

# National Technical Assistance Center

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Creating Violence Free and Coercion Free Mental Health  
Treatment Environments for the Reduction  
of Seclusion and Restraint

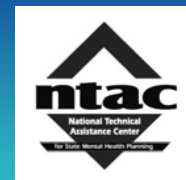
*Older Persons Division*

*NASMHPD*

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National Technical Assistance Center

National Center for S/R Reduction



# Brief Historical Overview

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- 1996: PA S/R Project starts
- 1998: Hartford Courant Series
- 1999: GAO Report (Congress)  
NASMHPD MD S/R Report
- 2000: CWLA Project starts
- 2001: Curie to SAMHSA



# Brief Historical Overview

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- 2002: NASMHPD Training Curriculum created National “Call To Action” in DC held
- 2003: CMHS National Action Plan for S/R  
NTAC Training-26 state delegations  
New Freedom Report – *Transformation*  
Independent projects support core strategies identified (Success Stories; Colton (VA); Murphy/Davis (OR); CWLA)

# S/R SIG Project

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## 2004-05 Activities

- 8 State Incentive Grants to identify alternatives to reduce use (WA, HI, LA, MA, MD, KY, IL, MO)
  - Three-year project includes large scale evaluation project with HSRI, NREPP application
  - Development of T&TA materials, site visits, web site, Advisory Committee, consultant teams
  - 25 more state delegations trained
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# What We Know at this Point

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- The reduction and elimination of S/R is *possible*
- Facilities through country have reduced use considerably without additional resources
- This effort *does take* tremendous leadership, commitment, and motivation



# What We Know at this Point

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- Reducing S/R requires a *different way* of looking at the people we serve and the staff who serve them
- Although there is no *one way* to do this, best practice core strategies have been identified

# Frame the Issue

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- The reduction of seclusion, restraint and coercive practices requires a **CULTURE CHANGE** that is resonates with recovery and the transformation of our mental health systems.
- For this to happen we need to “change the way we do business”
- However, change on local level is slow

# WHY?

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- Healthcare systems including BH continue to be fragmented
- Not customer friendly or person-centered
- Not outcome oriented
- Resources are wasted
- Poor communication between providers
- Practices not based on evidence

# Facilitating Culture Change in Healthcare Organizations

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- Institute of Medicine describes new rules to transition the redesign and improvement in care *(IOM, 2001)*
  - Continuous healing relationships
  - Customized to individual needs/values
  - Consumer is source of control
  - Free flow of information/transparency
  - Reducing risk to ensure safety
  - Anticipation of needs
  - Use of Best Practices

# Facilitating Culture Change in MH

## The New Freedom Commission

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- A Call for System Transformation
- System Goal = Recovery for everyone
- Services/supports are consumer centered
- Focus of care must increase consumers' ability to self manage illness and build resiliency
- Individualized Plans of Care critical
- Consumers and Families are full partners

*(NF Commission, 2003)*

# FINDING:

## Reducing S/R is a cornerstone to creating recovery oriented SOC

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- Improves safety for service recipients/staff
- Teaches respect and negotiation skills
- Moves from focus on control to one of partnership and empowerment
- Avoids re-traumatization
- Creates more responsive environments for consumers and staff
- Facilitates treatment success

# Recovery Principles

## Brief Overview

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- Goal of the NF Commission system  
Recovery/Building Resiliency
  - Individuals can recover and have a meaningful life in their communities
  - Primary concepts include the avoidance of labeling, offer of hope and promotion of a highly individualized, inclusive treatment process

# Definitional Issues

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- Federal Regulations regarding S/R differ by population, facility type and agency
- States also have individualized definitions and usage that are different
- These constraints hinder the use of one definition for all
- *Intent* of use is most important concept

# NTAC Training Definitions

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- *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 or normal access to one’s body”

*(HCFA Interim Rules, 1999)*

# NTAC Training Definitions

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- *Seclusion:*

“ The involuntary confinement of a person in a room where they are physically prevented from leaving or believe they are”

*(NASMHPD, 2003)*

# Definitional Issues

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- While there are varieties of restraint and seclusion and also different levels of intensity and intrusiveness, it is not the purpose here to judge them.
- Our stance is to help reframe the issue to one of **prevention** to avoid the having to “lay on hands.”

# Definitional Issues

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- We do believe that all use of S/R should be restricted to situations of *imminent danger* and that the majority of our efforts need to be focused on preventing the need to use coercive interventions
- We also hold that while we are reducing it is of extreme importance to use S/R as safely and briefly as possible

# Final Points

## *Current Situation*

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- Practices in mental health settings have developed over time.
- Part of our inherited culture is the use of seclusion and restraint.

# Final Points

## *Current Situation*

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- We learned to use seclusion and restraint as a safety measure and “therapeutic technique.”
- We learned from our teachers, colleagues, co-workers, and mentors that seclusion and restraint was necessary.

# Final Points

## *Current Situation*

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- Many of us have used S/R reluctantly, and felt badly about it. Some of us used S/R as a “consequence” for behaviors not generally believed dangerous.
- We now know, that we can prevent use much of the time.

# Final Points

## *Current Situation*

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- Many facilities have reduced use to almost zero, with no extra money and without special training or assistance.

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- Based on predicted increase in the incidence of mental disorders among aging “boomers”, the number of elderly mentally ill is projected to swell from approximately four million in 1970 to 15 million in 2030.

(UCSD News, 1999)

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- More than 40 reporting of elder abuse are received in Ohio each day.

[www.butlercountyohio.org](http://www.butlercountyohio.org)

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- The average abused elderly person is :
    - 75 or older
    - Living with his/her children or relatives
    - In poor physical or mental health
    - Usually female

[www.butlercountyohio.org](http://www.butlercountyohio.org)

# Who abuse the elderly?

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- People often hear about elderly abuse in institutions, but only a small percent of elderly live in institutes.
- Most elderly persons live independently. This may be alone, with a spouse, or with relatives.

[www.butlercountyohio.org](http://www.butlercountyohio.org)

# Who abuse the elderly?

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- Most families don't abandon, abuse, neglect or take advantage of their elderly relatives. But studies don't point to the family as the single greatest source of elder abuse.
- Daughters, sons, grandchildren or other relatives may be abusers. Physical abusers are usually male.

(Ibid)

# Who abuse the elderly?

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- Psychological abusers are usually 50 or older. These relatives may have been looking forward to a time of personal freedom. They instead find themselves supplying almost constant personal and medical care to an elderly relative.
- In many families where abuse happens, conflicts have existed for years. There may be a pattern of violence in the family. The parent may have treated the child badly earlier in life. These problems come to a head when family members move into the same home.

(Ibid)

# How are the elderly being abused?

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- Much has been written about abuse of the elderly by strangers. However, there is a higher chance that family members will:
  - give improper or little care to the elderly
  - neglect them or keep them in isolation
  - deny proper food or medical care
  - verbally abuse them
  - threaten them with nursing home placement
  - physically restraint them
  - hit or beat them
  - misuse their money or property
  - wish for their death to preserve an inheritance that will otherwise need to be spent on their care (Ibid)

# Do the abused elderly tell anyone?

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- The abused elderly often are not willing to tell anyone about their situation. They may resign themselves to the abuse due to:
  - embarrassment
  - pride
  - fear
  - love for the abuser
  - a belief that living in an institute is the only other choice

(Ibid)

# Do the abused elderly tell anyone?

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- At times they do seek help. They may try to tell someone, but not be believed. Or they may suffer from a medical condition that prevents them from understanding or clearly explaining what is happening to them

(Ibid)

# Prevalence of trauma in lives of individuals with developmental disabilities.

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- More than 90% of people with developmental disabilities will experience sexual abuse in their lifetime.

(ARC, 1995)

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- 56% of 171 cases of sexual assault of adults with mental retardation involved paid staff, family members and others.
  - 42% involved perpetrators who were other adults with mental retardation.

Furrey, Granfield and Karan, 1994)

# Exposure to Trauma

## General Population

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- Until recently, trauma exposure was thought to be unilaterally rare (combat violence, disaster trauma)  
*(Kessler et al., 1995)*
- Recent research has changed this. Studies done in the last decade indicate that trauma exposure is common even in the middle class  
*(Ibid)*
- 56% of an adult sample reported at least one event  
*(Ibid)*

# Prevalence of Trauma Mental Health Population

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- 90% of public mental health clients have been exposed

*(Muesar et al., in press; Muesar et al., 1998)*

- Most have multiple experiences of trauma

*(Ibid)*

- 34-53% report childhood sexual or physical abuse

*(Kessler et al., 1995; MHA NY & NYOMH, 1995)*

- 43-81% report some type of victimization

*(Ibid)*

# Prevalence of Trauma Mental Health Population

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- 97 % of homeless women with SMI have experienced severe physical and sexual abuse - 87% experience this abuse both as child and adult

*(Goodman et al., 1997)*

# Trauma in American Children

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- 3.9 million adolescents have been victims of serious physical assault and almost 9 million have witnessed an act of serious violence

*(Kilpatrick et al., 2001)*

- In 1998, 92% of incarcerated girls reported sexual, physical or severe emotional abuse in childhood

*(DOC, 1998)*

# What is Trauma?

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- Definition (NASMHPD, 2004):
  - The personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence, terrorism and disasters.

# Types of trauma resulting in serious and persistent mental health problems:

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- Are *usually* not a “single blow” event e.g. rape, natural disaster
- Are interpersonal in nature: intentional, prolonged, repeated, severe
- Occur in childhood and adolescence and may extend over an individual’s life span

(Terr, 1991; Giller, 1999)

# Impact of Trauma over the Life Span

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- Effects are neurological, biological, psychological and social in nature, including:
  - Changes in brain neurobiology
  - Social, emotional & cognitive impairment
  - Adoption of health risk behaviors as coping mechanisms (eating disorders, smoking, substance abuse, self harm, sexual promiscuity, violence)
  - Severe and persistent behavioral health, health and social problems, early death

*(Felitti et al, 1998; Herman, 1992)*

# Definition of Trauma Informed Care

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- Treatment that is directed by:
  - ✓ a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual and
  - ✓ an appreciation for the high prevalence of traumatic experiences in persons who receive mental health services. *(Jennings, 2004)*

# Trauma Informed Care Systems

## Key Principles

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- Integrate philosophies of care that guide all clinical interventions
- Are based on current literature
- Are inclusive of the survivor's perspective
- Are informed by research and evidence of effective practice
- Recognize that coercive interventions cause traumatization and re-traumatization and are to be avoided

*(Fallot & Harris, 2002; Ford, 2003; Najavits, 2003)*

# Trauma Informed Care Systems

## Key Features

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- Recognition of the high rates of PTSD and other psychiatric disorders related to trauma exposure in children and adults with SMI/SED
- Early and thoughtful diagnostic evaluation with focused consideration of trauma in people with complicated, treatment-resistant illness

*(Fallot & Harris, 2002; Cook et al., 2002; Ford, 2003; Cusack et al.)*

# Trauma Informed Care Systems

## Key Features

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- Valuing the consumer in all aspects of care
- Neutral, objective and supportive language
- Individually flexible plans and approaches
- Avoid shaming or humiliation at all times

*(Fallot & Harris, 2002; Cook et al., 2002; Ford, 2003; Cusack et al.; Jennings, 1998; Prescott, 2000)*

# Trauma Informed Care Systems

## Key Features

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- Awareness/training on re-traumatizing practices
- Institutions that are open to outside parties: advocacy and clinical consultants
- Training and supervision in assessment and treatment of people with trauma histories

*(Fallot & Harris, 2002; Cook et al., 2002; Ford, 2003; Cusack et al.; Jennings, 1998; Prescott, 2000)*

# Universal Precautions as a Core Trauma Informed Concept

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*Presume that every person in a treatment setting has been exposed to abuse, violence, neglect or other traumatic experiences.*

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# Recognizing Care Systems That Lack Trauma Sensitivity

# Systems without Trauma Sensitivity

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- Consumers are labeled & pathologized as manipulative, needy, attention-seeking
- Misuse or overuse of displays of power - keys, security, demeanor
- Culture of secrecy - no advocates, poor monitoring of staff
- Staff believe key role are as rule enforcers

# Systems without Trauma Sensitivity

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- Little use of least restrictive alternatives other than medication
- Institutions that emphasize “compliance” rather than collaboration
- Institutions that disempower and devalue staff who then “pass on” that disrespect to service recipients.

*(Fallot & Harris, 2002)*

# Systems without Trauma Sensitivity Related Characteristics

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- High rates of staff and recipient assault and injury
- Lower treatment adherence
- High rates of adult, child/family complaints
- Higher rates of staff turnover and low morale
- Longer lengths of stay/increase in recidivism

*(Fallot & Harris, 2002; Massachusetts DMH, 2001; Huckshorn, 2001)*

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# Organizational Commitment to Trauma Informed Care

# Organizational Commitment to Trauma Informed Care

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- Adoption of a trauma informed policy to include:
  - commitment to appropriately assess trauma
  - avoidance of re-traumatizing practices
- Key administrators get on board
- Resources available for system modifications and performance improvement processes
- Education of staff is prioritized

*(Fallot & Harris, 2002; Cook et al., 2002)*

# Organizational Commitment to Trauma Informed Care

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- Unit staff can access expert trauma consultation
- Unit staff can access trauma-specific treatment if indicated

*(Fallot & Harris, 2002; Cook et al., 2002)*

# Organizational Commitment to Trauma Informed Care

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- Assessment data informs treatment planning in daily clinical work
- Advance directives, safety plans and de-escalation preferences are communicated and used
- Power & Control are minimized by attending constantly to unit culture

*(Fallot & Harris, 2002; Cook et al., 2002)*

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“Hurt people, hurt people”.

Sandra Bloom, M.D.