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Balancing Risk & Safety When Reducing Restraint & Seclusion

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Canadian Institute for Health Information

- 24% of mental health inpatients in Ontario experience some form of restraint or seclusion
- Control interventions used most often:
  - Acute control medications (59%)
  - Physical/mechanical restraint (21%)
  - Seclusion (20%)
- 40% diagnosed with schizophrenia & psychotic disorders

CIHI, 2011

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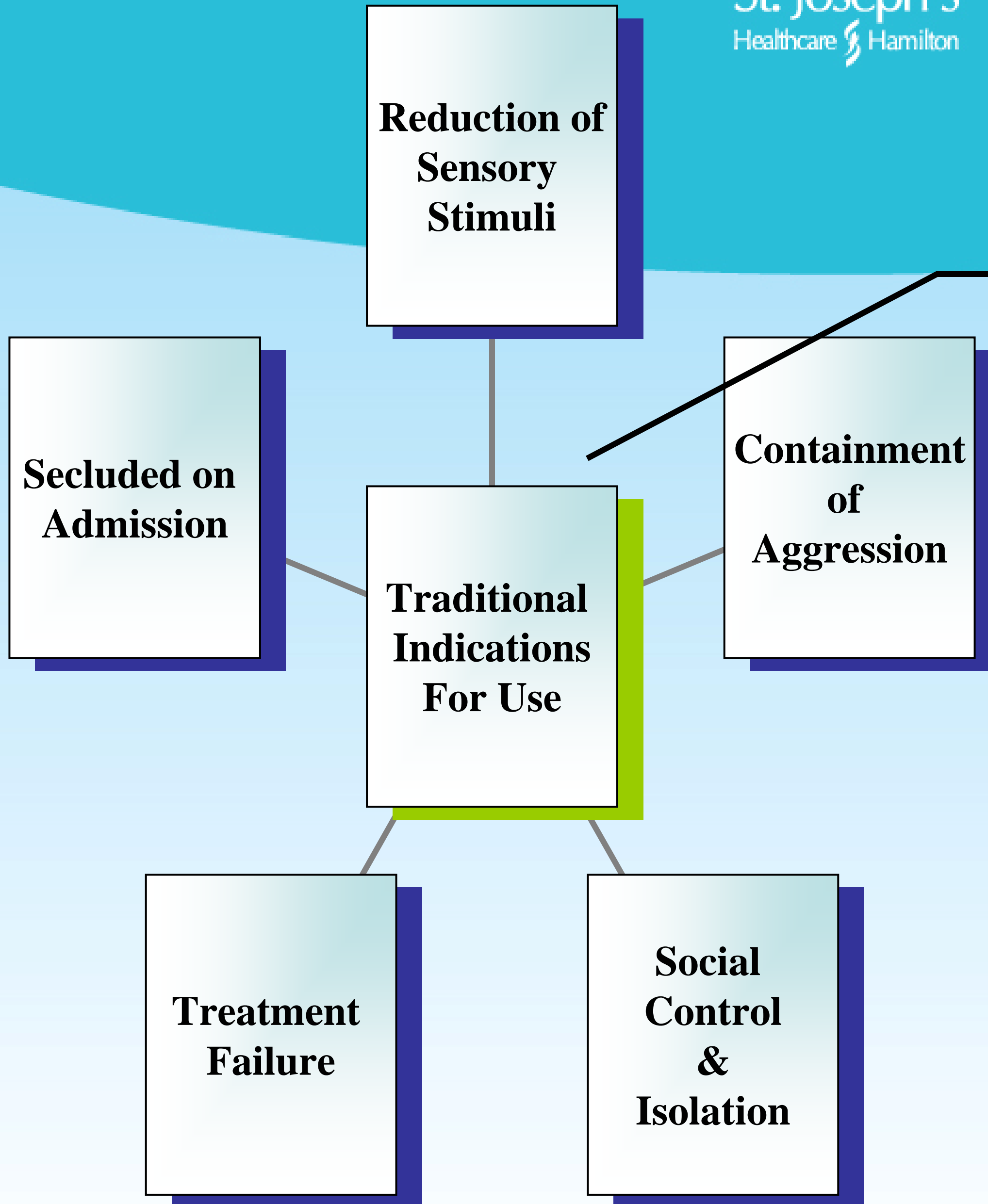

There is little, if any, empirical evidence to determine the safety &/or effectiveness of the use of seclusion & restraint

Nelstrop et al, 2006

Brown & Tooke, 1992; Lee et al, 2004; LeGris, 1999; Meehan et al, 2000

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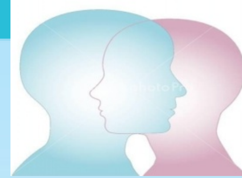
The Experience of S/R



Patient

- Emotional – stigma, powerlessness, loss of dignity, humiliation, disempowerment
- Physical – sensory deprivation, isolation, loss of contact with others, positional asphyxia, increased risk for injury &/or death

Staff

- Interruption of therapeutic relationship
- Lost opportunities for health teaching, problem-solving
- Increased assaults & injury

Meehan et al, 2000; Martinez et al, 1999

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Trauma Informed Care

- Many patients have hx of violence & trauma
- Trauma may lead to, or contribute to mental health issues
- Important to avoid re-traumatization
- Trauma specific interventions address consequences of trauma & involves collaboration & empowering the individual
- Accessibility to Trauma Support Groups

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Change in Culture Requires

- Openness to look at S/R in a new way
- Trauma-informed care
- New clinical skills & reflective practice
- New knowledge & knowledge transfer
- Supportive & evidence-informed policy
- Involvement of all stakeholders
- Investment for sustainability

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Best Practice

- S/R interventions must be used as an absolute last resort
- S/R should be used only once all other less restrictive methods have been tried
- S/R can be prevented
- RNAO is currently developing a Best Practice Guideline for the Reduction of Restraints *(to be published in Dec. 2011 or beginning of Jan. 2012)*

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Mental Health & Addiction Program

- Six core strategies
- Strong leadership commitment
- Shift in culture
- Person-centred services/supports
- Consumers & families as partners
- Trauma-informed
- Significant success to date

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Public Health Model

- **Primary Prevention**
  - – Preventing the need for S/R
- **Secondary Prevention**
  - – Early intervention, thereby reducing need
- **Tertiary Prevention**
  - – Reversing or preventing negative consequences when S/R cannot be avoided

The idea of using this model was introduced to us by Kevin Huckshorn & colleagues

Core Strategies

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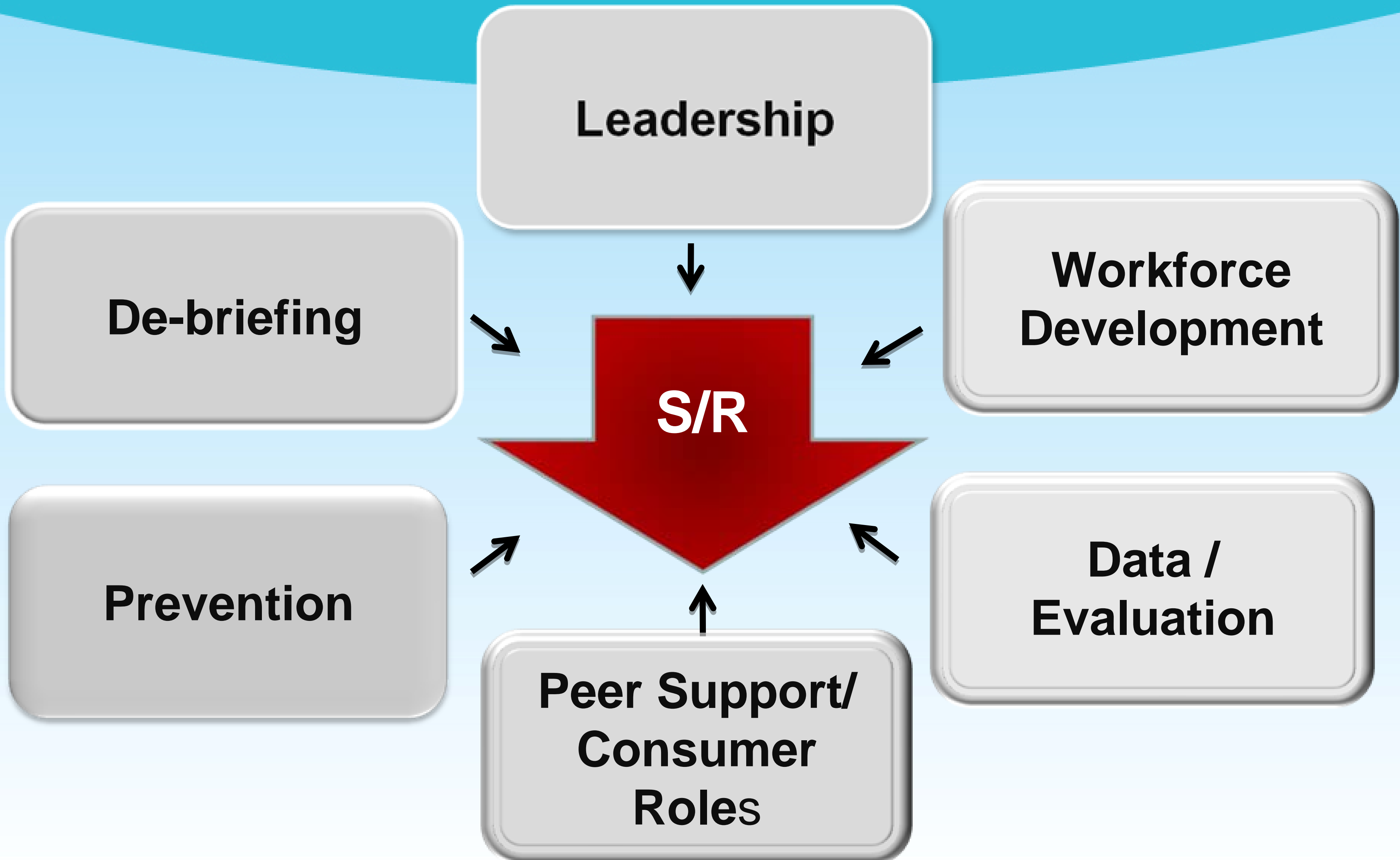

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Six Core Strategies

1. Leadership toward organization change
2. Workforce development
3. Use of data to inform practice
4. Peer support/Consumer roles
5. Use of S/R prevention tools
6. Debriefing techniques

National Technical Assistance Center

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Leadership

- Need for organizational culture shift
- Leaders play a key role
- Retreat
- Cultural survey of staff
- Communication of new vision
- Revised person-centred philosophy/policy
- S/R reduction influences redevelopment plan
- On-going dialogue between leadership & staff
- Community Advisory Board support
- VP emphasizes vision at every opportunity

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New Philosophy

The Mental Health and Addiction Program at SJHH is committed to reducing and ultimately eliminating the use of restraint and seclusion in its programs and services

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Workforce Development

- Philosophy statement
- Job Postings
- Job Descriptions
- Hiring Questions
- Performance Appraisal
- Crisis Prevention Training
- Gentle Persuasive Approach
- Clinical Orientation
- Unit Based Orientation

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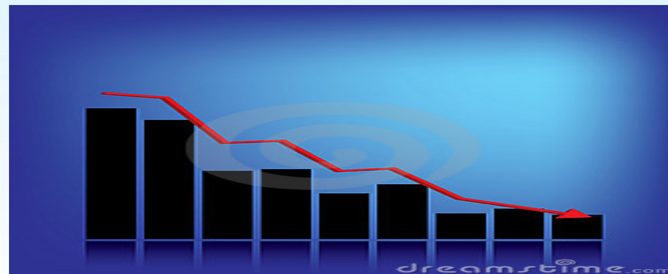
Data & Evaluation

- Changed methods of collecting data
  - Quarterly reporting/score card
  - Data review at unit meetings
  - Celebration of success re S/R reduction
- Research evaluation/Quality improvement



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Peer Support/Consumer Roles

- Review current status of consumer roles
- Identify roles/responsibilities
- Identify strategies
- Consumer satisfaction survey
- Involvement in all debriefing activities

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Prevention

- Person-centred & Trauma-informed care approach
- Assessment on admission with comfort plan
- Risk assessment
- Comfort rooms/comfort carts
- Nicotine Replacement Therapy
- Meaningful activities
- Weekly Community Meetings
- Therapeutic milieu
- Psychotherapies (DBT, CBT, MI)
- Environmental scans (therapeutic programs)

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Redevelopment

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Comfort Plans

- My Distress Signs & Signals
- Comfort & Calming Measures
- My Triggers or Irritants
- Seclusion & Restraints
- Medications
- Physical Contact
- Gender Concerns

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Music Therapy Comfort Plan

- Innovative music therapy service developed in coordination with seclusion & restraint initiative
- Provides individualized development of music based resources paired with stress management techniques as coping tools to enable individuals to alleviate anxiety & aggression & decrease the need for seclusion or restraint

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Debriefing

- Will take place after each incident of seclusion or restraint
- Includes an analysis of:

1. Triggers
2. Antecedent behaviours
3. Alternative behaviours
4. Least restrictive or alternative interventions attempted
5. De-escalation techniques preferred
6. Treatment plan strategies

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Five Levels of Debriefing

1. Post-Acute Debriefing
2. Debriefing of Individual Secluded/Restrained
3. Debriefing of Family
4. Formal Debriefing
5. Ongoing Review

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Case Scenario

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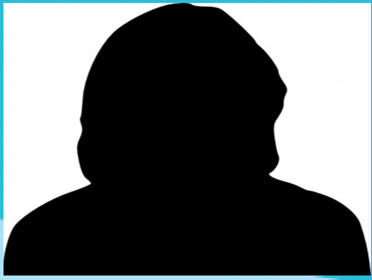
Assessment

- Assess risk for harm to self & others
- Assess strengths & vulnerabilities
- Ask about lived experience
- Identify signs of anxiety & distress
- Identify potential triggers for crisis
- Identify how symptoms affect her life
- Assess past & current coping
- Assess what changes patient would like to make
- Complete psychosocial & family history



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Treatment Plan

- Build a trusting relationship
- Develop plan to manage risks & boundary issues
- Identify patient's individual needs & preferences
- Invite collaboration (in exploring options, finding solutions)
- Use DBT strategies
- Make daily/weekly schedule to structure time
- Anticipate rel'ships/transitions may evoke strong emotions or reactions
- Consultation with specialists (in developmental disability)
- Invite collaboration with other community providers

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Outcomes

- Frequency & nature of aggressive behavior
- Safety of clients
- Knowledge/skills of staff & clients
- Attitude change
- Frequency & duration of SR
- # & severity of staff injury
- # & severity of patient injury

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Questions/Discussion