Reducing Risk and Preventing Violence, Trauma, and the Use of Seclusion and Restraint

Overview of 6CS© Work to Reduce the Use of Seclusion and Restraint

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An Evidence-Based Practice to Prevent Conflict and Violence in Behavioral Health Inpatient & Residential Settings

September 6, 2016

Five year, eight-state US Research Project led to these finding (2004-2009)

- Research data gathered/analyzed by HSRI in Cambridge, MA (independent contract)
- Eight 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)

Framing the Issue

- A "systemic" practice change, such as reducing violence & use of S/R requires a **CULTURE CHANGE** in behavioral health treatment settings that results in far more than just reducing S/R. *(Huckshorn, 2006; 2013)*

- This "*Culture Change*" includes taking a look at how staff interact with clients, what skills your staff have, and defining/implementing recovery, resiliency and transformation principles

- Best practice core strategies have been identified

- However, this kind of systemic organizational change is often difficult… for many reasons…

Development of the 6CS© Curriculum to Reduce the Use of S/R

- Ongoing Review of Literature (1960 to present/ongoing continuously)
- Six CS© Faculty: Best practice information emerged 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.
- Core strategies emerged in themes over time.

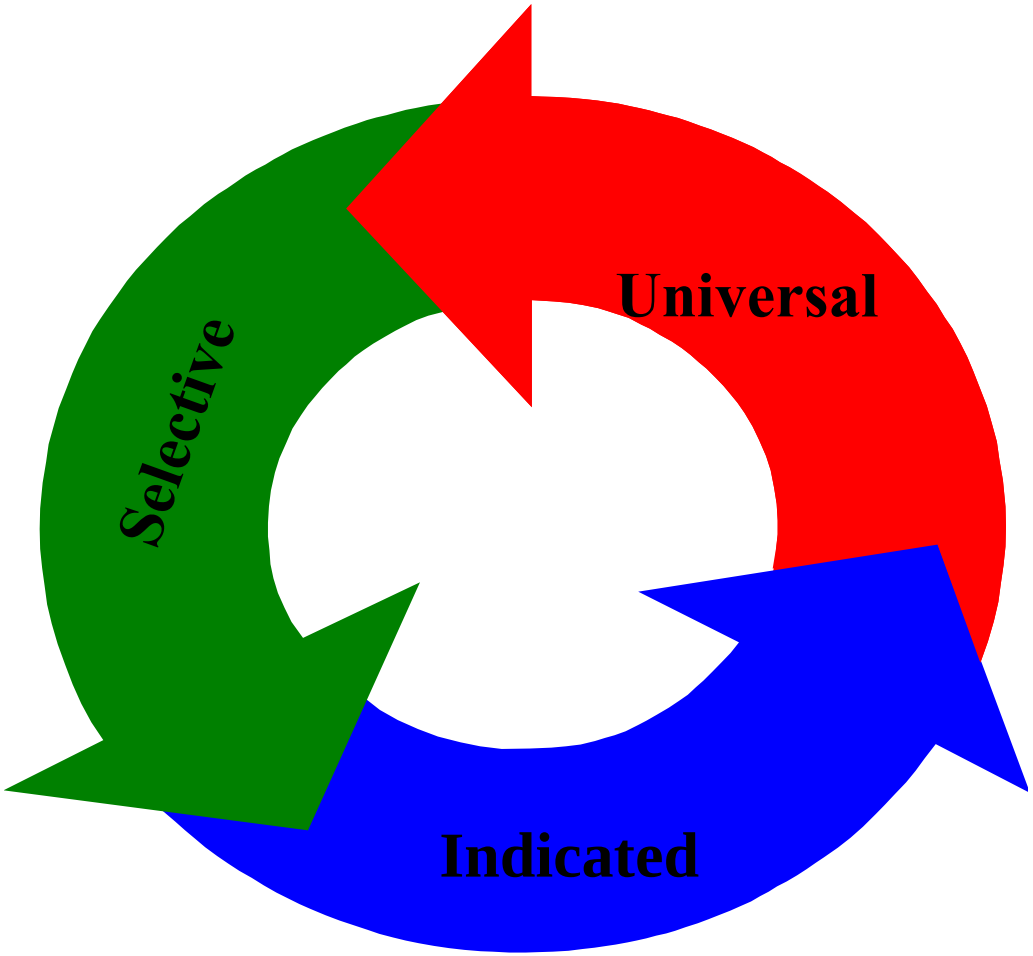
CORE BELIEFS PROVIDED THE FOUNDATION FOR THE 6CS CURRICULUM (THEORETICAL MODEL)

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

(Anthony & Huckshorn, 2008; IOM, 2005; New Freedom Report, 2003; NASMHPD Med Directors SR Report, 1999; Caldwell and LeBel, 2013)

Public Health Prevention Model

(Nat. Academies Press, 2009)



The Public Health Prevention Model

- The Public Health approach is a model of disease prevention and health promotion and is a logical fit with a practice issue such as reducing use of S/R or using TIC in practice.

- This approach, designed to keep large populations well; identifies contributing factors and creates remedies to prevent, minimize and/or mitigate the problem if it occurs.

- Re “Violence and S/R use” it refocuses us on prevention while maintaining safe use

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

The Public Health Prevention Model Applied to Primary Health

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

The Public Health Prevention Model applied to S/R Reduction

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

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

THE SIX CORE STRATEGIES© TO PREVENT VIOLENCE AND S/R

1) ***Leadership*** Toward Organizational Change
2) Use ***Data*** To Inform Practices
3) Develop Your ***Workforce***
4) Implement ***S/R Prevention Tools***
5) Full inclusion of ***service users (Peers)and families in all activities***
6) Make ***Debriefing*** rigorous

6CS #1: Leadership Sets Clear Goals Based on a Vision or Policy Goals

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

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

6CS #1: Principles of Leaders *Valuing Exemplary Performance*

Effective Leaders build their organization around exemplary performers:

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

(Anthony & Huckshorn, 2008; Huckshorn, 2013)

6CS #2: Using data to Inform Practice

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

6CS #3: Workforce Development

- Staff need to get training on the following important topics and be mentored.
- **Prevention Model:** Work focus on primary/secondary strategies
- **Aggression & Violence Risk:**

  Identify risks for aggression or violence in order to prevent the use of seclusion or restraint (S/R)
  - Individual, environmental, & situational risk factors

- **Medical/Physical Risk:**

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

6CS #3: Workforce Development

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

1) Patient characteristics (blame the patient…)
2) Environmental factors e.g. "triggers"
3) Situational: a combination of the above

- The situational model has been the most useful in understanding the conflicts that lead to S/R use.
- Attention to only the "patient" or only "the setting" ignores this multi-dimensional relationship and the variables that inter-relate to lead to conflict

6CS #3: Workforce Development

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

6CS #3: Workforce Development

- Workforce Development also includes:
  - Communicating Hospital Vision and Values,
  - Reviewing/revising "new employee orientation" to include this work,
  - Assuring that important competencies are included in job descriptions and evaluations,
  - Adequate mentoring and supervision,
  - Routine performance evaluations that address basic competencies

(Megargee, 1982; Mohr, 2000; NASMHPD, 2012, Huckshorn, 2013))

6CS #4: Prevention Strategies

Why Are They Used?

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

6CS #4: PREVENTION TOOLS

Essential Risk Assessments:

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

6CS #4: PREVENTION TOOLS

Essential Crisis Plan Components:

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

Common Attributes of Each Crisis Prevention Plan

- Reflects the person's trauma history
- Uses available environmental resources
- Encourages staff & client creativity
- Incorporates sensory interventions
- ***Needs of the individual supersede the rules of the institution***, aka staff need to be able to bend rules…

6 CS #5: Full Inclusion of Peers/Families & Consumer Roles in Mental Health Settings

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

6 CS #5: Full Inclusion of Peers/Families & Consumer Roles in Mental Health Settings

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

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

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

6 CS #6: Rigorous Debriefing

Definition of Debriefing

- A stepwise tool designed to rigorously analyze a critical event, to examine what occurred and to facilitate an improved outcome next time (manage events better or avoid event). *(Scholtes et al, 1998)*

Debriefing Questions

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

(Cook et al, 2002; Hardenstine, 2001)

Patient & Staff Debriefing Goals

1) To "discover" the story of why this event occurred.

2) To prevent future use of seclusion and restraint with this person and others.

3) To address organizational problems (rules, attitudes, practices, training, environment of care) and make appropriate changes.

(Massachusetts DMH, 2015; Huckshorn, 2013; Cook et al, 2002; Hardenstine, 2001)

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