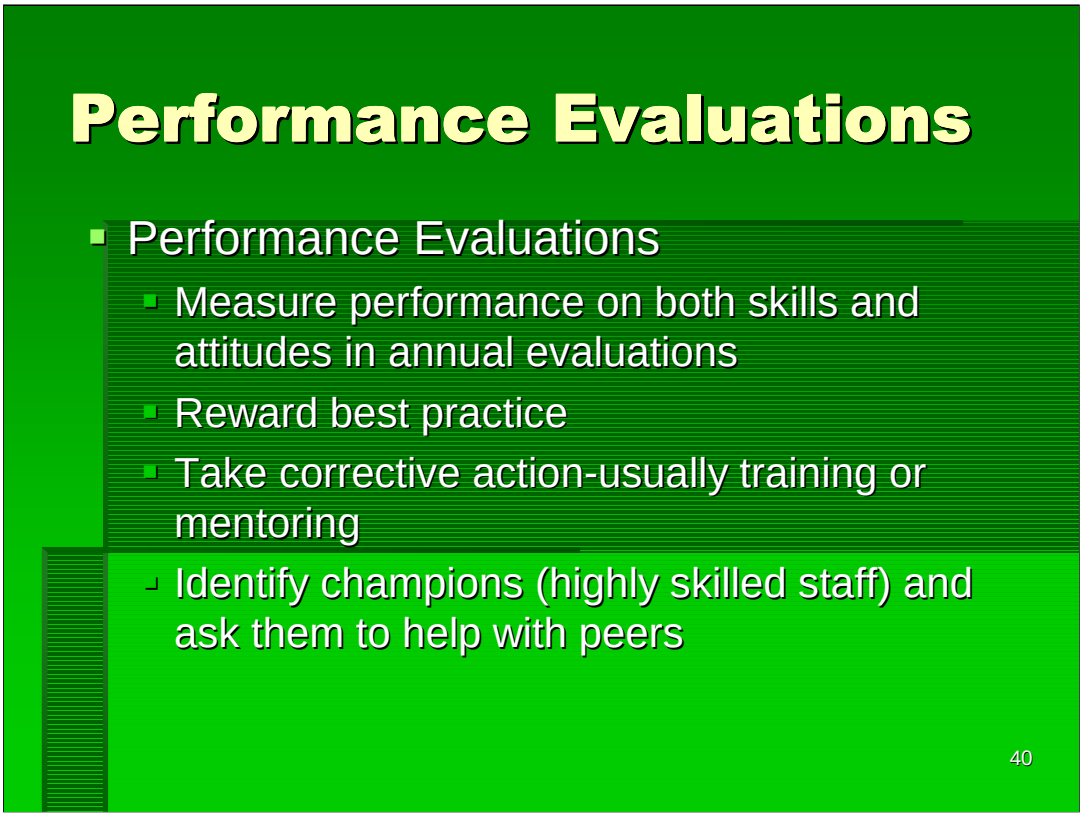
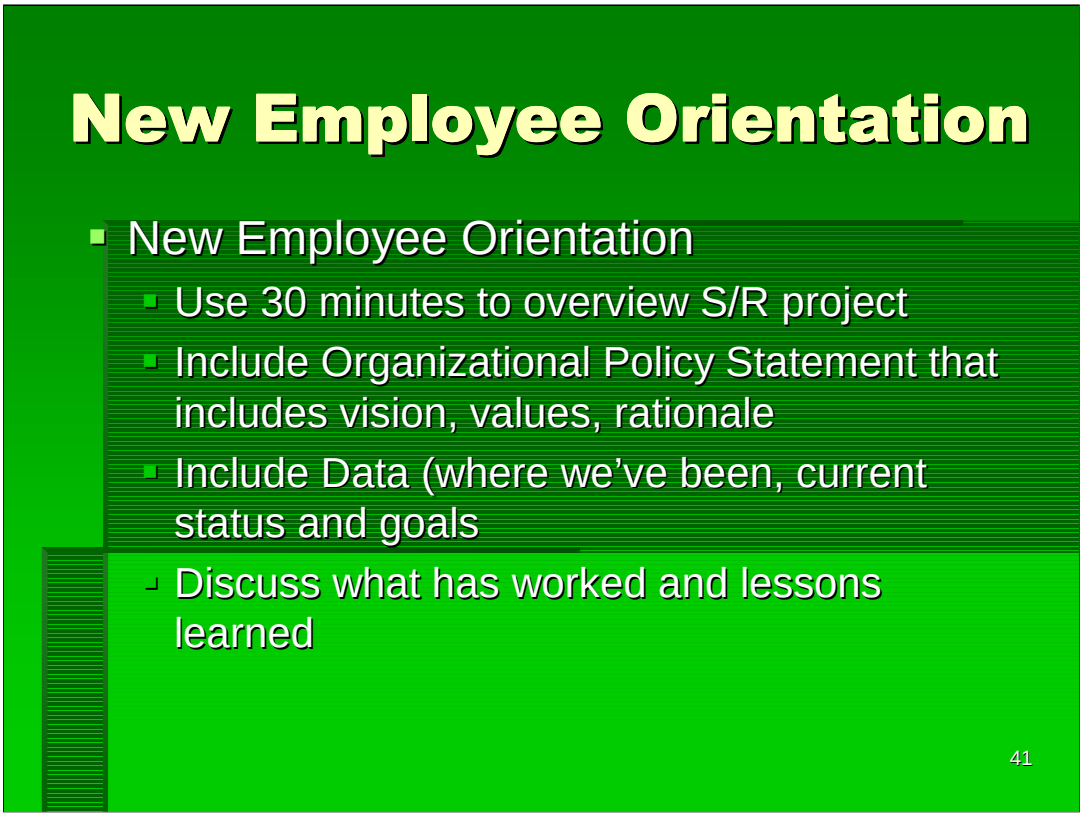


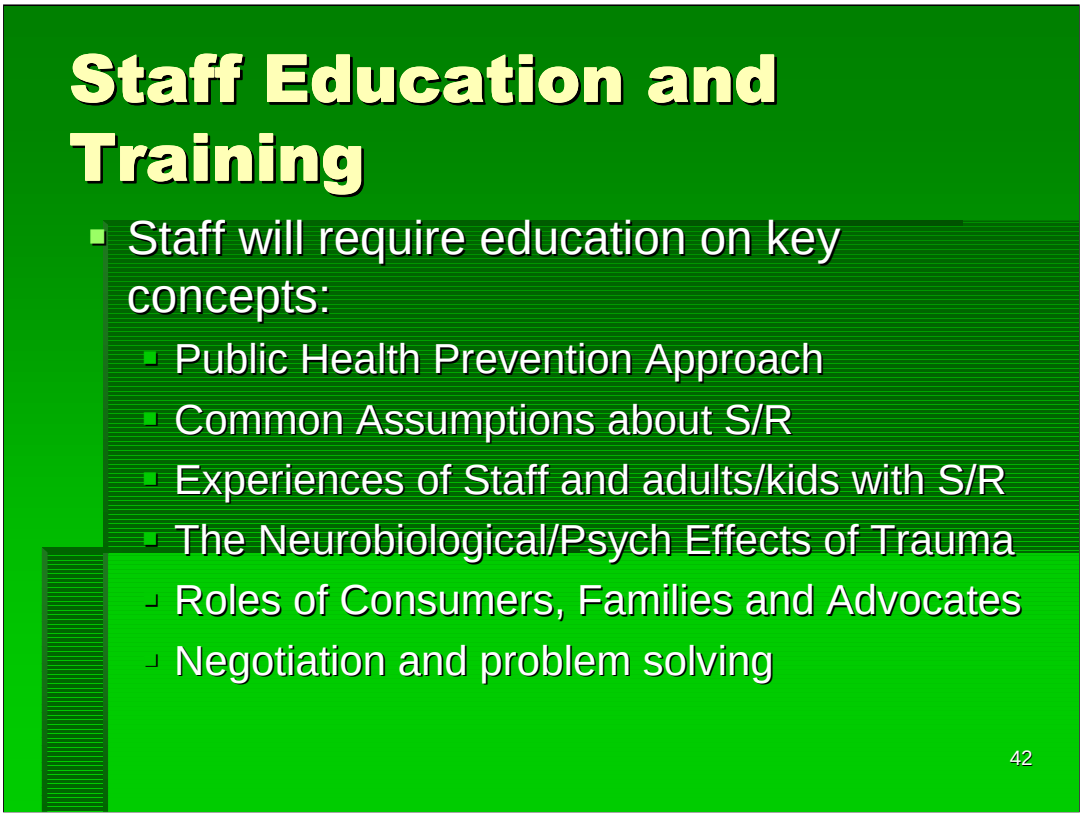

The other is attitude competence. You can have an extremely qualified and technically competent person whose attitude doesn't change much. In other words someone who is exceeding good at meeting documentation requirements but not so good in interacting with residents and that needs to be addressed. Measure competencies of staff by things like using person-first language; demonstrating the ability to give someone some choices instead of the win/lose situation; minimizing the display of some of the things that consumers have reported as being pretty overtly or covertly intimidating.




Then in performance evaluations, measure these expectations. Basically, keep S/R reduction high on the priority list; keep it on everybody's radar screen. Take corrective action, usually in training or mentoring. You will find through this process who your highly skilled, trained staff are who can help you do this; help your role model and mentor and sometimes you can buddy them up with people.




Last, new employee orientation. When you hire your people and they come in that first day or two or three days depending on what your orientation looks like, use 30 minutes to overview your seclusion and restraint reduction project. It's very powerful to have the CEO or the COO or one of the executive staff to come in and do this piece. To talk about where you've been, where you're going, where you are now, some of the challenges you faced; how you've handled them; and welcome this new group of staff to join you in this initiative. Show some data, if you can, and how you've looked at that data; they analyze it and how that data has helped you.




Staff will also require key education and training on much of what we're talking about today and that's why we provide you all of the power point modules on CD. We want you take them back; adapt them for your use; try not to reinvent the wheel. Very shortly we will have available narratives for each module, so that you can give this to your training staff and they can feel pretty comfortable in providing the content to some of these modules if they haven't made it to the training.

Some of the key issues in terms of staff education that need to be covered by your facility (staff will not get this information unless you do this) include: public health prevention; common assumptions about seclusion and restraint; experiences of staff and consumers and kids with seclusion and restraint; the neurobio psychological effects of trauma; the importance of inclusion of the people we serve; negotiation and problem solving and the list kind of goes on and you'll see it in there

# Staff Education and Training

- Creating Trauma Informed Systems and Services
- Principles of Recovery/Building Resiliency
- Matching Interventions with Behaviors
- Use of S/R Reduction Tools (violence, death/injury, de-escalation, safety plans, environmental changes)
- Roles in rigorous debriefing

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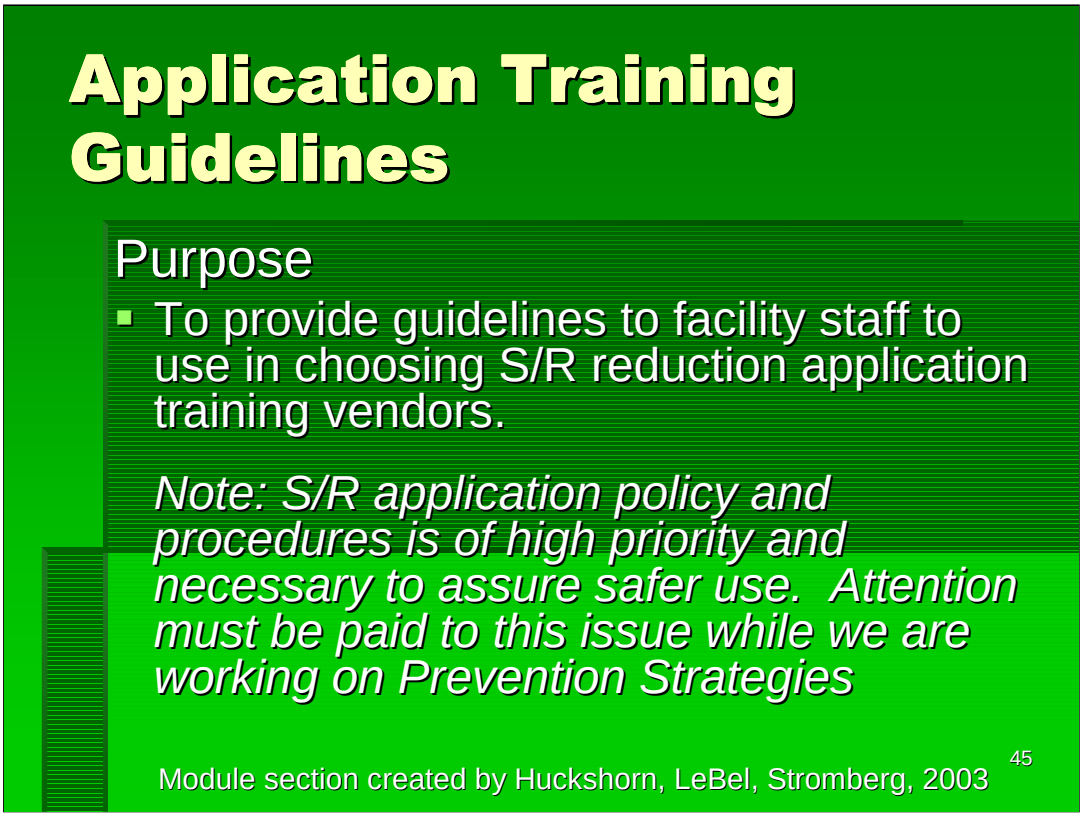
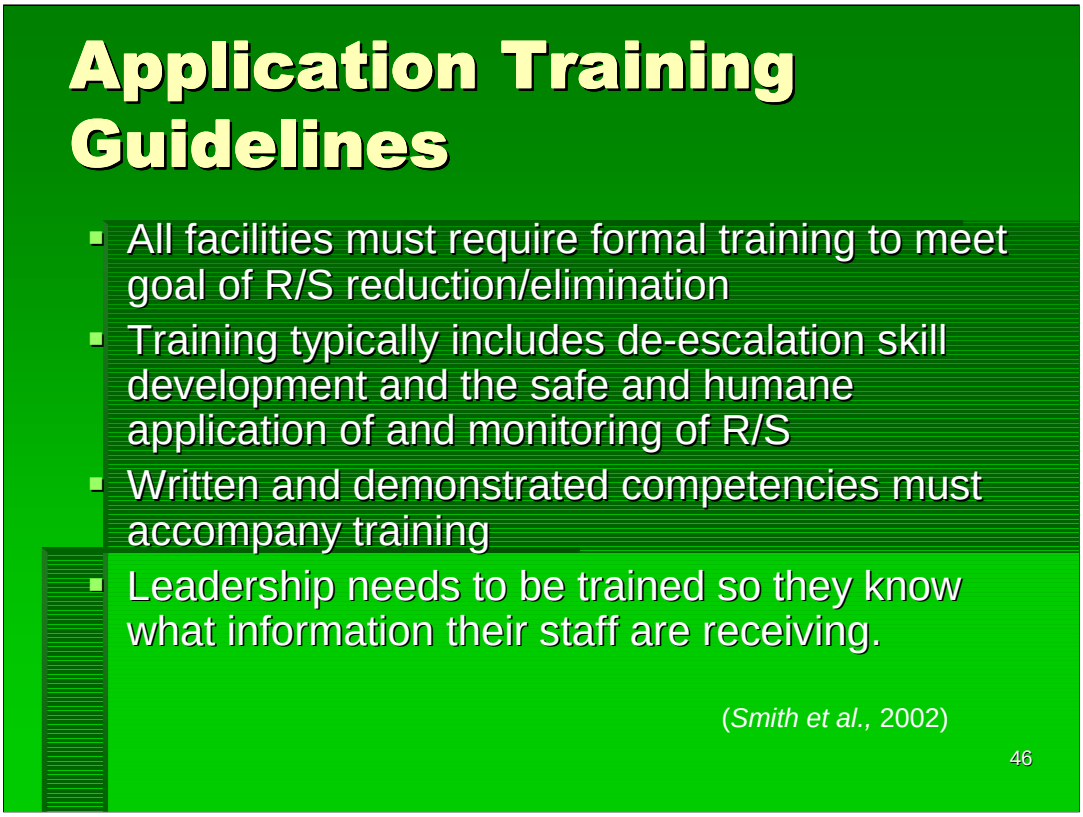
Another important piece of workforce development is looking very scientifically, if you will, at your seclusion and restraint application training, sometimes called aggression control training. Everybody has different words for that. This training is very important because it maintains safety as best as we know how while we're learning how to reduce and eliminate seclusion and restraint but there are some guidelines and boundaries around the choice and use of this training I just want to briefly cover.

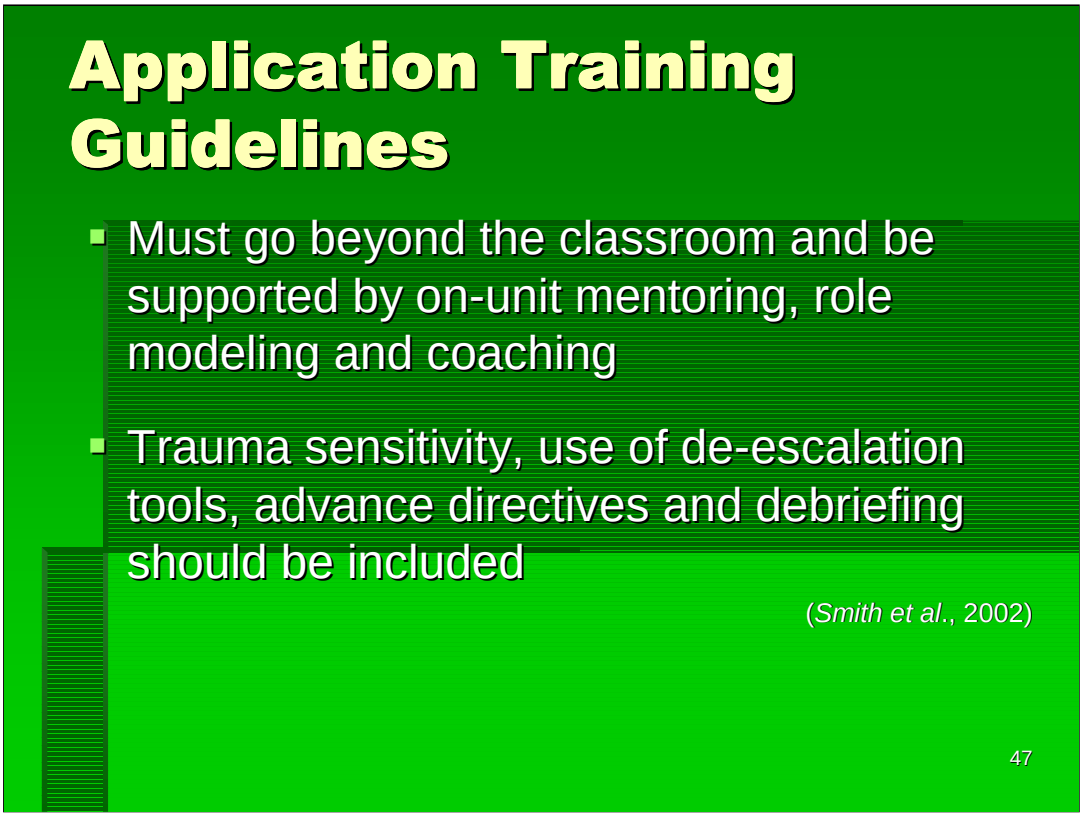



The purpose of “application training” is to provide guidelines to facility staff to use in choosing seclusion and restraint reduction application training vendors. Some of you will have home-grown state written application procedures. S/R policies and procedures are of high priority and necessary to assure safe use while a facility is working on prevention.




Most facilities will require formal training to meet the federal regulations. Training usually includes skill development in problem solving and win-win negotiation. This type of training needs to include the development and measurement of staff competencies and facility leaders need to attend to hear what staff are being taught.

Leadership, first of all and I'm talking about executive leadership, needs to attend this training. I can't tell you how many times we've gone into facilities and none of the senior leadership staff, even the clinicians, have gone in and been certified in this training because they just don't have enough time. It's critically important because no matter what the vendor comes to tell you about their training and they want you to buy their product obviously, they also are very aware of this reduction initiative and many of them feel very strongly that that's a good way to go, but what they tell you and what happens when their trainers come in can be very different and there could be large disconnects. So someone go and check out what is actually being trained to your staff.




I hope that at this point in the training today you're starting to see that this is a very important part, but it's only a small part of the whole initiative. Training must go beyond just the classroom and be supported by on-unit mentoring, role modeling and coaching by other senior staff; that train the trainer model is sometimes good for that. It should include some discussion of trauma sensitivity, the use of de-escalation tools other than medication and the advanced directives of crisis planning that help us identify before the fact the triggers that someone might have to become violent and how to do a debriefing.


Some of the options in choosing the right training program include two different models but all need to be focused on de-escalation, trauma informed care, negotiation, and only a minority of that time needs to be spent on how to apply seclusion and restraint equipment. The reason is, obviously, if you spend 75% of your time teaching staff complicated martial art type maneuvers and holds, they're going to need to use them because they'll lose them. Some of those are very complicated. I've been to multiple different kinds of trainings in my career and have found that some training focuses on skills that are forgotten the day after because they were so complicated and then the complicatedness of it caused them to freeze and they ended up having to apply. So that's another reason to have a senior person in there. The other is, again, if you only spend 25% on de-escalation, trauma informed, reducing seclusion and restraint use at 75% on the other, what do you think your staff remembers?

Facilities that choose internal state trainers can use a train the trainer model that the facility can own and refine over time. Others can use external trainers but need to choose those that have demonstrated effectiveness in reducing S/R use, injury rates and emergency medications. Training in all cases needs to focus on advanced negotiation and de-escalation skills and not holds or take downs. In addition staff training must be part of mandatory new hires and early on.

# Application Training Guidelines

- Must be part of mandatory annual training or review for all direct care staff
- Best if augmented with ongoing training throughout year
- Competency must be documented and included in personnel files and be part of performance review process

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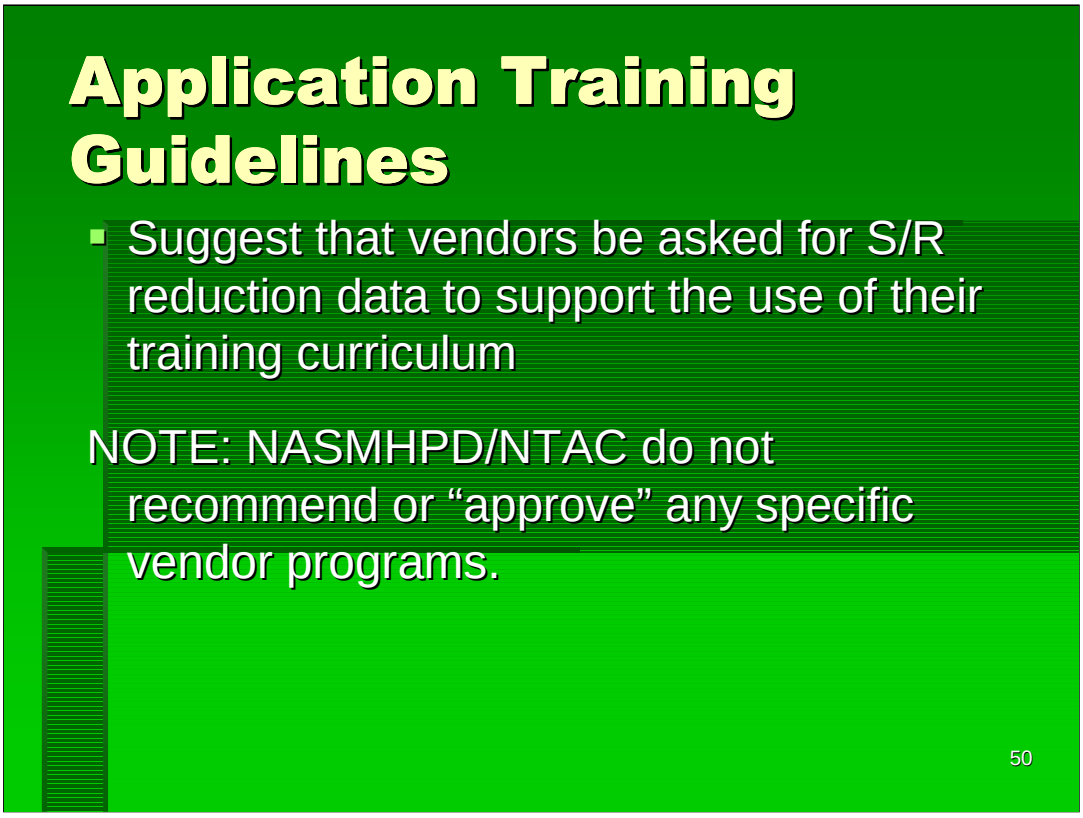
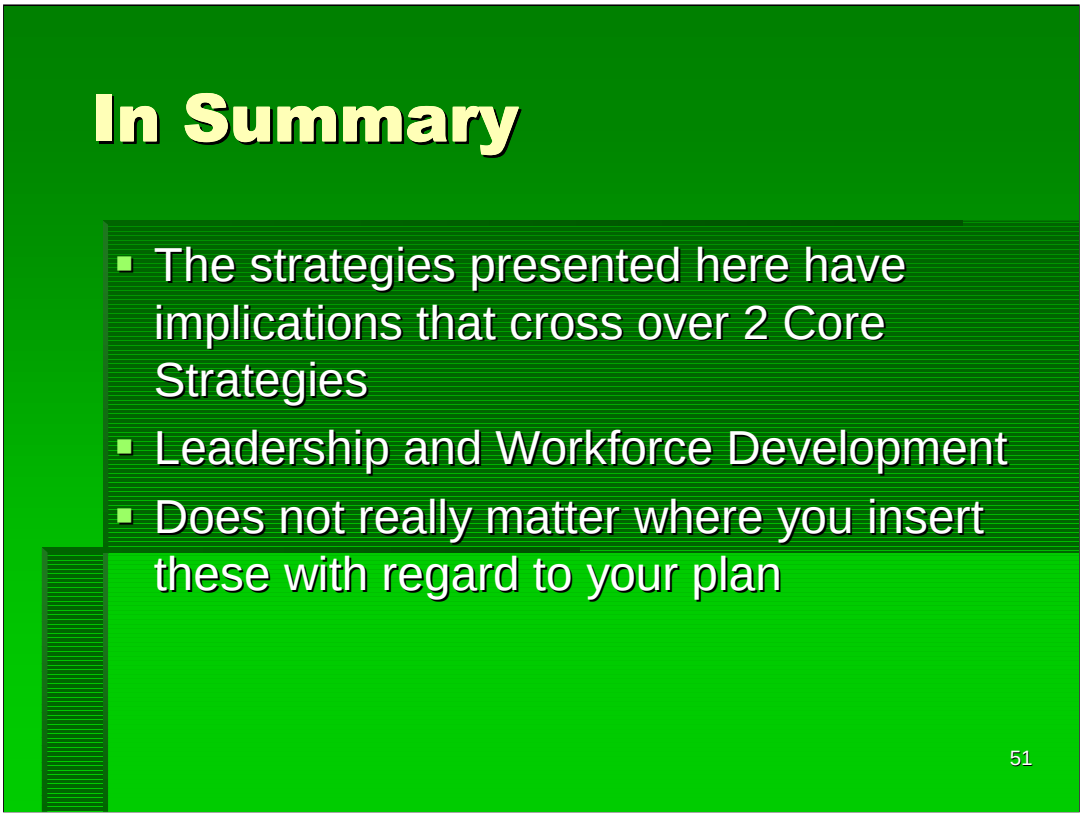
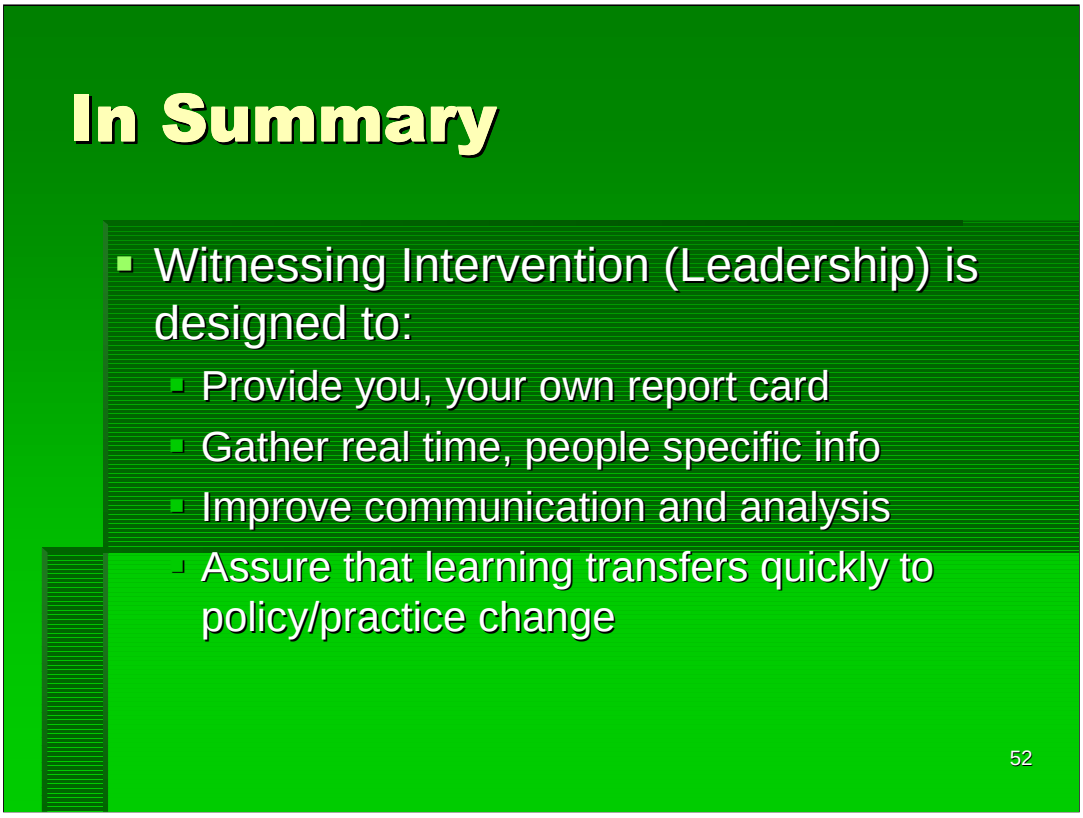



Also, just to make a point, there have been several vendors who we have learned have sent out letters and other kinds of marketing materials that indicate that NTAC approves of training materials. We do not support or recommend any particular vendor. It's not our position; we're not experts on what the vendors are doing, so if you do get any kind of information like that, please let me know and also you can pretty much know that that's not untrue.

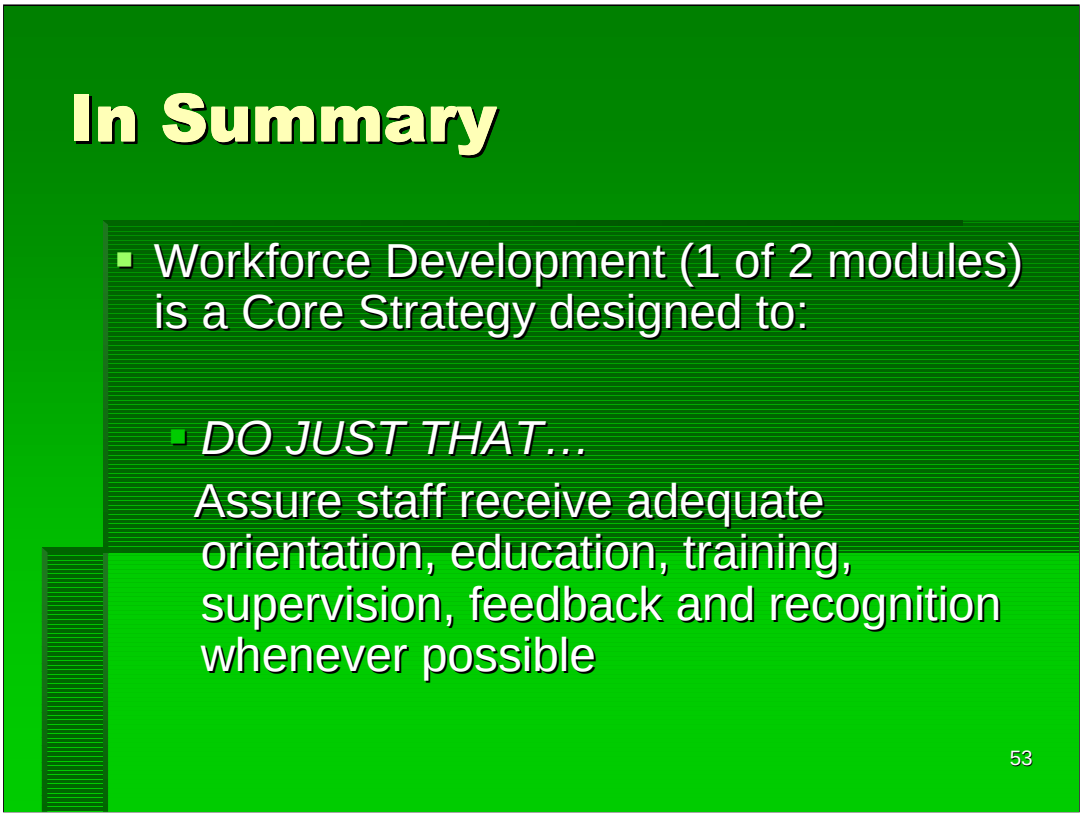
NTAC strongly suggests that if you're using a vendor that you nicely and respectfully ask them, (since it's been six years since the *Hartford Courant* came out and four to five years since this initiative hit the federal level) that vendors should be able to give us some data on how effective their particular model is. They're using these strategies in multiple sites and they need to show us some data, so we can start to figure out which vendor programs are indeed reducing the use of seclusion and restraint and I think that's a fair question. I'm not trying to imply at all that you say if you don't give me data we're going to fire you or find somebody else; I think we're too early in this process but I think you all as a people who are paying the bills need to start asking people for some outcome data just like many of our funders ask us to provide outcomes and I think it's a perfectly legitimate question and the dialogue needs to start.




The strategies here are designed to provide you your own report card of what's going on in your facility; gather real time, people-specific information; improve the communication between your senior staff or staff that are involved in these incidents and assure that learning transfers quickly and doesn't get bogged down. The strategies presented here cross over leadership and workforce development. Together these suggestions are designed to assure that staff receive adequate orientation, education, training, supervision, feedback and recognition whenever possible.




Witnessing, specifically, is designed to provide you a “report card” in real time and directly after an event so that leadership can meaningfully review and analyze the institutional triggers and risk factors that lead to S/R use. It is also the only mechanism that can quickly transfer this kind of new information into policy.




Workforce development strategies, as presented here DO JUST THAT… Provide guidelines that assure adequate new hire procedures and orientations, and provide for necessary education, training, supervision, feedback and recognition of best practices.