

# Creating a Culture of Care

A Toolkit for Creating a Trauma-Informed Environment



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# Introduction

## The STARS Grant

In September 2007, Texas was awarded a federal grant from the Substance Abuse and Mental Health Services Administration for the reduction or elimination of restraint and seclusion in four state mental hospitals in Austin, Big Spring, San Antonio, and Vernon/Wichita Falls. The project was titled State of Texas Alternatives to Restraint and Seclusion (STARS). It used as its template for change a document titled “Six Core Strategies for Reducing Restraint and Seclusion” by Kevin Huckshorn.

Through the STARS grant, Texas was able to realize significant improvements in the culture of care at the state mental hospitals, most notably reflected in reductions in both the numbers of incidents of restraint or seclusion, the numbers of patients involved, and the length of time spent in restraint or seclusion per incident.

The grant advisory committee included representatives of public and private mental health facilities and state agencies with responsibility for people with mental illness, intellectual and developmental disabilities, juvenile and adult criminal offenders, children and adolescents, and adults in state-run residential care. In the process of meeting, it became evident that many of the tools used to change the culture of care and reduce restraint and seclusion in state mental hospitals could be applied in other care settings as well. The findings of the STARS project are applicable to all human service settings, and this toolkit was developed broadly for this purpose.



## Single Most Important Finding: Trauma-Informed Care

***We need to presume that the clients we serve have a history of traumatic stress and exercise “universal precautions” by creating systems of care that are trauma informed.—Hodas, 2005***

The single most important finding of the project was that restraint and seclusion are emblematic of an approach to care that is based on control and coercion. In such a culture of care, attempts to reduce the use of restraint and seclusion will ultimately fail.

Statistics suggest that most people receiving mental health services have been significantly traumatized, with “trauma” defined as the experience of violence and victimization including sexual abuse, physical abuse, severe neglect, loss, domestic violence, and/or the witnessing of violence, terrorism, or disasters (NASMHPD, 2006). The American Psychiatric Association defines trauma as a situation in which an individual’s response involves intense fear, horror, and helplessness, an extreme stress that overwhelms the person’s capacity to cope (DSM IV-TR, 2000).

Further, Dr. Joan Gillece, the director of SAMHSA’s National Center for Trauma-Informed Care, cites the following statistics and many more that substantiate the fact that victims of trauma are found *across all systems of care*:

- 90% of public mental health clients have been exposed to trauma.
- 97% of homeless women with serious mental illness have experienced severe physical and sexual abuse, with 87% experiencing the abuse in both childhood and adulthood.
- 70-90% of incarcerated girls in the child mental health and youth detention population have experienced sexual, physical, and emotional abuse.

Up to two-thirds of men and women in substance abuse treatment report childhood abuse and neglect.

The pervasive underlying influence of trauma on the lives of the people being served and, to some extent, on the lives of the individuals providing care, requires recognition and informed management to reset the value base of care giving. The therapeutic value of services is diminished or negated when

delivered in an environment that does not take into account the effect that trauma has on individuals receiving services. The National Center for Trauma Informed Care has a wealth of material that supports the objectives of this toolkit (<http://www.samhsa.gov/nctic/>).

## The Toolkit

In order to benefit the most people possible, this toolkit has been intentionally designed to be of use in any setting in which restraint or seclusion is used. One of the state's partners in its efforts to reduce and eliminate restraint and seclusion has been the Hogg Foundation for Mental Health at the University of Texas, Austin. The Hogg Foundation provided valuable support to mental health providers in 2006 by bringing federal experts into San Antonio for a two and a half-day conference on reducing and eliminating restraint in a wide range of settings (including mental health). The Hogg Foundation is now providing similar support for state centers that serve people with intellectual and developmental disabilities and for state-licensed residential treatment centers serving adolescents and youth.

This toolkit is provided in the same spirit—that is, in acknowledgement that the underlying principles of trauma-informed care that are so useful in reducing and eliminating restraint and seclusion are not specific to mental health settings. These principles should have the broadest application possible, especially in view of the fact that individuals seen in one type of care setting are often seen in other types of care settings throughout their lifetimes.

# Leadership



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## Goal

*To provide the organizational guidance, direction, and vision necessary to promote genuine and meaningful change of culture, practices, attitudes, and day-to-day behavior of every employee, volunteer, and participant in the organization.*

Most organizational cultures change continuously and naturally in response to multiple influences on individuals and the organization as a whole. **Planned** culture change requires **significant commitment** from leadership in the organization. Leadership is not limited to governing entities such as the board of directors or the executive team or to individual positions such as the chief executive officer.

Although organizational leaders are critical in changing the culture of care, they alone are not enough to change the day-to-day practices of an organization. All leaders, formal and informal, especially clinical and medical practitioners, must be engaged in understanding and supporting change.

Listed here are the specific tools necessary to affect genuine culture change. These tools can help drive change to trauma-informed care in any service delivery setting, program, or organization. As you review the tools, you may decide that some are more readily implemented or useful than others for your organization. The leadership of your organization will need to determine which are most applicable to your setting and best meet your individual conditions.

A matrix describing key leadership positions and their responsibilities as well as specific examples of tools is at the end of this section.

## Six Tools for Leadership

### 1. *SWOT Analysis*

Develop an opportunity statement based on an analysis of your organization's strengths, weaknesses, opportunities, and threats (SWOT). Use this as a beginning point to lead culture change. See [http://www.businessballs.com/free\\_SWOT\\_analysis\\_template.pdf](http://www.businessballs.com/free_SWOT_analysis_template.pdf). This information can provide the springboard for an organization change plan (example at end of chapter).

### 2. *Vision, Value, and Mission*

Define the vision, values, and mission for the organization to be compatible with trauma-informed care. Emphasis should be on the culture needed to provide trauma-informed care. An outgrowth of that culture shift may include an enhanced working environment for employees and consumers, a non-coercive environment reducing conflicts and reduction of restraint and seclusion. Even if the current mission statement is appropriate, change it anyway as a means of symbolizing the intended change within the organization. In defining or redefining the vision, values, and mission:

- A. Involve consumers, all levels of staff and leadership, including the director/CEO.
- B. Review
  - a. Organizational priorities—to identify and manage conflicting priorities; and
  - b. Resources—to reallocate resources to achieve change (e.g., to hire peer support specialists, to furnish comfort rooms, etc.).
- C. Operationalize the vision, values, and mission at the level of individual departments.
- D. Evaluate progress at regular staff meeting to ensure that changing the culture of care stays on the agenda.

### 3. *Policies and Procedures*

Review and revise existing policies and procedures to ensure they are aligned with and reference trauma-informed care.

Commission a trauma-informed care committee divided into subcommittees that focus on training, policies & procedures, environment, and debriefing. Major units of the organization should have independent committees that report to the organization-wide committee.

Ensure advocacy staff and external consumer consultants are well informed regarding the organization's trauma-informed care philosophy, approach, and mechanisms, including restraint-related policies and the existence of a review committee.

If restraint or seclusion is ever utilized in your organization, create a restraint policy statement and action plan congruent with revised mission and values.

- A. Define restraint as a safety measure of last resort that is regarded as a treatment failure.
- B. Create a restraint reduction committee (define roles and responsibilities, including review of quarterly data reports).
- C. Develop goals, objectives, and action steps (assigned to specific staff).
- D. Implement a data collection and reporting system that enables monitoring of key variables (restraints, "near misses," etc.).
- E. Plan for executive oversight and review (through quarterly reports of incidents).
- F. Establish and recognize champions and a structure to support them.
- G. Create a plan for person-centered activities and programming to ensure opportunities exist for person-centered, effective treatment activities within the organization and the community.
- H. Obtain leadership agreement to use data to evaluate and reduce restraint through
  - a. Review of quarterly reports,
  - b. Standing agenda item for staff meetings, and



- c. Regular evaluation of the impact of restraint reduction efforts on the whole organization and system (identify unintended or unforeseen consequences).

#### 4. *Incident Review*

Implement on-call or administrator-on-duty assignments for 24-hour on-site response to observe, analyze, debrief all restraint incidents, and report to the oncoming administrator in 24-hour programs or during service hours for others.

Implement a non-punitive incident review process with staff involved in a restraint/seclusion incident for the purpose of understanding and implementing strategies to avoid similar incidents (e.g., further training, policy changes, etc.).

5. *Workforce Development*

Develop the organizational training plan and curriculum in advance so that it follows quickly after the kick-off or town hall meeting that informs employees of the new vision and operating philosophy.

If resources allow, fund a position to serve as the champion for implementing a trauma-informed care culture. If additional resources are not available, consider reallocating job duties so that “champion” expectations fall clearly within an individual’s performance expectations.

Develop recognition strategies for staff that practice trauma-informed principles.

Include trauma-informed practice measures in all employee performance plans ([see example](#)).

6. *Communications*

Make the vision, values, and mission visible (bumper stickers on mirrors in bathrooms, signs on gates, letterhead, email tagline for all signatures, name badges, etc.).

Publish a CEO monthly newsletter that includes recognition and reference to principles of trauma-informed practices (example follows).

Collect and publish restraint data regularly in a manner visible to all staff, visitors, and individuals receiving services.

## Implementation Tips

- Before engaging in culture change, assess where the leadership team is and plan accordingly. A leadership team that is not fully on board will make it less likely to succeed. Be sure to spend time up front to ensure adequate support.
- Engage consumers in defining the organization's vision, values, and mission.
- Encourage "on board" clinical staff and medical professionals to engage peers who are slow to adopt new ideas through in-service seminars, structured discussions, etc.
- Always have a member of the leadership team attend service-planning or treatment team meetings.
- Leadership team members should be prepared to help staff work through circumstances in which the new approach doesn't seem to work. The emphasis should always be on finding practical solutions to overcoming barriers.
- Prepare the organization-wide training plan and curriculum in advance so that it follows quickly after the organization staff is informed of the new direction.
- Maintain energy and focus by ensuring department heads and managers continually interweave trauma-informed focus in discussions of cases and issues.
- Do not assume managers and supervisors are able to cascade information within the organization. Leadership should directly communicate trauma-informed vision, values, and mission to staff on an on-going basis.
- Be prepared to manage out actively the employees who cannot embrace trauma-informed care and practices.
- Analyze workgroups that may be struggling to perform within the new cultural expectations. Reassign members in order to break up any negatively self-reinforcing groups.

- In the first year, focus efforts on shifting the treatment approach or safety planning. In the second year, introduce an additional focus on reducing restraint and seclusion. Begin tracking and showing the data.

## Cautions

- Because most medical professionals are trained to regard behavioral illnesses from a medical perspective, it is sometimes difficult to transition to a patient or consumer-centered approach.
- Naysayers will be quick to latch onto exceptions that prove “this is the kind of problem we run into, this is why it won’t work for our population.”
- Cultural shifts take time, focus, and perseverance. Prepare leadership to expect slow progress, with some periods of regression along the way.
- It is difficult to maintain energy and focus year after year—especially as the reduction curve “flattens.”

## Examples and Additional Resources

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Organizational Change Planning Worksheet

Any major change in an organization, especially one that requires the culture to be altered over time, takes many steps. Some people get on board quickly, some people resist but then come along, and some refuse to change and just want to wait it out. Organizational leadership should identify the almost overwhelming aspects of change and figure out how to make change manageable over time.

Consider breaking down the transformation of the organization’s culture into manageable parts.

What are the major areas that have to be considered, and what are the main components of each of those areas? An example may be “training” or “gaining staff buy-in,” etc.

Major Considerations	Components of this consideration are:
	1.
	2.
	3.
	4.
	5.
	1.
	2.
	3.
	4.

	5.
	1.
	2.
	3.
	4.
	5.

### Principles of Trauma-Informed Care

These Principles can be applied to various activities that occur within the organization. Generally, they are used as a tool for developing, evaluating and coordinating care for clients.

- ✓ Partnering – with patients, staff, families, students, the community -- EVERYONE
- ✓ Offering choices and options
- ✓ Encouraging patient involvement in treatment
- ✓ Communicating hope



- ✓ Advocating on behalf of the client
- ✓ Assisting clients to voice concerns
- ✓ Actively spending time with clients– more than just watching and directing
- ✓ Using person-first language ([http://www.hogg.utexas.edu/uploads/documents/Language\\_Matters\\_brochure\\_final\\_090810.pdf](http://www.hogg.utexas.edu/uploads/documents/Language_Matters_brochure_final_090810.pdf) for more information about person-first language)
- ✓ Supporting clients in managing trauma in healthy ways
- ✓ Using methods and techniques for managing the milieu in a way that supports partnering (community meetings, managing transitions, etc.)

## Person First Language

*People-first language* puts the person *before* the disability, and describes what a person *has*, not who a person *is*. Are you "cancerous" or do you have cancer? Is a person "handicapped/disabled" or does she "have a disability"? Using a diagnosis as a defining characteristic reflects prejudice and robs the person of the opportunity to define him or herself.

Let's reframe "problems" into "needs." Instead of, "He has behavior problems," we can say, "He needs behavior supports." Instead of, "She has reading problems," we can say, "She needs large print." "Low-functioning" or "high-functioning" are pejorative and harmful. Machines "function;" people live! Moreover, let's eliminate the "special needs" descriptor—it generates pity and low expectations!

A person's self-image is tied to the words used about him. People First Language reflects good manners, not "political correctness," and individuals who said, "*We are not our disabilities*" started it. We can create a new paradigm of disability and change the world in the process. Using people-first language is right – just do it, now!

### *A FEW EXAMPLES OF PEOPLE FIRST LANGUAGE*

#### Instead of:

Handicapped, disabled, special needs.

He's mentally retarded.

She's autistic.

He's a schizophrenic.

She's learning disabled.

He's a quadriplegic/crippled.

She's confined to/wheelchair bound.

#### Say:

Children/adults with disabilities.

He has a cognitive disability.

She has autism.

He has schizophrenia.

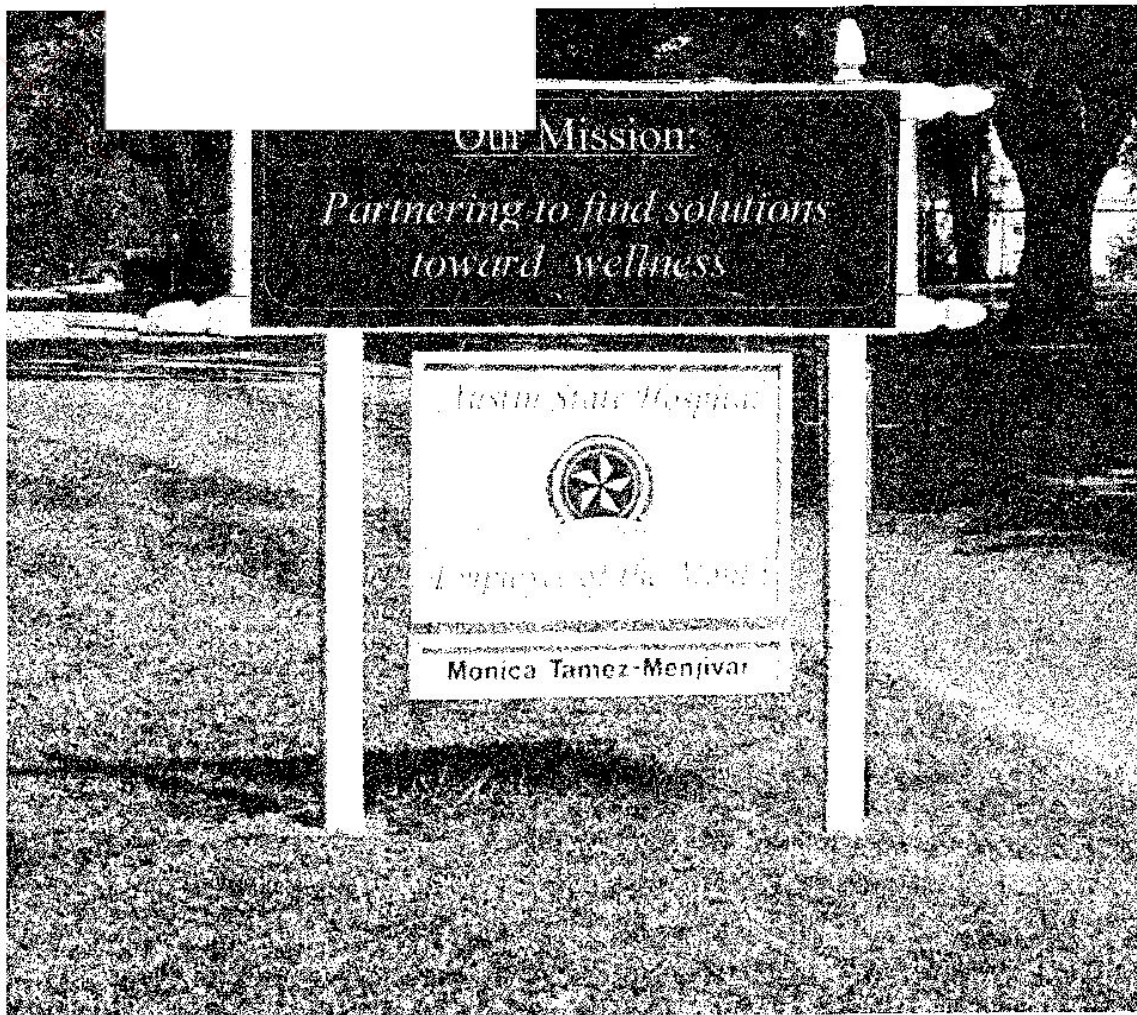
She has a learning disability.

He has a physical disability.

She uses a wheelchair.

He's in special ed; a special ed kid.	He receives special ed services
Normal or healthy people.	People without disabilities.
Is non-verbal.	Communicates with her eyes/device/etc.
Birth defect/Brain damaged	Congenital disability/Brain injury
Handicapped parking, hotel room, etc.	Accessible parking, hotel room, etc.

Example of Staff/Community Communication



000000000000

Superintendent Communiqué

Friday, January 21, 2011

Yes, the **legislative session** has started, and there are all kinds of rumors and stories about facility closures, cut in pay, cut in benefits, etc. It is obvious that Texas is in a very significant financial hole, and it will take some drastic measures to get out of it. However, keep in mind that nothing is a done deal until the House budget bill is approved in May. There are many discussions between now and then.

As I have told you before, the best thing we can do is keep focused on the business at hand, taking care of the patients. People will look to the results of our services and our impact on the patients we serve when making decisions about the budget. So just stay focused and don't put too much energy into worrying about the state budget. And for now, rumors are just that – rumors.

This is your last call for getting a free **ASH polo shirt** if you get a flu shot. You must have gotten a shot by the end of January, either here or in the community, to get the shirt. It's cold now, but when it warms up, you're going to be awfully jealous of all your co-workers styling in their free shirts and you don't have one.

It's that time of year when we start the various **student rotations** here at ASH. We have many new student groups – nursing, social work, psychology, medical, etc. – and you just have to look around at our current staff to know how successful we have been in recruiting former students. A huge number of our staff is here because of the great experiences they had when they were doing student rotations here. You make a huge difference in our ability to recruit – keep it up!

☆☆☆☆☆ *Caught in the IACT* ☆☆☆☆☆

The recent **IACT** recognitions include the following staff – congratulations and great going for helping make ASH a welcoming and partnering treatment environment for the patients we serve:

**Jim Bride, RN** – “The CAPS unit was faced with challenging staffing issues this weekend, but Jim was able to manage it safely. We had an outing scheduled but the chances of the kids going looked meager because of the staffing. Jim was able to patch things together in a short period of time without compromising the safety of any of the CAPS units and allowed the outing to occur. Jim didn't just give up for the lack of staff and was able to provide the opportunity for the kids to attend a great concert by using his efficient staff management skills.” – *Activity Coordinator*

**Christy Clakley, PNA** and **Michael Pinson, PNA** – “A very agitated young woman was carried into a crowded admissions front room by policemen - double handcuffed in a mesh vest with protective head gear and a face mask. The situation had been and clearly was still potentially extremely explosive. Christy and Michael immediately assisted - initially cautiously, tactfully and prudently - then with appropriate confidence. The patient was soon able to be freed from restraints. Michael and Christy's skillful and respectful intervention defused a very tense situation, restored dignity, and, in due time, put an extremely troubled patient at ease. I was very proud to be in ASH Admissions and work with these sensitive, caring, and dedicated colleagues.” – *ASH Physician*

**Stan Martinez, RN** – “On Friday I was taking five APS East patients to a UT soccer game and needed a staff to accompany me. Staffing was very tight across campus. I called Stan Martinez and he came to my rescue. He sent Harvey Bowers, RN with me. The patients were able to go and they had a great time thanks to Stan's willingness "to partner to find solutions towards wellness". I appreciate his willingness to help out.” – *Activity Coordinator*

**Beverly Trejo, PNA, Luis Guajardo, PNA, and Torie Thieman, Activity Coordinator** – “Everyone should take a minute to go and look at the mural painted on the comfort room wall on SS-EF. Everyone had a good time painting and it looks absolutely terrific! Thanks to the three of you for heading this up!” – *Service Director*

**Rachel Morgan-Shaw, PNA and Freddie Brown, PNA** – “I was out on the patio speaking to a patient when I observed Rachel and Freddie interacting with a female patient who was very distressed. They were able to calmly escort her back to the unit. I was present directly and observed the HTHT verbal principles in progress.”  
– *SS Social Worker*

**Ruben Reyes, PNA** – “Thank you for helping APS-C with a Spanish-speaking newly admitted patient on such short notice. Great work and it really made a difference to the patient and to the unit staff.” – *APS PNA*

**7-3 Admissions Staff** – “I wanted to let you know that every single time I call the Admissions office for some question regarding a patient, the staff is always 100% professional and helpful. They also have incredible patience too, because I know I have asked the same question before. They do a great job!” – *Community Relations*

**Lanna Spencer, RN** – “The last few nights at CAPS, no RN was there at shift change. Lanna stayed until after 1 a.m. one night, then 3 a.m. the next. Another night there were only 3 PNAs for 11-7 at the beginning of the shift, and Lanna stayed willingly and with no complaints and wanted to make sure the 11-7 PNAs felt supported and safe. Great teamwork and support!” – *CAPS Nursing*

**Evelyn Cunningham, RN** – “I wanted to point out what a good job Evelyn did on a difficult case. She spent a lot of extra time counseling a patient who was discharged from the court but had no immediate place to go. He needed to stay overnight, and Evelyn carefully worked with him and ensured that his rights weren't violated. She seems to care a lot about doing her job well!” – *APS Social Work*

**Tiffany Levy, Activity Coordinator, Ray Washington, Ed/Rehab, Yvonne Williams, PNA, and APS East Staff** – “The Outdoor Field Day for East was a big success, thanks in big part to the efforts of Tiffany, Ray, and Yvonne. Most of our patients were able to attend. The patients really seemed to have a good time, and some of the staff participated in a game of ring toss or two. Tiffany and Yvonne were in charge of the food preparation and setup. Ray took charge of monitoring the 20

volunteers and the patients. Thanks to the whole 7-3 APS East staff for making sure patients complied with their diets and for monitoring the patio so that everyone remained safe during the activities. Great job to all!" – *APS Nursing Administration*

**Trinia Easley, PNA** and **Marshall Smith, RN** – "Trinia and Marshall have been advocating to get Spanish speaking patients' safety plans translated into Spanish. This is a great way to ensure those patients understand and are participating in their treatment." – *TCD Staff*



## Standard Job Tasks

Below are suggested job tasks for all employees and all supervisors/managers.

### Job Tasks for All Employees:

#### Job Task:

INTERACTIONAL BEHAVIOR: Demonstrates respect for and consideration of others in relations with clients, visitors, and all staff within the organization, while contributing to a social environment in which respectful behavior pervades all aspects of the organization. This includes demonstration of the following behaviors in all interactions including face-to-face, telephone, and written/emailed: cultural sensitivity, respect/dignity, politeness/courteousness, compassion/empathy, appreciation/recognition, and conflict resolution/problem-solving.

#### Performance Standards:

1. Continued failure to demonstrate listed interactional behaviors.
2. Repeated failure to demonstrate listed interactional behaviors.
3. Continued success in demonstrating listed interactional behaviors.
4. Meets item 3 above and directly contributes to improvement in interactional behavior of other staff members/subordinates.
5. Meets item 4 above and recognized as a role model by other staff.

Job Task:

RESTRAINT/SECLUSION REDUCTION: Effectively works within defined role to reduce the use of restraints and seclusions through the implementation of strategies put forth through the organization's mission, vision, values, and training. Models interactions that reflect trauma-informed care and empower clients to participate actively in their treatment.

Performance Standards:

1. Displays behaviors that reflect trauma-informed care.
2. Encourages client participation in treatment.
3. Treats clients with dignity and respect and as staff would want to be treated in a treatment situation at all times.
4. Participates in performance improvement initiatives that foster environment of support and caring, furthers patient autonomy, and focuses on the use of minimal physical interventions when possible.
5. Understands the basic aspects of trauma-informed care and the potential for re-traumatization of clients using physical interventions.

***Job Tasks for All Supervisors/Managers***

Job Task:

RESTRAINT/SECLUSION REDUCTION: Effectively works within assigned department's role and structure to reduce, directly or indirectly, the use of restraints and seclusions. Is seen by internal and external customers as a role model in espousing precepts of the mission, vision, and values of the organization as well as the concepts of trauma-informed care.

#### Performance Standards:

1. Role models treating others as you would be treated, with dignity and respect, at all times and expects staff in assigned areas to work toward incorporating dignity and respect into every interaction, regardless of role within treatment services, support services, or ancillary services.
2. Undertakes performance improvement initiatives that will effectively reduce the use of restraints and seclusions in the clinical areas or will improve interactions and workplace behaviors in other areas.
3. Understands that effective communication is a key ingredient to effective role modeling and promotion of wellness, both for consumers and for staff. Practices and encourages good communication among staff and between staff and clients.
4. For clinical leaders, incorporates trauma-informed care principles into clinical service areas and role models the same.

## Core Strategies Implementation Matrix

**Facility**\_\_\_\_\_

**COMP – Complete    PC – Partially Complete    INC – Incomplete**

Action	Steps	Status	Comments	Target Date
<b>GOAL ONE: To reduce the use of restraint by defining and articulating a mission, philosophy of care, guiding values, and assuring for the development of a restraint reduction plan and plan implementation. The guidance, direction, participation and ongoing review by executive leadership are clearly demonstrated throughout the restraint reduction project.</b>				
Has the facility reviewed/revised facility mission statement, philosophy and core values to assure congruence with restraint reduction initiative? (For example, referencing restraint reduction as congruent with principles of positive behavior support; building a trauma informed system of care; creating violence-free and coercion-free environments; assuring safe environments for staff and consumers; and facilitating least restrictive placement.) This step must include an organizational values exercise where values statements are cross-walked with actual clinical and administrative practices to assure congruence.	Review and evaluate current mission and values statement for compatibility with restraint reduction and trauma-informed care philosophy			
	Revise statements to incorporate/make congruent with restraint reductions and trauma-informed care			
	Inform facility staff of statements via memo, training, posting revised statements, etc.			
Has the facility developed a facility restraint policy statement that includes beliefs to guide use and is congruent with mission, vision, values and positive	Review current restraint policy			

<p>behavior support principles? (This statement would include statements that indicate that restraint is not treatment, but a safety measure of last resort; that restraint indicates treatment failure; and the facility's commitment to reduction/ elimination etc. There are examples of policy statements available to review.)</p>	<p>Revise to incorporate/make congruent with restraint reductions and trauma-informed care</p>			
	<p>Ensure it is clear that restraint is not treatment, but a failure of the treatment plan and/or of implementation of the plan</p>			
<p>Has the facility leadership developed an individualized facility-based restraint reduction action plan based on a performance improvement and prevention approach as the overall umbrella including the assignment of a restraint reduction committee; the creation of goals, objectives and action steps assigned to responsible individuals and noted due dates; and are there consistent reviews and revisions with senior executive oversight and review?</p> <p>(See policy statement, policy and procedures, actual plan.)</p>	<p>Restraint reduction committee (RRC) established</p>			
	<p>Periodic (at least quarterly, more often at first and as necessary) meetings established</p>			
	<p>Goals and member responsibilities addressed at meetings</p>			
<p>Has facility leadership reviewed and analyzed their restraint related data in an effort to discover critical details of events such as time of day, location, points of conflicts? Has leadership determined data-driven facility goals to reduce restraint? (See data component for specifics.) (This objective is</p>	<p>Review monthly restrictive procedures reports.</p>			

leaderships' commitment and intention to use and monitor real time data in the reduction efforts.)	Review quarterly trend analysis reports.			
Has the facility leadership committed to create a collaborative, non-punitive environment, to identify and work through problems by communicating expectations to staff, and to be consistent in maintenance of effort? (This step may include a statement to staff that, while an individual staff member may act with best intent, it may later be determined that there were other avenues or interventions that could have been taken. It is only through staff's trust in leadership that they will be able to speak freely of the circumstances leading up to a restraint event so that this event can be carefully analyzed and learning occurs. However, the rules defining abuse and neglect are clear and the previous statement does not lift accountability for those kinds of performance issues.)	<p>Review restraints with the understanding that people do the best they can with the information and skills that they have</p> <p>Reviewing the restraint with the staff member(s) involved provides the opportunity to improve the individual support plan and/or provide additional training to staff members to implement the plan</p>			
Is all staff aware of the role of the facility Director to direct the restraint reduction initiative? (This will include senior level involvement in motivating staff including an understanding and commitment from the facility director. A "kickoff" event for the rollout of this initiative is recommended or a celebration if facility is already involved in a reduction effort. This	Facility Director executes a memo, discusses at leadership and other meetings the initiative to reduce restraints			

step calls for active, routine and observable Director activities including the inclusion of status reports at all management meetings.)				
Has leadership evaluated the impact of reducing restraint on the whole environment? (This includes issues such as increased destruction of property; extended time involved in de-escalation attempt, additional admission assessment questions, debriefing activities and processes to document events, etc.)	RRC discuss and establish boundaries and limits regarding safety issues for prolonged de-escalation periods			
	RRC discuss and establish boundaries related to damage or loss to property associated with encouraging prolonged de-escalation (within safety limits), when working to avoid restraint			
Has the facility leadership set up a staff recognition project to reward individual staff, unit staff, and restraint champions for their work on an ongoing basis?	Publicly acknowledge staff members (particularly direct care) for efforts to reduce restraints			
	Focus on recognizing (reinforcing) "near-misses"			
Does the leadership-approved restraint reduction plan delegate tasks and hold people accountable through routine reports and reviews?	RRC devise and create plan			
	RRC will assign responsibilities			
	RRC will meet at least quarterly (to coincide with trend reports) to review progress toward goals			

Has leadership addressed staff culture issues, training needs and attitudes? (See Workforce Development.) (Leadership will assure staff training and development in knowledge, skills, and abilities for prevention and management of behavior that might otherwise result in restraint and in restraint application techniques and will include Competency Training and Development staff.)				
Has leadership reviewed the facility's plan for person-centered activities in an effort to assure that active, daily, person-centered, effective treatment activities are offered to all persons receiving services; that these services are offered off living units preferably; and that persons attending have some personal choice in what activities they attend? The minimal criteria to meet under this objective is to assure that service recipients are not spending their days in enclosed areas with no effective active treatment occurring that is effective in teaching living, learning, recreational and working skills.	Close analysis of programming and daily life of residents (Active treatment pilot project)			
	Vocational supports (sheltered work, supported work, competitive employment) offered and residents evaluated on basis of skills and interest(s)			
	Day programming/retirement for individuals no longer working or not interested in or suitable for work (young school-aged individuals)			



<p>Has facility leadership ensured oversight accountability by watching and elevating the visibility of every event 24 hours a day/7days per week by assigning specific duties and responsibilities to multiple levels of staff including on-call executives, on-site nursing supervisor, direct care staff, advocates/consumers?</p> <p>1. On-call Executive Role (member of executive team)</p> <p>a. 24/7 on-call supervision for event analysis</p> <p>b. Use knowledge gained by event analysis to identify organizational problems, potential resolutions and ensure timely follow-up</p> <p>c. Make restraint a standing agenda item for all meetings at all levels (Incident Management, Leadership, Restraint Reduction, Behavior Therapy Committee, Human Rights Committee, etc.)</p> <p>d. Ensure that data are collected, used, and shared</p> <p>e. Ensure staff accountability and performance recognition</p>	<p>Administrator on duty (AOD) is available for consultation; assigned staff rotate after-hours calls</p>			
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<p>2. On-site Supervisor Role</p> <p>a. 24 hour on-site response, supervision and attendance at all events and near misses when possible (to observe what worked and why)</p> <p>b. Take lead following a restraint event by debriefing all staff involved, the service recipient, all event witnesses, gathering event timelines, reviewing documentation, and providing a report (verbally and written) to oncoming supervisor or administrator</p> <p>3. Line Staff (Direct Care)</p> <p>a. Understand and be able to describe the organizational approach in reducing restraint</p> <p>b. Be introduced to project and philosophy, through:</p> <ul style="list-style-type: none"> <li>- New hire application and interview</li> <li>- New staff orientation</li> </ul>	<p>Campus Coordinator be present for all restraints; participate in debriefings</p>			
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<ul style="list-style-type: none"> <li>- Job description</li> <li>- Competency review</li> <li>- Meet performance criteria in evaluations</li> <li>- Demonstrate positive attitude about the project</li> </ul> <p>4. Consumer Role</p> <p>a. Use employed internal consumer advocacy staff or external consumer consultants to act as interviewers, gather data, investigate and to provide a critical perspective</p> <p>b. Be represented on all restraint related committees and task forces</p>				43
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<b><i>GOAL TWO: To reduce the use of restraint by using data in an empirical, non-punitive, manner. Includes using data to analyze characteristics of facility usage by unit, shift day, and staff member; identifying facility baseline; setting improvement goals and comparatively monitoring use over time in all care areas, units and/or state system's like facilities.</i></b>				
Has the facility collected and graphed baseline data on restraint events to include, at a minimum, incidents, duration, use of involuntary medication and injuries?	Gather information regarding restrictive procedures monthly			
	Review data monthly in order and analyze trends prior to the quarterly trend report			
Has the facility set goals and communicated these to staff, setting realistic data improvement thresholds? Has the facility created non-punitive, healthy competition among units or sister facilities by posting data in general treatment areas and through letters of agreement with external facilities?				
Has the facility chosen standard core and supplemental measures including restraint incidents and duration by shift, day, unit, time; use of involuntary medications; consumer and staff related injury rates; types of restraint; debriefing activities; grievances; consumer demographics including gender, race, diagnosis, and other measures as desired?	Minimum information necessary for trend analysis: shift, day, unit, time period; type of restraint(s), injuries (resident and staff)			
	Evaluate trends for most residents including most restrained; closely analyze these individuals and report any trends that emerge to the PST for addressing			

	Incorporate into the trend analysis characteristics of staff members involved in restraint			
Does leadership have access to data that represent individual staff member involvement in restraint events and is this information kept confidential and used to identify training needs for individual staff members? (for supervisors only)	Begin reviewing staff member characteristics regarding restraint; include tenure at facility, tenure in the home, home vs. pulled vs. agency staff member; staff member assigned as charge; if chemical restraint – who made request for medication			
Is the facility able to observe and record “near misses” (and the processes involved in those successful events) to assist in leadership and staff learning of best practices to reduce restraint use?	Review means to qualitatively and/or quantitatively explain “near misses;” Currently may be available if Campus Coordinator gets involved (in daily report)			

**GOAL THREE: To create a treatment environment whose policy, procedures, and practices are grounded in and directed by a thorough understanding of the neurological, biological, psychological, and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services and the experiences of our staff. Includes an understanding of the characteristics and principles of trauma-informed care systems. Also includes the principles of recovery-oriented systems of care such as person-centered care, choice, respect, dignity, partnerships, self-management, and full inclusion. This intervention is designed to create an environment that is less likely to be coercive or conflictual. It is implemented primarily through staff training, education, and human resource development activities. Includes safe restraint application training and the inclusion of technical and attitudinal competencies in job descriptions and performance evaluations. Also, includes the provision of effective and person-centered treatment activities on a daily basis that are designed to teach life skills (See Goal One).**

Has the staff development department introduced trauma recovery/resiliency, prevention, and performance improvement theory and rationale to staff?	Develop trauma-based perspective to be addressed throughout New Employee Orientation (NEO) – Consult with CTD			
	Incorporate information into PBS and competency based training during NEO			
Has the facility revised the organizational mission, philosophy, and policies and procedures to address the above theory and principles?				
Has the facility appointed a committee and chair to address workforce development agenda and lead this organizational change? (Include HR)				
<p>Has the facility assured for education/training for staff at all levels in theory and approaches including:</p> <ul style="list-style-type: none"> <li>▪ Experiences of consumers and staff?</li> <li>▪ Common assumptions and myths?</li> <li>▪ Trauma-informed care?</li> <li>▪ Neurobiological effects of trauma?</li> <li>▪ Performance improvement principles?</li> <li>▪ The restraint reduction core strategies, as appropriate?</li> </ul>	Incorporate throughout NEO – Consult with CTD			

<ul style="list-style-type: none"> <li>▪ Risk for violence?</li> <li>▪ Medical/physical risk factor for injury or death?</li> <li>▪ The use of safety planning tools or advance directives?</li> <li>▪ Core skills in building therapeutic and person-based relationships?</li> <li>▪ Safe restraint application procedures including continuous face-to-face monitoring while a person is in restraint?</li> <li>▪ Non-confrontational limit setting?</li> </ul>				
<p>Has the facility encourage staff to explore home “rules” with an eye to analyzing these for logic and necessity? (Most facilities have historical rules that are habits or patterns of behavior that are not congruent with a non-coercive, positive behavior support environment; for instance, putting people who are merely intrusive into restraint.)</p>	Home supervisors, direct care staff (DCS) and Personal Support Team review home rules			
	Decide which are coercive or meant to “control” (vs. establishing boundaries and interactions between residents); make necessary changes to/elimination of rules			
	Report findings to the Unit Director; Unit Director will report to the RRC and facility Director			

	Director and RRC will analyze trends and make recommendations regarding “rule making” for the facility			
Has the facility addressed staff empowerment issues? (For example do staff have input into rules and regulations?) Does the facility allow staff to suspend “rules” within defined limits to avoid incidents?				
Does the facility empower staff? (e.g., self-schedule, flex schedules, and switch assignments)				
Does the facility assume that all staff at all levels is responsible, capable adults, albeit perhaps injured by trauma, and communicate this value to all? How?				
Has the facility included CTD in the planning and implementation efforts to include the development and insertion of knowledge, skills and abilities considered mandatory in job descriptions and competencies for all staff at every level of the organization? Does this include both technical competence and attitudinal competence and how these are demonstrated?				



<b>GOAL FOUR: To reduce the use of restraint with a variety of tools and assessments that are integrated into each individual consumer's personal support plan. Includes the use of assessment tools to identify risk factors for violence and restraint history; use of a trauma assessment; tools to identify persons with risk factors for death and injury; the use of de-escalation or safety surveys and contracts; and environmental changes to include comfort and sensory rooms and other meaningful clinical interventions that assist people in emotional self-management.</b>				
Has the facility implemented assessment tools to identify risk factors for incidents of aggression and violence? (Research shows best predictor is past violent behavior and past involvement with restraint use.)	Begin using violence assessment tools; examples of tools are available			
Has the facility implemented assessment tools on the most common risk factors for death or serious injury caused by restraint use? (These include obesity, history of respiratory problems including asthma, recent ingestion of food, certain medications, polypharmacy, history of cardiac problems, and history of acute stress disorder or PTSD.)	Acquire assessment tool or establish protocols			
	Medical statement indicating restraint would not cause additional harm			
Has the facility implemented the use of a trauma history assessment that identifies persons at risk for re-traumatization and addresses signs and symptoms related to untreated trauma sequelae?	Begin incorporating trauma assessment in psychological evaluations			
	Utilize assessment tools to guide trauma assessment; examples of tools are available			
Has the facility implemented a de-escalation tool or safety planning assessment that includes the identification of individual triggers and personally	Safety Plans for Crisis Intervention (SPCI) are being implemented for individuals that have restraint procedures			

chosen and effective emotional self-management interventions?	indicated; examples of de-escalation tools are available			
	Focus of SPCI is to provide strategies to aid in returning the resident to affective baseline			
	Include procedures including self-calming, distraction techniques, non-contingent access to sensory or comfort rooms			
<p>Has the facility:</p> <ul style="list-style-type: none"> <li>a. Implemented communication techniques/conflict mediation procedures?</li> <li>b. Reduced environmental signs of overt/covert coercion?</li> <li>c. Made environment of care changes (e.g., use of comfort rooms and sensory rooms)?</li> </ul>				
Has the facility utilized an aggression control behavior scale such as the Lalemond Behavior Scale that assists staff to discriminate between agitated, disruptive, destructive, dangerous and lethal behaviors and decreases the premature use of restraint/seclusion?	Locate Lalemond or similar scale		Xxx Lalemond Scale	
	Train psychology staff or other PST members (e.g., QMRP)			

(Lalemond Scale is proprietary at this point but we can probably get approval to use or adopt principles.)	Implement scales and use to guide Behavior Support Plans (BSP) and SPCI			
	Has the facility written policies and procedures for use of the above interventions and disseminated these to all staff?			
Has the facility created a way that individual safety planning or de-escalation information is readily available in a crisis and is integrated into the personal support plan?	De-escalation information incorporated in the BSP and SPCI			
Has the facility made available expert and timely consultation with appropriately trained staff or consultants to assist in developing individualized behavioral interventions for service recipients who demonstrate consistently challenging behaviors?	Use of psychologist, behavior analyst, or psychology consultant			
	Psychology staff periodically review trends in relation to treatment planning and plan development			

<b>GOAL FIVE: To assure for the full and formal inclusion of consumers or their representatives in a variety of roles in the organization to assist in the reduction of restraint.</b>				
Has the facility integrated consumer and/or family/guardian choices at every opportunity?	Involvement in the annual Personal Support Plan, addendums, etc. for the resident, guardian, family member, or any combination; participation in the Human Rights Committee			
Has the facility created roles for older adolescent/adult consumers and family members/guardians in committees relevant to restraint reduction?			Delete. This is redundant with the second item following it.	
Has the facility educated staff as to the importance and need to involve consumers at all operational levels, both through respectful inclusion in operations decisions as appropriate and in the consistent attention to the provision of choices?				
Has the facility included consumer representation in key committees and workgroups throughout organization?				
Has the facility empowered consumers to do their facility related jobs and support this work (new roles for consumers) at the highest level by setting up appropriate supervision systems?			Delete as non-applicable? Ombudsman?	

Has the facility implemented consumer/family/guardian satisfaction surveys, discussed results with staff, and used results to direct revisions in service provision?				
Has the facility invited external advocates to provide suggestions and be involved in operations?				

<b><i>GOAL SIX: To reduce the use of restraint through knowledge gained from a rigorous analysis of restraint events and the use of this knowledge to inform policy, procedures, and practices to avoid repeats in the future. A secondary goal of this intervention is to attempt to mitigate to the extent possible the adverse and potentially traumatizing effects of a restraint event for involved staff and consumers and all witnesses to the event. It is imperative that senior professional and administrative staff participate in these events.</i></b>				
Has the facility revised policy and procedures to include two debriefing activities for each event as follows:  <ul style="list-style-type: none"> <li>An immediate “post-event” debriefing that is done onsite after each event, is led by the senior on-site supervisor who immediately responds to that unit or area? (The goals of this post-acute event debriefing is to assure that everyone is safe, that documentation is sufficient to be helpful in later analysis, to briefly check in with involved staff, consumers and witnesses to the event to gather information, to try and return the milieu to pre-event status, to identify potential</li> </ul>	Campus coordinator or unit psychologist (if immediately present) completes debriefing with the DCS and the resident following restraint (before end of the shift; may wait until the next shift to complete debriefing with the resident).			

<p>needs for policy and procedure revisions, and to assure that the consumer in restraint is safe and being monitored appropriately. If the facility has implemented “witnessing” (see Goal One) the on-site supervisor calls in the information gathered in this post-acute debriefing event to the off-site executive staff person who is on call or reports to administration if during weekday hours.)</p> <ul style="list-style-type: none"> <li>▪ A formal debriefing that includes a rigorous analysis that occurs one to several days following the event and includes attendance by the involved staff, the personal support team, and a representative of administration. (It is recommended that this formal debriefing follow the steps in a root cause analysis or a similar rigorous problem solving procedure to identify what went wrong, what knowledge was unknown or missed, what could have been done differently, and how to avoid in the future. It is also recommended that root cause analysis be used in situations where individuals are injured; where restraint has been used more than twice in a month and at any time where restraint event lasts more than eight hours.)</li> </ul>	<p>Unit psychologist analyze trends for individual clients or homes</p>			
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<ul style="list-style-type: none"> <li>Has the facility assured the involvement of the consumer in all debriefing activities either in person or by proxy? (It is extremely important to include the consumers experience or voice in this activity and if the consumer cannot or will not participate it is recommended that another consumer or staff person act as that person's advocate at the meeting. It is also recommended that the consumer, involved staff, or advocacy roles, also be involved and that the person running the meeting is well versed in objective problem solving and was not involved in the triggering event.)</li> </ul>	<p>Director of Behavioral Services and Assistant Director of Behavioral Services (maybe include data analyst) review debriefings and complete trend analysis</p> <p>Incident management review; functional behavior assessments???</p>			
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	Institute means for staff members to attend debriefings (possibly schedule weekly at Incident Management Meeting).			
<p>Do the debriefing policies and procedures specify: (see restraint Debriefing Policies and Procedures)</p> <ul style="list-style-type: none"> <li>a. Goals of debriefing?</li> <li>b. Who is present?</li> <li>c. Responsibilities/Roles?</li> <li>d. Process?</li> <li>e. Documentation?</li> <li>f. Follow-up?</li> </ul>	Current document incorporates this information			



Has the facility implemented debriefing policies and procedure that address staff responses to the event, consumer responses and issues, and “observer” response and issues?				
Has the facility provided training on how debriefing will revise treatment planning?	Analysis of trends in debriefings, trend reports, etc. is made available to the personal support team; this information can be used to guide treatment plan development			
Has the facility made an attempt to assist staff in their individual responses to restraint events, up to and including the use of EAP (Employee Assistance Program) services or other supportive resources?				

# Debriefing



**DESCRIPTION AND GOAL**

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## Description and Goal

Debriefing is the process of rigorous analysis of restraint and seclusion incidents and “near misses” in order to use the knowledge gained to inform policy, procedure, and practices. A second purpose for debriefing is to mitigate the adverse and traumatizing effects of incidents for the staff, client, and witnesses involved.

The focus of debriefing should always be on what can be done to help avoid the client becoming agitated, as opposed to how the client needs to change. Similarly, debriefing should avoid any semblance to blaming or faulting the staff, as this will undermine the creative problem-solving and team engagement power of this strategy.

Debriefing consists of three elements:

1. An immediate, post-event discussion of what happened among staff and witnesses (as appropriate) and may or may not involve the client. Care should be taken to avoid re-traumatizing those involved. The purpose of this discussion is to confirm understanding of events, ensure everyone involved is safe, and manage immediate emotions.
2. Post-event discussion with the client to determine triggers, identify self-calming strategies, manage emotions, inform the safety plan, and teach alternative coping behaviors. This is often conducted by a peer support specialist (see section 6—[Consumer Involvement](#) for a description of the peer support specialist role) or a member of the clinical staff. This may take place some time after the event (or the following day) when the client is ready to discuss the incident.
3. Formal problem analysis with the treatment team, direct care staff, and administrative leader(s) in order to identify root causes. This should take place 24-48 hours after the event when all parties can be assembled. It may or may not include the client, but at a minimum should include a peer support specialist’s or clinical staff’s documentation of the post-event discussion with the client.



## Tools

- Debriefing structure:
  - Document the initial description of events and immediate analysis as an intervention progress note. The initial debriefing should be a conversation. Any form to guide this conversation runs the risk of becoming a “check-box exercise” rather than a genuine discussion.
  - Peer support specialists or the staff person conducting the client debriefing should be given direction about the type of information needed by the treatment team. This may be provided as a series of questions. The debriefing should include discussion with the client of what might prevent a similar event from happening again, including both what staff can do to support the client and what the client can do to manage his/her emotions if a similar situation occurs again.
  - A formal problem-solving approach should be followed when conducting the problem analysis debriefing. (See Problem-Solving [Quality Wheel](#)).
  - Track restraints, seclusions, and near misses in a simple spreadsheet that notes when the incident occurred, when it was debriefed and by whom, and that summarizes the discussion and decisions.
- Key Personnel
  - On-site clinical supervisor or administrator. Ideally, this person is summoned and involved prior to a restraint. At a minimum, the supervisor or administrator should be involved in the initial post-incident conversation.
  - Initial debriefing facilitated by a clinically trained professional.
  - Client debriefing conducted by a peer support specialist or staff with whom the client relates.

- Problem analysis should be conducted by a person trained in a problem-solving approach and able to remain objective. Facilitator should be clinically skilled in root cause analysis, typical behavioral escalation, effective strategies for avoiding escalation and strong communication skills.
- Video
  - When available, analysis of video (including the events leading up to the agitation) is a helpful tool for problem analysis.

## Implementation Tips

- Begin debriefing conversations with an apology to staff and the client for having to have experienced a restraint.
  - Serves as recognition that restraint incidents are upsetting to staff as well as the client.
  - Acknowledges that the goal is to avoid putting staff in a position where they must restrain.
- Debrief staff involved along with the treatment team.
  - Demonstrates that everyone is on the same team with the same goals.
- Use debriefing as an opportunity to learn how best to implement elements of the client's safety plan.
- Debriefing should focus on the entire context, not just the incident (e.g., triggers, enabling events, etc.).
- Hold regularly scheduled formal debriefings with videos, documentation, questionnaires, etc.

- Address what happened, what can be learned, specific concerns from reviewing incidents, changes to safety plans, medication changes, changes to policy.
- Provide a daily report of restraints to all clinical staff for review.
- Email the chief administrator or clinical director when restraints occur.
- Define structure and expectations of debriefing including goals, attendees, roles and responsibilities, process, documentation, and follow up.
- Articulate policies and procedures for debriefing. Make certain the goals of debriefing are clear. Debriefing is intended to support staff in providing insight into how best to support treatment and avoid the need for restraint and seclusion.
- Allow staff to use debriefing as a way to express their own emotional responses.
- Acknowledge positive interventions and creativity that supports the trauma-informed culture—even if those creative efforts were failures.
- Publicize and celebrate successes derived through information gained in debriefing.



## Cautions

- Do not allow the form (if used) to drive the process. Debriefing should be a conversation rather than an exercise in completing required documentation.
- Debrief every incident.
- Debriefing can be perceived by staff as disciplinary/punitive rather than problem solving in nature.
- Scheduling of all core staff at one time may be problematic, especially in a campus setting.
- There must be leadership support and buy-in for every element of culture change. Without this, debriefing will fail to produce useful information.

## Examples and Additional Resources

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## Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint

Name: \_\_\_\_\_ Type: \_\_\_\_\_

Date: \_\_\_\_\_ Time Restraint Started: \_\_\_\_\_ Time Monitor Arrived: \_\_\_\_\_

Any item checked as a problem should be addressed in the Comments/Actions section.

Assess the immediate consequences of restraint. Take immediate action if applicable.

1.1	Physical distress, medical emergency or other condition requiring immediate attention of nurse or doctor?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
1.2	Risk of serious injury due to the restraint?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
1.3	Issues with protection of person's clothing and personal property?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
1.4	Issues with protection of person's privacy?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
1.5	Issues with protection of the safety of all involved?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Comments/Actions: \_\_\_\_\_  
\_\_\_\_\_

Assess the application of restraint. Take corrective action as applicable.

2.1	Applied correctly? (According to PMAB training and/or instructions in Safety Plan)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
2.2	Correct position? (Not face down or up physical, or face down mechanical restraint)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
2.3	Approved type of restraint? (PMAB/Safety Plan approved, medically approved)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
2.4	Reason for restraint and release criteria explained to person restrained?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
2.5	Continuous one-to-one supervision during restraint?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
2.6	Restraint stopped when person restrained no longer a danger to self or others?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Comments/Actions:

---

Determine if restraint was necessary. Take corrective action as applicable.

3.1	Person's behavior an immediate and serious risk of harm to self or others?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
3.2	Graduated range of less restrictive measures exhausted or considered in justifiable manner before restraint? Psychologist contacted for alternatives prior to chemical?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
3.3	Least restrictive intervention to manage the person's behavior?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
3.4	Appropriate reasons for restraint? (Not for convenience of staff or punishment)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Comments/Actions:

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Determine if procedures were followed. Take corrective action as applicable.

4.1	Checked by nurse? Circle checks done: injury    vital signs    mental status	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
4.2	Restraint Checklist completed correctly?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
4.3	Timely opportunities provided for movement, exercise, to toilet, and to drink fluids?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
4.4	Consultation with a professional obtained? (If needed)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
4.5	PBSP/Safety Plan implemented correctly? (If person has a PBSP, Safety Plan)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
4.6	Physician's order obtained? (Required for chemical or a restraint not in Safety Plan)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
4.7	Injury report started? (If injury)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
4.8	Medications given in the time period prescribed? (If in restraint at med pass)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
4.9	Meal offered as near to mealtime as possible? (If in restraint at meal time)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
4.10	Shift change review of restraint? (If in restraint at shift change)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>
4.11	If restraint not at the Center, nurse assessment completed within 30 minutes of return?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A	<input type="checkbox"/>

Comments/Actions:

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Determine outcomes and recommended changes based on those outcomes.

5.1	Restraint cause injury to anyone? Who?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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5.2 Person assisted to regain composure and to return to ongoing activities?

Yes

☐

No

☐

5.3 Staff emotions, reactions, safety concerns that should be addressed?

Yes

☐

No

☐

5.4 Further staff training needed? (Document training and/or identify who needs it)

Yes

☐

No

☐

Comments/Actions:

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5.5 Regarding the whole episode:

- What worked?

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- What didn't work?

---

- What might be tried to prevent restraint?

---

5.6 If a chemical restraint:

- What are the results? (Calmed, behavior the same or worsened, asleep)

---

- What are the effects on alertness, coordination, and communication?

---

Names of Staff Interviewed:


Interview/Observation of Person Restrained (once safe to do so, if not contraindicated by Safety Plan)

6.1	Does the person report or act traumatized? (Statements or symptoms of fear, withdrawn, hyper vigilant, too easily startled)	Yes		No	
6.2	If the individual is to be provided with an opportunity to discuss the restraint with another staff person, did this occur or was it set up?	Yes		No	
6.3	Person's response when given explanation of why the restraint was necessary?				N/A
6.4	What does the person restrained indicate were triggers to the behavior that resulted in restraint?				
6.5	What does the person restrained indicate would be better de-escalation strategies?				
6.6	What does the person restrained indicate is needed to be ready to reconnect with staff? If appropriate, what was done?				

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Ratings, documentation of observations, and actions taken are based on direct observation and/or client/staff interview.

Restraint Monitor's signature:

Date:

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Reviews: (based on information presented)

7.1 Date of Unit review:

7.2 Date of IMM review:

Unit Director/Designee:

DIRM/Designee:

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Copies: Unit Director, Psychologist, QMRP, Risk Manager, Medical Office if chemical restraint



## Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint

Name:

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Address:

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### Chemical Restraint Clinical Review:

Note if documentation indicates whether the medication was used in a clinically justified manner, the potential medication related risks that should be considered, and actions/recommendations, if any.

### Medication, Dose and Date Administered:

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Pharmacist:

8.1 Date:

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Psychiatrist:

8.2 Date:

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**Copies of Chemical Restraint Clinical Review: Unit Director, Psychologist, QMRP, Risk Manager**



## Client Debriefing Guide

Name:

Unit:

Time/Date of S/R episode:       (am/pm)                         /  

1. Before the restraint, what were you feeling and what was happening on the unit?

1a. What led to you feeling that way?

\_\_\_\_\_

2. When you began feeling that way, did you tell the staff? (Circle) Yes    No

If yes, how did they respond?

2a. How could staff have responded in a more helpful way?

3. Did you and the staff use your safety plan? Do we need to change it?

(Circle) Yes No

(Circle) Yes No

3a. Is there anybody helpful to talk to when you begin to feel that way? What about during or after a restraint?

Are they in your safety plan? (Circle) Yes No

4. If you believe changes are needed to your safety plan, what changes are needed?

5. What do you think was the reason for being placed in seclusion/restraint?

6. Did staff explain to you the reason you were being placed in restraint/seclusion? (Circle) Yes No

7. Was the restraint/seclusion the best solution? (Circle) Yes No

7a. If yes, how was it the best solution?

7b. If no, what would have been a better solution?

8. Did staff tell you what would make it safe to be released? (Circle) Yes No

If yes, what were you told?\_\_

9. Do you have any physical complaints or injuries? (Circle) Yes No

If yes, describe

10. Was your privacy and dignity respected during the restraint or seclusion? (Circle) Yes No

If no, explain

11. Describe how you felt during the restraint. (Use worksheet if you need help)

12. Describe some triggers that could lead you to not feeling well.

13. What helps you feel better and more in control when you are not feeling well?

(Use worksheet if you need help)

14. What would you like to do differently for yourself to prevent the future use of seclusion or restraint?

15. Is there anything we can do to help you recover from this incident?

Signature:

Signature/Title of Employee:

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Time and Date form Completed:



## WORKSHEET

1. Check the boxes below to describe how you felt during the seclusion/ restraint.

☐ anger   ☐ comfort   ☐ cared for   ☐ confusion   ☐ helped   ☐ helpless   ☐ secure

☐ rage   ☐ sleepy/tired   ☐ betrayed   ☐ violated   ☐ sad   ☐ relaxed   ☐ embarrassed

☐ bored   ☐ isolated   ☐ frightened   ☐ upset

☐ other \_\_\_\_\_

2. What helps you feel better and more in control when you are not feeling well?

☐ watching television   ☐ being alone   ☐ walking the hall   ☐ crying

☐ exercising   ☐ fresh air   ☐ playing a game   ☐ talking with a staff member

☐ writing   ☐ snacking   ☐ showering/bathing   ☐ quiet time

☐ napping      ☐ praying/meditating   ☐ rocking chair      ☐ medication

☐ listening to music   ☐ pet therapy      ☐ weighted blanket   ☐ comfort room/comfort cart

☐ warm towel      ☐ talking on the phone   ☐ talking with a friend or family

☐ other \_\_\_\_\_

## Problem-Solving Process and Quality Wheel

The following problem-solving process is a useful tool for systematic analysis of events with the treatment team, direct care staff and administrative leader(s) in order to identify and address root causes.

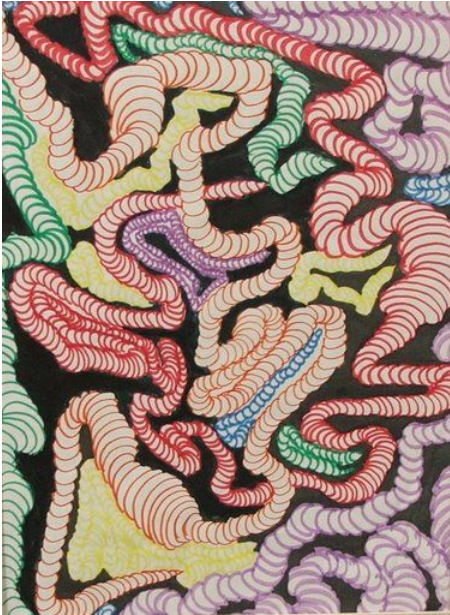
Quality Wheel Problem Solving Steps	Tools and Techniques
1. Describe problem/opportunity	Affinity Diagram Flow Chart Basic Questions General/Specific Force Field Analysis

	Brainstorming Nominal Group Technique
2. Analyze current situation	Cause and Effect Diagram Check Sheet Control Chart Flow Chart Histogram Interrelationship Digraph Pareto Chart Process Capability Scatter Diagram Basic Questions Brainstorming
3. Explore improvement options	Pareto Chart Tree Diagram Matrix Diagram Nominal Group Technique Brainstorming
4. Select preferred approach	Process Decision Program Chart Devil's Advocate Nominal Group Technique Multivoting
5. Develop action plan	Action Plan Management Presentation
6. Implement action plan	Activity Network Diagram Deployment Chart

<p>7. Evaluate/study results, acting on findings</p>	<p>Activity Network Diagram Cause and Effect Diagram Check Sheet Control Chart Dot Plot Flow Chart Histogram Pareto Chart Process Capability Scatter Diagram Action Plan Deployment Chart</p>

## The Quality Wheel

# Use of Data



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<b>THREE TOOLS FOR USE OF DATA</b>	<b>72</b>
<b>IMPLEMENTATION TIPS</b>	<b>74</b>
<b>CAUTIONS</b>	<b>75</b>



## Goal

This strategy encompasses far more than the collection and reporting of data for the purpose of statistical measurement. Here, data are viewed as a critical resource to guide policy, practices, and to inform day-to-day decisions by staff at all levels of the organization. In many organizations, using data to inform decisions represents a significant culture shift that requires training, leadership support, and modeling. Data collection systems should be “people-friendly” and the staff must be supported and encouraged as they become more comfortable with understanding, interpreting, and applying the information that data provides. Those responsible for auditing and analyzing data must also perceive themselves and be perceived as a resource in helping the organization move forward in its evolving culture of care.

Detailed data collection can be used to:

- Analyze trends by unit, shift, day, staff member, etc.;
- Identify facility baseline numbers, which can be used to set goals; and
- Comparatively monitor restraint/seclusion use over time.

This data also provides important information for the development of policy, treatment strategies, risk mitigation, staff development, and resource allocation.



## Three Tools for Use of Data

### 1. Data Collection

- Establish a data collection system that is easy to use for all levels of staff.
- Create or tweak the existing data collection system to enable the recording of restraint/seclusion incidents that can be analyzed by shift, day, unit, duration, type of restraint(s), injuries and to whom, staff and individuals involved, etc.
- Create a “dashboard” of key indicators. The dashboard should be visually user-friendly, utilizing graphs and/or charts that enable easy visual comparative analysis.
- Post dashboard data so that all staff can access it (e.g., on internal website).
- Capture data suggestive of trends, practices, and external causal events.
- Collect data about “near misses”.

### 2. Review, analysis and application

- Dashboard data should be reported monthly
- For large organizations, monthly reports should be reviewed and discussed as a regular agenda item by the organization’s quality improvement committee or team, performance improvement initiative team, key leadership team, medical staff, other clinical or treatment-related staff. In smaller organizations, such discussions should be conducted in leadership and/or clinical staff meetings.
- Provide data to risk managers, particularly data that reflects a relationship between reductions in restrictive events and risk exposure (e.g., property damage).

- Create forums for open discussion among colleagues about the implications of the data, including discussion of practices or events that may be causal. An example is to hold monthly Unit Director meetings in which each Director presents unit data for discussion. Convey the philosophy that data is information that will inform which practices work, which do not, and how to make the environment more therapeutic. Avoid any implication that data collection is intended to punish or penalize poor workers or units.
- Use individual data to inform treatment plans and staff development plans.
- Provide training to staff for how to interpret data and make data-based decisions.
- Post single key indicator signage in high traffic area (e.g., “days since last restraint”). Be sensitive to and avoid possibility of unintentionally stigmatizing.
- Use national, state, and other industry comparative information to help staff see how the organization is doing relative to other similar entities.

### **3. Use of Auditors**

- Auditors function as internal reviewers of policies and practices to ensure the organization functions in compliance with internal and external standards. Their role in a trauma-informed culture is to provide the organization with feedback as to how well it is accomplishing the goals and to suggest modifications to policies and practices that will support accomplishing those goals.
- Auditors should work closely with the clinical director, nursing director, and trainers as a source of feedback for what works and is done well as well as things that could be done better.
- Auditors should deliberately seek to provide more positive feedback than corrective. Auditors should seek to find good work being done and document it, communicating to the staff that they are helping staff to “get credit” for good work.
- Auditors should periodically and randomly select incidents reports for review.
- Auditors should help staff overcome obstacles to good documentation and data collection.



## Implementation Tips

- Auditors must be perceived as credible and knowledgeable regarding the work and the constraints faced by staff.
- Ensure that staff recognizes data collection and analysis is a method for improving the care given to patients, increasing safety of staff and consumers and a means for easing the difficulties of their work.
- Patient safety plans are an additional source of data. These reflect patients' "triggers" as well as coping mechanisms. These data may inform individual treatment approaches but can also be aggregated to suggest strategies the organization might implement to affect general populations.

## Cautions

- Staff may lack sophistication with data collection, analysis, and interpretation. Significant training and reassurance may need to be provided.
- Data collection should be IT enabled. Many organizations may lack sufficient IT support.
- If events occur infrequently, it may be difficult for staff to remember the documentation that is required.
- Comparisons between units may be counterproductive if the units serve very different populations or exist within very different constraints.
- There is a natural tendency for data collection efforts to become “check box” exercises rather than a source for genuine, applicable information.

## Additional Resources

National Quality Forum [www.qualityforum.org](http://www.qualityforum.org)

National Association of State Mental Health Program Directors Research Institute, Inc. Behavioral Healthcare Performance Measurement System  
<http://nri-inc.org/projects/bhpms/hbips.cfm>

Healthcare.gov [www.healthcare.gov](http://www.healthcare.gov)

National Institute of Mental Health <http://nimh.nih.gov/index.shtml>

U.S. Department of Health and Human Services, National Mental Health Services Survey <http://info.nmhss.org/>

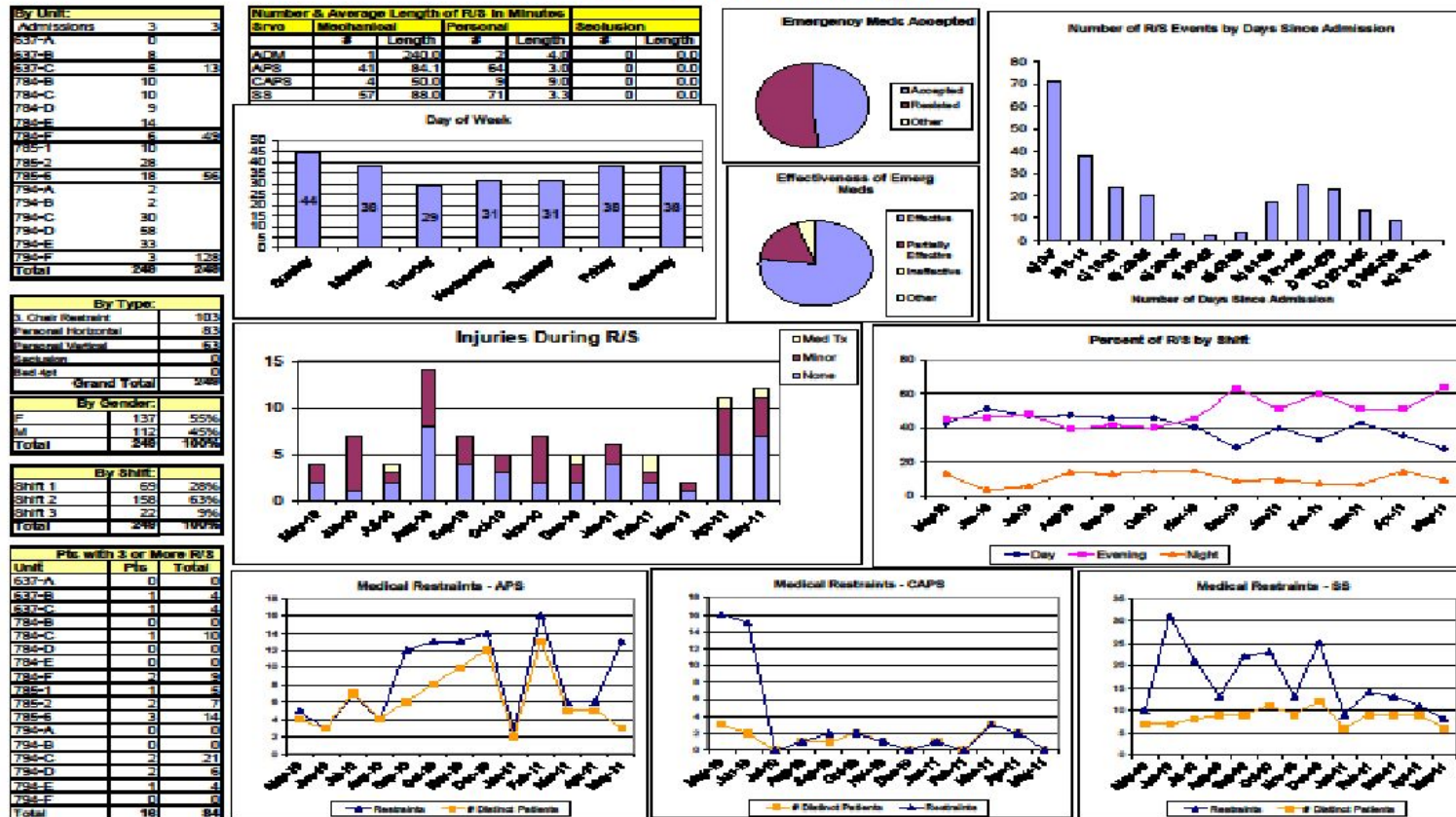
### **Dashboard examples:**

State Mental Health Facilities Quarterly Performance Indicators

<http://www.dshs.state.tx.us/mhreports/PIMHpub.shtm>

## Monthly Restraint and Seclusion Report

Restraint/Seclusion Events for May, 2011







# Workforce Development



<b>GOAL</b>	<b>79</b>
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## Goal

Creating a culture of trauma-informed care depends on the organization's ability to develop a workforce that has both the skill and the will necessary to create an environment free from coercive practices. Based on the principles of recovery and the characteristics of a trauma-informed system of care, workforce development should be adequately resourced, fully supported by leadership, and understood to be an on-going and multi-dimensional effort. Workforce development includes but is not limited to staff training, personnel policies, hiring practices, and informal communication systems.

# Tools

## I. Training

### 1. Planning

- Explore existing staff attitudes and beliefs about the elements of trauma-informed care (e.g., coercive vs. non-coercive practices). Consider implementing an employee-wide survey that will both inform curriculum development and implementation strategies as well as provide an attitudinal baseline against which to measure the effectiveness of the workforce development effort.
- Involve advocates and clients to inform training implementation plans as well as curriculum content. Utilize focus groups to review and/or participate in training as an added source of input.
- Prior to initiating the training employee-wide, promote the initiative to all levels of staff so that they are aware of what is coming and to gain support.
- Identify “Champions” to be involved in keeping the culture change momentum. These are people who exhibit attitudes, qualities, and skills that will be introduced and reinforced in training materials. They are also leaders among their peers who have influence over workplace culture. Trainers should be selected from the population of “champions”.

### 2. Curriculum

- Review and incorporate trauma-informed content into all existing training (e.g., new employee orientation, technical training curricula—including computer software, etc.).
- Involve staff from all levels and all areas in the design/customization of training.

- Build skill in exercising good judgment through experiential learning rather than memorizing specific techniques for intervening in specific circumstances.

***Training Content should include:***

- [Six Core Strategies](#)
- Organizational values (culture of care)
- Principles of trauma-informed care
- Neurobiological effects of trauma
- Performance improvement principles
- Effective communication (including de-escalation skills)
- Developing and maintaining therapeutic relationships
- Basic Principles of Behavior Analysis (including determining functions of behavior, “triggers”, behavior, consequences)
- Therapeutic responses to unwanted behaviors/situations
- Experiences of consumers and staff
- Assumptions and myths about the population of clients you serve
- Medical and physical risk factors for injury or death
- Safety planning tools
- Safe restraint application procedures

### 3. Roll Out

- Introduce key elements of the culture change early and accurately to the entire organization to reduce the circulation of erroneous information.
- Strategically select participants in initial training sessions:
  - Those most likely to be involved in performing restraints
  - Those most apt to positively influence other staff as well as those who may potentially undermine efforts
  - Those most able to participate in implementation and planning committees
  - Representatives from all parts of the organization
  - Skeptics and “nay-sayers”
  - Do not train entire units together. In most organizations it is impossible to take an entire unit off the floor for training at one time, but even where it possible, it is inadvisable as units may resist together thus strengthening their reluctance to adapt to the new environment. Ensure staff members on a single unit are all trained within a short time period.
  - Ensure each class consists of a mixture of positions training together--new and incumbent, direct care, professionals, non-direct care, different shifts, etc.
  - Train entire workforce before holding people accountable for operating in new ways.
  - Leadership should be visibly involved with and participating in training.
  - Include non-clinical staff (e.g., administrative, custodial, etc.) in all training.

- Tap into similar facilities that have been successful in implementing a culture of trauma-informed care. Utilize staff from these facilities as trainers and mentors, and utilize their experiences as models within your facility's training.

#### 4. **On-going Support**

- Train staff who believe they already understand and use these approaches to act as formalized role-models/mentors.
- Recognize managers and supervisors of units for successful implementation of strategies for reducing restraint and seclusion.
- Provide peer recognition opportunities.
- Provide "booster" trainings annually/periodically.
- Trainers should regularly visit on-site to provide suggestions and to problem-solve with staff for how to implement strategies taught in classes. This also provides trainers with valuable examples for use in subsequent training sessions.
- Engage Champions through regular communication forums. Involve them in subsequent follow up training design and implementation.

## **II. Human Resources Policy and Procedures**

- Focus on building staff confidence rather than uncertainty. Examine lingering evidence of trepidation in order to address its causes directly. This may involve further training or changes to policies and procedures.
- Review policies and rules to determine consistency with principles of trauma-informed care (e.g., control vs. to establish safe boundaries), make changes as needed.

- Establish reasonable and useful levels of staff empowerment. Ensure staff understand the extent and limit of empowerment to make intervention decisions.
- Review and revise position descriptions to incorporate knowledge, skills and abilities relevant to the provision of trauma-informed care along with behavioral descriptions of the performance of these.
- Establish a recognition approach to acknowledge staff actions that promote recovery.



## Implementation Tips

- Think through implementation very carefully. How will you build momentum? How will you maintain it? Who will be expected to complete training and by when? What if someone doesn't take it within the time frames? Will supervisors be held accountable? Many questions need to be thought through before implementation.
- Consider how the course(s) will be tracked and what expectations are non-negotiable (e.g., if you miss more than one hour in the 16-hour course you will have to retake the class, if you are more than 15 minutes late you will have to sign up for another class, etc.).
- Training cannot be a one-time event. All staff will need refresher training as well as non-classroom exposure to information and supports.
- High turnover requires frequent training sessions in order to ensure that everyone is "on the same page".
- Low turnover raises the likelihood that "old timers" will fail to change and thus undermine the staying power of the trained knowledge, skills, attitudes and abilities. For this reason, it is imperative to engage staff with more experience early on.
- Few organizations can train everyone at once, but failing to train everyone within a short time period risks return to "business as usual" as the gravitational pull of the old ways is almost always stronger than initiative to change.
- Make it a big deal, i.e., champions, t-shirts, posters, etc. This shows administrative support from the top administrators to local administrators.
- Create a rewards program for those who embrace the changes and are "caught" reinforcing changes.
- Use a train-the-trainer model. Train key employees and certify them in this training. Give them the tools they need to capture adult audiences' attention and to manage the classroom discussion that should frequently take place. These management skills are critical to maintain focus and avoid extended gripe sessions.

## Cautions

- Staff may fear that by not intervening coercively, they may be accused of negligence if someone gets hurt.
- The culture change required of staff usually involves less reliance on prescribed responses to situations and greater reliance on making good judgments. This can create anxiety, especially for staff unaccustomed to making decisions.
- People may feel that their only tool for “safety” (i.e., restraint and seclusion) is being taken away, without being replaced with anything.

## Examples and Additional Resources

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Example Instructor Support Network Communiqués	89
Curriculum resource	99

Six Core Strategies for Reducing Restraint and Seclusion
<p><b>STRATEGY ONE: LEADERSHIP TOWARDS ORGANIZATIONAL CHANGE:</b></p> <p>GOAL ONE: <i>To reduce the use of seclusion and restraint by defining and articulating a mission, philosophy of care, guiding values, and assuring for the development of a S/R reduction plan and plan implementation. The guidance, direction, participation and ongoing review by executive <u>leadership</u> is clearly demonstrated throughout the S/R reduction project.</i></p>
<p><b>STRATEGY TWO: USING DATA TO INFORM PRACTICE</b></p> <p>GOAL TWO: <i>To reduce the use of S/R by using <u>data</u> in an empirical, non-punitive, manner. Includes using data to analyze characteristics of facility usage by unit, shift day, and staff member; identifying facility baseline; setting improvement goals and comparatively monitoring use over time in all care areas, units and/or state system's like facilities.</i></p>
<p><b>STRATEGY THREE: WORKFORCE DEVELOPMENT</b></p> <p>GOAL THREE: <i>To create a treatment environment whose policy, procedures, and practices are grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services and the experiences of our staff. Includes an understanding of the characteristics and principles of trauma informed care systems. Also includes the principles of recovery-oriented systems of care such as person-centered care, choice, respect, dignity, partnerships, self-management, and full inclusion. This intervention is designed to create an environment that is less likely to be coercive or conflictual. It is implemented primarily through <u>staff training and education</u> and HRD activities. Includes safe S/R application training, choice of vendors and the inclusion of technical and attitudinal competencies</i></p>

*in job descriptions and performance evaluations. Also includes the provision of effective and person centered psychosocial or psychiatric rehabilitation like treatment activities on a daily basis that are designed to teach life skills (See Goal One).*

**STRATEGY FOUR: USE OF S/R REDUCTION TOOLS**

*GOAL FOUR: To reduce the use of S/R through the use of a variety of tools and assessments that are integrated into each individual consumer's treatment stay. Includes the use of assessment tools to identify risk factors for violence and seclusion and restraint history; use of a trauma assessment; tools to identify persons with risk factors for death and injury; the use of de-escalation or safety surveys and contracts; and environmental changes to include comfort and sensory rooms and other meaningful clinical interventions that assist people in emotional self management.*

**STRATEGY FIVE: CONSUMER ROLES IN INPATIENT SETTINGS**

*GOAL FIVE: To assure for the full and formal inclusion of consumers or people in recovery in a variety of roles in the organization to assist in the reduction of S/R.*

**STRATEGY SIX: DEBRIEFING TECHNIQUES**

*GOAL SIX: To reduce the use of S/R through knowledge gained from a rigorous analysis of S/R events and the use of this knowledge to inform policy, procedures, and practices to avoid repeats in the future. A secondary goal of this intervention is to attempt to mitigate to the extent possible the adverse and potentially traumatizing effects of a S/R event for involved staff and consumers and all witnesses to the event.*

*It is imperative that senior clinical and medical staff, including the medical director, participate in these events.*

In a multi-facility organization, trained and internally certified trainers were sent in teams all across Texas to make sure the first class of “Champions” at every facility was trained correctly and in the same way. They observed all trainers train to make sure there was trainer accountability. They followed up with newsletters on a monthly basis. (see examples below).



## December 2009—San Antonio State Hospital

The *Healing Today, Hope for Tomorrow* instructor team at San Antonio State Hospital (SASH) compiled their training tips and stories to share with other facilities.

Thank you Howard Fields, Larry Grosskopf, Frances Holland, Cissy Monreal, Renea Reesman, Randy Sabandal, and George Templeton. Great job SASH team!

In January, we will hear from the team at Rio Grande State Center.

Have a happy holiday season!

—FSS CTD staff

## **A Time for Holiday Cheer**

Many people spend the holidays with friends and loved ones. This is a time to connect and gather joyously together. Unfortunately for many individuals, the holidays can be a lonely and painful time. Spreading holiday cheer means being sensitive to the needs of everyone around us and acknowledging their feelings of both happiness and sadness.

Mindful of this need, Fran Holland, SASH Nurse Educator and HTHT facilitator, posed this question to the other HTHT team members, “How can we work the ‘holiday’ angle into the course?”

The following is an idea on how to incorporate holiday sensitivity needs into the HTHT training.

### **Activity Instructions:**

#### **Step 1:**

Type the following two questions onto a handout and distribute to your class.

#### **Step 2:**

Have staff members break up into small groups and reflect on these questions. Have a spokesperson for each group record the answers on the sheet of paper and share their ideas with the entire class.

#### **Question 1:**

What can make the holidays difficult for our patients? How about our staff?

#### **Question 2:**

What can staff do to make the holidays better for our patients that are lonely?





Participants getting to know each other

## **Heard Around & About**

“I have been here a long time and this training was very good. I really learned a lot, especially how we have an impact on how we respond or just how we talk to the patients.”

—Maria C.

## **A Peer Recovery Specialist’s Perspective**

Paul Eisenhauer is a Peer Recovery Specialist at the San Antonio State Hospital. Paul is a vital piece of the “treatment puzzle” on the SASH Adolescent unit.

The following is a brief interview with Paul Eisenhower designed to help give us insight into how SASH can continue to strive towards the providing the best “CHE” possible!

Q. What have you observed staff doing well in order to foster a caring healing environment?

A. On the Adolescent unit, staff go above and beyond to provide one to one treatment for our patients with MR. These individuals need a lot of interaction and caring, and staff do everything they can to provide this. I have been impressed seeing them work with these kids.

Q. Any other thoughts on what staff does well or what staff can do to better create a caring healing environment?

A. Some staff have keys and many can come and go when facing a difficult situation. Yet the RN's and PNA's have to stay and always deal with challenging behaviors. They are there no matter what, everyday to do their job, day in and day out.

Q. How important are the comfort rooms in fostering a caring healing environment?

A. The comfort rooms replace the seclusion rooms. Moving patients to a seclusion room was not a good environment. The comfort rooms are a big difference! The comfort room is an important tool to reduce restraint and seclusion, and another option for dealing with de-escalation.

Q. In a previous conversation you had talked about the right for patients to feel safe. Can you expand upon this?

A. Every patient has the right to feel safe. This may mean keeping a patient away from someone that they feel may harm them or moving to another room. I have seen this on the adolescent unit. We have practice court and center court and kids are sometimes moved around. The unit is willing to adapt the program in order to make patients feel safe.

## **Creating Comfort with the Comfort Room**

By Kathy Fortino-Williams, Social Work Supervisor and Unit Director SASH Adolescent unit

We use the comfort rooms because it is really good for the patients. It helps them when they are feeling upset and stressed out. They will request to go into the comfort rooms which will give them time to be alone, play music, read magazines, and listen to music in order to get away from the regular stress on the unit.

The comfort rooms are used to prevent increased aggression, calm patients down, and provide a safe place for patients to regroup. A lot of times patients that are feeling really upset and angry will request to go into the comfort room. Spending time there helps them to calm down so that we do not have to use restraint and seclusion.

## Heard Around & About

“I really liked it and now I am able to put a title or name to some steps that we are already doing here on the unit. This training will benefit all the new employees.”

—Daniel F.



George Templeton encourages participants

## **Behind the Scenes with a True Champion**

On any given day, people can expect to see the smile of Lydia Martinez as she enters the adult acute units at the SASH.

Lydia Martinez, one of two SASH Peer recovery specialists, demonstrates a passion and enthusiasm for helping the patients that she serves. As a former patient, Ms. Martinez now serves as patient advocate and mentor regarding medication compliance and other aspects of the recovery model. Ms. Martinez granted permission (and openly welcomed) to be identified as a former patient. She said that she can serve as hope for others currently hospitalized.

“I am still very much in the process of learning how I can directly influence restraint and seclusion reduction,” reported Ms. Martinez. “But I definitely feel that listening to and supporting patients and relaying any info in regard to their perspective to the treatment team is valuable.”

Treatment team members value Ms. Martinez’s input and include her as part of the treatment planning process. She provides Spanish translation during psychiatric interviews and relays information to team members after spending much time listening to patients’ expressed needs.

Ms. Martinez states that she has received a great deal of support from treatment team members and is assigned to specific social workers on each acute unit for supervision, guidance, and training. Ms. Martinez reported that she also receives help/advice from SASH’s other peer recovery specialist, Paul Eisenhauer.

Ms. Martinez’s enthusiasm is best summed up in her own words, “I am excited about the opportunity I have to work on the acute units and work toward reducing restraint and seclusion. I feel I am a part of working towards greater awareness and consistently providing CHE, a caring, healing environment.”

She describes how the HTHT course has impacted her saying, “I like how the HTHT program is looking at changing the culture, and a shift to reduce restraint and seclusion. HTHT emphasizes being open and flexible with the patients. I can’t

stress how important developing a therapeutic relationship is so that patients will know that they can come and let staff know what their needs are.”

## HTHT on the Units

By Isidro C. Hernandez, PNA IV Supervisor Adolescent Unit

I feel that the *Healing Today, Hope for Tomorrow* training has been very rewarding for me and for the employees I supervise. I am always looking for better ways to provide the best quality care. People have it in them to give their time, ease pain, understand problems, care for the individual, and be sensitive to their feelings. People just have to learn how to make themselves available and use these skills.

Since the training we have implemented an adolescent unit perfect attendance program. We all know that if the employees don't come to work it affects the unit, and we had to try to do something to motivate the employees to come to work. We promote CHE by giving praise for doing a good job, and recognize the employees that have perfect attendance for the month.

We talk to them in an in-service training about the unit program, expectations of the job, and share some of our personal experiences such as how we handle negative and positive situations. We give them examples of how to handle situations and ways to respond to patients.

We encourage the employees that will be attending the annual refresher to really participate in the HTHT course because that is their chance to express some of the experiences they have encountered through out the years at SASH. We encourage the employee to take the least restrictive measures by offering patients choices and alternatives. We hope to achieve positive results and avoid any restraints.

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## *Hope for Tomorrow*

### **Stress-Busting Tips**

Dealing with stress on your own can be overwhelming and difficult. Remember the support that your co-workers and family can provide and ask for it if and when necessary.

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### **Local Focus**

What skills can I improve this week?

How can I achieve CHE today?

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## **Bimonthly Thought for a Caring Healing Environment**

You are the patient's advocate. Avoid using negative language such as can't, won't and don't and phrases such as "that's the rules." If a rule is in place, provide an explanation of why the rules exist. Even when you can't change the rules, try and find a different path to achieve the same results.

---

## **Practicing Therapeutic Communication Techniques**

Broad openings—allow the patient to take the initiative in introducing the topic.

Example openings—"Is there something you'd like to talk about?"; "Is there something on your mind?"; "Where would you like to begin?"

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## **Providing a Caring Healing Environment Employees Exemplifying CHE**

Dona Davis Angelina Unit-

Dona is not only PNA II on a very busy unit she finds the time to talk with each patient & employee she is with. As she listens she is very attentive to patients' verbal & non-verbal communication. She recently diffused a hostile situation without either patient being seriously injured. After the tense time was over she was encouraging the staff with her helping them to de-stress. She told the staff what a good job they were doing & allowed them to discuss the occurrence.

Lavora Dunford- works 2-10 on the Cypress Unit. She works very hard on the ward keeping it organized and clean. She is always willing to help others and making sure the ward is a safe environment for the patients. She performs above and beyond her duties and has excellent therapeutic communication skills.

Debbie Rushing-

During the birthday party, we were unable to make a connection with a young lady. The only response we could get was the occasional head nod. Knowing that she was from Debbie's area, I asked Debbie if she knew her name and how we could better communicate with her. Debbie smiled, called the patient by name, and was able to discover exactly what the young lady wanted.



This is, once again, a perfect example of someone taking the time to make our hospital a Caring, Healing, Environment.

Bobby Cook & Reginald Carter- Every time Rehab has a music class on the Nueces Male Unit, these two are, at least, at the door trying to keep the clients interacting and engaged. I just wanted to make sure word got out that their efforts are appreciated.

George Jenkins- Like the gentlemen above, George is always very Interactive with the patients, but today he went a step further by guiding a fellow employee. I apparently have a bad habit of opening doors without considering what may be happening on the other side. Today George warned me that, "blind" corners and entrances can be a safety hazard for both staff and clients. He encouraged me to be aware of my surroundings before opening and entering doorways.

Some of these employees have not yet completed Healing Today Hope for Tomorrow. So there are many of us already practicing providing a caring healing environment. Our foremost thought is do no further harm to those in need of healing.

### **Is there anyone you have seen providing a Caring Healing Environment?**

If so please e-mail any of the Healing today & Hope for Tomorrow facilitators, Teri Marrow, Ian Chandler, Diane Fields, or Holly Campbell & have them recognized & encouraged. I know there are more of them here! We just need their names, unit, what they did, & how they create CHE. Be alert to ways we are already providing our patients & staff a more caring healing environment & send us the information. We want to recognize their hard work.

### **New “Chemasters to be”**

Welcome new “Chemasters to be” Glenna Martin, Derrick Dickerson, & Trish Davilla!

They will be in Austin in late May for training. We are so excited for the new trainers on board here @ RSH. This truly is a transformation. We are all encouraged just by participating in Healing Today Hope for Tomorrow. Not only is this a lesson in humanity; this is great encouragement for all our employees & patients.

**Complete curriculum for achieving culture change from Substance Abuse and Mental Health Services Administration**

<http://store.samhsa.gov/pages/searchResult/roadmap>

# Strategies to Empower Clients



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## Goal

Reducing or eliminating the incidence of restraint and seclusion rests upon the implementation of multiple strategies. This section describes the variety of specific assessments, environmental tools, and other strategies that staff and clients can use to effectively calm or avoid non-therapeutic behavioral escalations. These strategies are based in the beliefs that:

1. Clients should be actively involved in the identification of risks for restraints and seclusion,
2. Clients should have the power to influence how those risks will be mitigated, and
3. Staff members are influenced by their own histories of trauma that must be considered in order to create a genuine culture of care.

# Tools

## Assessments

- Assessment of restraint history
- Trauma assessment (national model at [www.samhsa.gov](http://www.samhsa.gov) )
- Assessment for risk of suicide (see example [Suicide Risk Assessment](#))
- Event trigger assessment
- Lalemond Behavioral Assessment Scale (to assist staff in distinguishing agitated, disruptive, destructive, dangerous or lethal behavior).  
<http://www.health.vic.gov.au/chiefpsychiatrist/creatingsafety/ntac/module8.pdf>

## Environmental Tools

- Comfort/sensory rooms: These are areas where clients may go to become calm. They are decorated and equipped with items chosen by clients to assist them in achieving comfort and calm. Examples may be music, photographs, reclining chairs, fish tank, weighted blankets, etc. The key is that each person may exercise choice regarding what she/he finds most calming. (See [photos](#) below).
- Evaluation and realignment of staff, programs and/or facilities to better accommodate the environmental and treatment needs of differing populations. This may involve structural, organizational and/or staff assignment changes with consideration to age, gender, demographics, diagnosis, etc. of individuals/staff.

## Other Tools and Strategies

- A coping plan or safety plan for each client that is visible and immediately available to staff and the individual client. At a minimum, the plan should include client-elected self-calming techniques, distraction techniques, and non-contingent access to sensory/comfort rooms. (See example [Safety Plan](#)).
- Communication and conflict mediation training for staff and clients.
- Individualized behavior intervention strategies designed and periodically reviewed by a psychologist or behavioral analyst.
- A review of client safety plans may reveal aggregated trends and preferences that could inform policy and practices.
- Peer Support Specialists. The specialist works with a client to improve the client's ability to communicate and participate with the treatment team and doctor. See more about Peer Support Specialists in section 6—[Consumer Involvement](#).
- “All About Me” packet. This packet is distributed to staff with information from the client about his or her personal triggers, preferences, coping strategies, etc.



## Implementation Tips

- Direct care staff should be involved in the identification of potential calming strategies and contents of comfort rooms (based on their knowledge of individual client needs and other factors).
- Involve an occupational therapist and expressive therapist (art, music, etc.) in training staff about sensory issues that may affect therapeutic approach.
- Provide interpreters to help staff de-escalate clients verbally when working with clients who are hearing impaired or speak a language other than English.
- If a face-to-face meeting is not possible, utilize videoconferencing with the staff of a transferring unit to make sure unit assignments meet the clinical needs of the client.
- Coordinate safety plans with any other agencies or facilities that also provide care and services to clients to ensure continuity of care.

## Cautions

- It is important to keep safety plans updated and current.
- Sensory rooms require space that may not be readily available or may require additional funds to outfit. (In this case, a sensory cart can be used.)
- A client who is in emotional distress may be difficult for other clients to tolerate. Thought should be given to ways to manage the impact on other clients, such as moving other clients away from the area or alternatives that do not involve coercive intervention.
- Property damage that does not endanger self or others is acceptable and is not a cause for punitive action or restraint and seclusion.
- Balance safety concerns with what is available in comfort rooms (e.g. electric cord for the fish tank could present a strangulation opportunity). There are certain risks. An evaluation of those risks vs. benefits must be made.
- Overcoming ingrained staff assumptions and beliefs may be challenging (e.g., belief that clients need to “earn” use of comfort rooms or comfort items vs. regarding self-elected calming strategies as equivalent to PRN medication).

## Examples and Additional Resources

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## Web resources

Roadmap to Seclusion and Restraint Free Mental Health Services, SAMSHA <http://www.samhsa.gov>

## What would have been helpful for you to hear?

- Use the person's name
- Let's sit down and talk about the problem
- It's your choice to discuss
- You are going to be OK
- We are here to help you
- Can we call someone for you?
- That someone was not going to hurt me
- Something gentle and kind
- I'm here to listen, I'm here for you
- It will get better
- This will pass
- I won't leave you
- What I wanted to hear was that I could get better
- I would have wanted to hear I would soon feel calmer
- How can we help?
- Your parents are coming (only helpful if this is reassuring to the client)

- I'm a person too and allowed to make mistakes
- All feelings are normal
- I'm here to listen, I'm here with you
- That I was OK, that I was safe
- Description of what was going on and where I was
- Do you want to talk about what you are feeling?
- Humor (be careful that your humor is understood and appreciated)
- Could I get you something?
- Are you comfortable?
- I can see that you are hurting. Can we talk?

I'm not sure it's the exact words that are most important, but rather, the tone of voice, body language and the physical environment of the verbalization. The words need to be firm but kind, spoken by someone with whom the client has had prior positive experiences.

The words should include references to experiences and people that the staff has determined ahead of time will help the client become grounded.

### **What other options may have been beneficial?**

- Taking a walk
- Physical exercise
- Read my Wellness Recovery Action Plan

- To be able to cry; chemical restraints often prevent this
- Have someone sit with me for a while
- Sometimes just to be heard helps
- Take shower or bath
- Draw
- Being able to yell
- A homey setting—soft chairs, drapes, pictures
- With permission, a hand on a hand, an arm around a shoulder—it is important to make contact EARLY on with someone about to “lose touch”
- Being allowed to have something of my own to comfort me
- Take time to review the file and ask questions
- Getting everyone’s attention off the misbehavior and onto what caused it to happen in the first place
- Talking to the doctor more about the medications
- A big overstuffed, vibrating, heated chair with a blanket, headphones, and gentle soft music.

### ***Suicide Risk Assessment***

<b>GENERAL INFORMATION</b>		<b>TAB 1</b>	Page 1 of 2
Assessment Date:		Assessment Time:	
Type of Assessment			
<input type="checkbox"/> Initial <input type="checkbox"/> Reassessment <input type="checkbox"/> Discharge			
Clear All Defaulted Fields <input type="checkbox"/> (Only works within RADplus)			
Draft/Final			
<input type="checkbox"/> Draft <input type="checkbox"/> Final			
Assessing Clinician:			
Page 2 of 2			
Primary Language:			
Preferred Language			
Interpreter Used? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Explain:			
<b>Informants</b>		<b>TAB 2</b>	Page 1 of 1
Informant(s)		Informant Reliability	

Specify Informant	
<input type="checkbox"/> Client	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
<input type="checkbox"/> Current Assessments / Evaluations	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
<input type="checkbox"/> Family / Significant Other / LAR	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
<input type="checkbox"/> Records of Previous Admission	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
<input type="checkbox"/> Other	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
<input type="checkbox"/> Another Provider	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
<input type="checkbox"/> Documents from MHA	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Informant Comments:	
<b>Suicide Assessment</b>	<b>TAB 3</b> <span style="float: right;">Page 1 of 5</span>
Able to Assess	Reason Unable to Assess
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Uncooperative/Unable <input type="checkbox"/> Discharged by Court
	<input type="checkbox"/> U.D. <input type="checkbox"/> Unknown
Comments:	



Reported Access to Firearms				
<input type="checkbox"/> Home	<input type="checkbox"/> Work	<input type="checkbox"/> Other Access	<input type="checkbox"/> Denies Access	<input type="checkbox"/> Unknown
Other Access:				
Suicide Intent				
<input type="checkbox"/> No intent to die	<input type="checkbox"/> Minimal intent	<input type="checkbox"/> Moderate intent	<input type="checkbox"/> Clear intent	
Expectation of Death				
<input type="checkbox"/> None	<input type="checkbox"/> Minimal	<input type="checkbox"/> Moderate	<input type="checkbox"/> Definite	
Lethality of Attempt or Plan				
<input type="checkbox"/> None/Ideation only	<input type="checkbox"/> Threat	<input type="checkbox"/> Non-lethal	<input type="checkbox"/> Potentially Lethal	
Suicide Ideation				
<input type="checkbox"/> None	<input type="checkbox"/> Minimal	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	
Impulsivity/instability				
<input type="checkbox"/> None	<input type="checkbox"/> Minimal	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	
Prior Attempts (static)				
<input type="checkbox"/> 2-10 years ago	<input type="checkbox"/> 1-2 years ago	<input type="checkbox"/> 6-12 months ago	<input type="checkbox"/> 1 week-6 months ago	
<input type="checkbox"/> No Prior Attempts				

Page 2 of 5			
Family History			
<input type="checkbox"/> None	<input type="checkbox"/> Attempt(s) only	<input type="checkbox"/> Serious Attempt(s)	<input type="checkbox"/> Completed suicide
Hopelessness			
<input type="checkbox"/> Hopeful	<input type="checkbox"/> Some hope	<input type="checkbox"/> Ambivalent	<input type="checkbox"/> Hopeless
Hallucinations			
<input type="checkbox"/> None	<input type="checkbox"/> Not specific	<input type="checkbox"/> Demeaning	<input type="checkbox"/> Command
Delusional Thinking			
<input type="checkbox"/> None	<input type="checkbox"/> Minimal	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Substance Abuse			
<input type="checkbox"/> None/sober	<input type="checkbox"/> Recreational	<input type="checkbox"/> Abuse/intoxicated	<input type="checkbox"/> Dependence/intoxicated
Anger/Revenge			
<input type="checkbox"/> None	<input type="checkbox"/> Minimal	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Anxiety/Agitation			
<input type="checkbox"/> None	<input type="checkbox"/> Minimal	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Insomnia			
<input type="checkbox"/> None	<input type="checkbox"/> Minimal	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe

Support System			
<input type="checkbox"/> Good support	<input type="checkbox"/> Some support	<input type="checkbox"/> Conflict/unstable	<input type="checkbox"/> None
Current Stressor(s) Severity			
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Page 3 of 5			
Loss and Trauma (static)			
<input type="checkbox"/> None	<input type="checkbox"/> Moderate	<input type="checkbox"/> Serious	<input type="checkbox"/> Multiple
Physical Pain			
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Psychological Pain			
<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Chronic/Severe Illness and/or Functional Impairment			
<input type="checkbox"/> None		<input type="checkbox"/> Acute illness/mild functional impairment	
<input type="checkbox"/> Chronic illness/mild functional impairment		<input type="checkbox"/> Chronic illness/mod to severe funct. Impair.	
Exposure to Combat			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Not Applicable
Marital Status (static)			

<input type="checkbox"/> Married/partner <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Page 4 of 5			
<b>Protective Factors</b>			
<input type="checkbox"/> History of Impulse Control	<input type="checkbox"/> Good Coping Skills	<input type="checkbox"/> Motivation for Living	
<input type="checkbox"/> Children in the Home	<input type="checkbox"/> Good Social Support	<input type="checkbox"/> Religious Beliefs Against Suicide	
<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Therapeutic Relationship	<input type="checkbox"/> Fears of Letting Down Relatives	
<input type="checkbox"/> Good Reality Testing	<input type="checkbox"/> No Protective Factors	<input type="checkbox"/> Absence of Acute Risk Factors	
<input type="checkbox"/> Other			
<b>Other Protective Factors</b>			
<b>Overall Risk Assessment</b>			
<input type="checkbox"/> Lower Risk	<input type="checkbox"/> Mild Risk	<input type="checkbox"/> Moderate Risk	<input type="checkbox"/> High Risk
<b>Plan of Action</b>			
<input type="checkbox"/> Inpatient Treatment		<input type="checkbox"/> Treat and Reduce Depression	
<input type="checkbox"/> CBT		<input type="checkbox"/> Initiate/Continue 1:1 Monitoring	
<input type="checkbox"/> Treat and Reduce Anxiety		<input type="checkbox"/> Improve Sleep	
<input type="checkbox"/> Initiate/Continue Routine Monitoring		<input type="checkbox"/> Treat and Reduce Delusional Thinking	

<input type="checkbox"/> Family Conference	<input type="checkbox"/> Treat and Reduce Anger
<input type="checkbox"/> Treat and Reduce Hallucinations	<input type="checkbox"/> Call Crisis Line As Needed
<input type="checkbox"/> Medical Tx of Pain/Chronic Illness	<input type="checkbox"/> Discharge
<input type="checkbox"/> Initiate/Continue Increased Monitoring	<input type="checkbox"/> Notify Physician
<input type="checkbox"/> Notify Registered Nurse	<input type="checkbox"/> Recommend Decreased Access to Firearms
<input type="checkbox"/> Other	
Page 5 of 5	
Other Plan of Action:	
Additional Comments:	

**Client Safety Plan**

## Client Safety Plan

Name	MPI	Epi	Unit	Last Update	Author
		2	Oak	5/29/11	A. Smith

Triggers	Warning Signs	Calming Strategies
<p>Crowds/people too close</p> <p>Feeling disrespected</p> <p>Needles/injections</p> <p>Primary Target: MDs, RNs, LVNs</p>	<p>Taking off my clothes</p> <p>Stretching my arms out wide</p> <p>Spitting</p> <p>Invading others' personal space</p> <p>Throwing objects</p> <p>Threatening</p>	<p>My Calming Strategies:</p> <ol style="list-style-type: none"><li>1. Talk to a staff member I trust</li><li>2. Write poetry</li><li>3. Go on the patio alone</li></ol> <p>Staff Supporting Strategies:</p> <ol style="list-style-type: none"><li>1. Remind client that he has medications orally</li><li>2. Remind client that he is to add a positive word to his calendar every day that he is without aggression.</li></ol>



## ***Comfort Rooms***







***List of additional resources from SAMHSA Substance Abuse and Mental Health Services Administration:***

<http://store.samhsa.gov/shin/content/SMA06-4055/SMA06-4055-I.pdf>

Identifying and Managing S/R Risk Factors:

[http://www.nasmhpd.org/general\\_files/publications/ntac\\_pubs/NETI%20presentations/NETI%2008%20Risks%20FINAL%203%206%2008.pdf](http://www.nasmhpd.org/general_files/publications/ntac_pubs/NETI%20presentations/NETI%2008%20Risks%20FINAL%203%206%2008.pdf)

Copeland Center for Wellness and Recovery:

<http://copelandcenter.com/>

Information regarding WRAP (Wellness Recovery Action Plan), a structured system to monitor uncomfortable and distressing feelings and behaviors and through planned responses, reducing, modifying, or eliminating them. It also includes plans for responses from others when you cannot make decisions, take care of yourself, or keep yourself safe.

# Consumer Involvement



A note about terminology: In this section, "consumers" are persons who have been or are currently in treatment but are not receiving services at the facility that is implementing these tools. The term "clients" refers to people currently receiving services at the facility.

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## Goal

Consumer involvement is the formal inclusion of clients, consumers (as defined above), family members, and advocates in a variety of roles and settings in order to ensure all efforts at culture change address the real needs and preferences of the population served. Some services provided by these stakeholders may involve compensation but many do not.

Described below are four key categories of tools for increasing consumer involvement:

1. Engaging Peer Support Specialists: highly trained consumers that provide peer counseling and related support to clients. Peer Support Specialists also serve as models for therapeutic behavior for direct-care staff and support their own wellness in the process.
2. Increasing Consumer Input
3. Empowering Clients
4. Enhancing Consumer-Staff Collaboration



# Tools

## Peer Support

- Create a well-trained and well-supported team of peer support specialists. These may be volunteers or contract staff (or a mixture of the two with well-delineated roles and responsibilities).
- If volunteers are utilized, they should be gradually incorporated into the pool starting with only a few hours per week, capping at no more than 10 hours per week so as not to undermine their own recovery.
- Peer support specialists should not be persons currently in treatment within the facility.
- Because they are peers, these will be people with their own recovery challenges. A well-run peer support program will be one in which acting as a specialist will support one's own recovery through learning to work in a team and contribute to the mission.
- Peer support personnel can provide a variety of services such as conducting post-incident debriefings with consumers and relaying pertinent information to the treatment team. Peer supporters work directly with clients to develop greater skill in communication through mentoring and role-play (e.g., how to talk to the doctor about your meds).
- Peer support personnel may develop mentoring relationships with clients as well as with colleagues to support their own learning and development.
- Consider parental or family peer support groups.
- Create supervision systems to enable consumers to perform other facility-related jobs.

## Consumer Input

- Consumers should be involved in looking at everything related to quality of care and quality of life for clients.
- Involve consumers in training staff (e.g., through panel discussions, interviews, etc.)
- Seek input through surveys and focus groups of consumers and family members.
- Create “Leadership Councils” of consumers to act as advisory bodies.
- Invite stakeholders to participate in agency and facility policy revision, in drafting the agency and facility mission statement, etc.
- Involve consumers in human rights or similar committees.
- Include consumers, families, and advocates in operational committees.
- Conduct customer satisfaction surveys.
- Involve consumers in the delivery of staff training (e.g., teaching about an issue that they have overcome or developed successful strategies to deal with).

## Client Empowerment

- Formalize reward and recognition programs for client actions that resulted in avoidance of restraints (e.g., by unit).
- With the client’s permission, seek family input in the creation of the individual client’s safety plan.

## Enhancing Consumer-Staff Collaboration

- Educate staff regarding the importance of consumer inclusion.
- Provide team building for staff and peer support personnel that should include activities that build empathy (e.g., through role-playing, consumer panel discussions, expert education, etc.)
- Staff-peer support team development should be facilitated with the goal of helping participants find common ground in their goals for client wellness and recovery and develop trust between them.



## Implementation Tips

- Be clear about the expectations of the Peer Support Specialist role and educate all staff about those expectations.
- Ensure consumers who are currently in treatment are not at risk for undermining their own recovery. Carefully interview, screen, and support consumers who have direct involvement with clients or client recovery to ensure they are able to put their own wellness first and have a strong support system in place.
- Seek involvement from consumers who have a bigger picture of the whole environment or related systems and agencies. You can find these people by working with advocacy groups and mainstream consumer organizations (e.g., National Alliance on Mental Illness, [www.nami.org](http://www.nami.org) ).
- Seek training for peer supporters through other agencies. The Texas Department of State Health Services provides training and certification for peer supporter specialist through its Via Hope initiative.
- Be prepared for some attrition among the peer support team as the role may prove to be too stressful for some.
- Promote the value of peer support personnel as vital change agents for the culture.
- Ensure that leadership, including clinical/medical leadership, buys into a peer support and consumer involvement model before attempting to implement one.
- Involving consumers and advocates may require securing additional funding. Look to advocacy groups as well as internal sources for additional fiscal resources to fund programs.
- Treat Peer Support Specialists as you would any other staff.
- Encourage Peer Support Specialists to take advantage of external support groups such as the Depression and Bi-polar Support Alliance or other community-based groups.



## Cautions

- For many organizations, involving peer support specialists as part of the treatment staff is a new paradigm and it will take time for both groups to develop trust in one another as colleagues. Considerable support from a peer support coordinator and on-going reinforcement and training may be necessary.
- Ensure that any attrition among the peer support team does not undermine staff trust and faith in the viability of the program by letting staff know from the very beginning that there will likely be some attrition (and why).
- Be sensitive to any nuance that defines staff as “one up” and peer personnel as “one down” in status or credibility.
- Take care that Peer Support Specialists’ focus is strength-based (e.g., what they do to stay well) rather than diagnoses or limitations.
- Ensure adequate support for peer support personnel (training, mentoring, opportunities to talk problems out, team building, etc.).
- It may be unwise to involve families in some circumstances such as:
  - When a child has been removed from the home for abuse or neglect
  - Short stays in acute care facilities distant from home
  - The family is unduly stressed or dysfunctional
  - The client is alienated from family
- Certain licensing and/or legal restrictions may apply to involving peers when working with children.
- Be prepared to respond to staff concerns that peer support personnel will undermine treatment protocols and plans.

- Counteract funding constraints (e.g., for certification of peer specialists) with fundraising activities.

## Examples and Additional Resources

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## Steps for Developing a Peer Mentor/Peer Specialist Program

1. Develop a volunteer base
  - a. Screen
  - b. Train
  - c. Collaborate with twelve step community (if applicable), Lifeworks (in Austin) [www.lifeworksaustin.org](http://www.lifeworksaustin.org) , NAMI [www.namitexas.org](http://www.namitexas.org) , DBSA [www.dbsatexas.org](http://www.dbsatexas.org), SHAC <http://www.austinmhc.org/>, Austin Clubhouse [www.austinclubhouse.org](http://www.austinclubhouse.org)
  - d. Interface with local MHMRs
2. Maintain cohesion among staff/peers/volunteers
  - a. Consider a “Mental Wellness Team” for the entire group and for each individual
  - b. Book Club reading inspirational/self help books
  - c. Wellness newsletter
  - d. Social activities with all employees/volunteers
  - e. Buddy system (e.g., peer-to-peer, staff-to-staff, staff-to-peer, volunteer-to-staff, etc.)
  - f. Art and creative groups
3. Knowledge, Skills, and Abilities Required for Peer Specialists/Volunteers
  - a. Ability to communicate unconditional positive regard for a wide variety of people including peers, staff, mental health professionals, other advocacy groups, and the public
  - b. Ability to respond to the issues and needs of people with serious mental illness with sensitivity, understanding, patience
  - c. Ability to demonstrate professional work ethic including confidentiality and professional boundaries
  - d. Basic computer skills
  - e. Able to demonstrate good judgment
  - f. Able to use active listening skills
  - g. Good verbal and written communication skills
  - h. Able to locate information and resources in order to serve needs of client
  - i. Skill in planning, prioritizing, and organizing workload to complete in a timely manner
  - j. Demonstrated skills in own recovery for at least 1 year

4. Education/Training/experience:
  - a. GED or high school diploma required.
  - b. Must have completed peer specialist certification from at least one approved curriculum.
  - c. Must be willing to identify self as a primary consumer of Mental Health services related to those of the served population.
5. Skills required:
  - a. Ability to recognize signs and symptoms of psychiatric illness
  - b. Ability to maintain healthy boundaries with peers, treatment team, and staff
  - c. Ability to communicate effectively verbally and in writing.
  - d. Ability to communicate own recovery story
  - e. Ability to listen effectively
  - f. Ability to problem solve
  - g. Ability to work effectively with treatment team
  - h. Prefer knowledge of WRAP and ability to guide peers in its use
  - i. Skills in documentation of peer progress
  - j. Basic computer skills
  - k. Ability to facilitate groups

## **Job Title: Peer Support Specialist**

### ***General Description of position:***

The peer specialist, under the supervision of the Peer Support Coordinator, works as part of the treatment team by developing and maintaining a supportive relationship with peers who are inpatient in order to address their strengths, goals, barriers, and recovery strategies related to peer's role in their recovery, especially regarding alternatives to restraint/seclusion, choices of medication and treatment, and linkage to community resources after discharge. Maintain departmental and hospital documentation and records. Perform other duties as assigned.

### ***Essential Tasks:***

- Utilize active listening skills to assist peers in recognizing areas of dissatisfaction and the benefits of changing beliefs, thoughts, and behavior.
- Utilize problem-solving skills to assist peers to identify barriers to recovery and to develop a plan to meet peer determined goals.
- Facilitate Recovery Support Groups.
- Link client with community-based consumer resources.
- Work with treatment team to advocate for client and to remove barriers to recovery
- Participate in consumer panels to educate staff about the consumer perspective and about peer support
- Participate in hospital wide committees and workgroups
- Debrief clients after a restraint or seclusion



***Education/Training/experience:***

- GED or high school diploma required. Prefer college degree in related field.
- Prefer peer specialist certification from Via Hope curriculum.
- Prefer prior experience as CPS in a hospital setting.
- Prefer prior experience as a peer facilitator or peer specialist with knowledge of Travis County resources. May be hired under condition of gaining certification within 1 year of hire.
- Must be willing to identify self as a current or former consumer of mental health services, preferably with the experience of hospitalization. Must have at least 1 year recovery

***Skills required:***

- Ability to communicate own recovery story
- Ability to listen effectively
- Ability to problem solve
- Ability to facilitate groups
- Ability to work effectively with treatment team
- Ability to guide peers in creating an individualized Wellness Journal

- Skills in documentation of peer progress
- Ability to recognize signs and symptoms of psychiatric illness
- Ability to maintain healthy boundaries with peers, treatment team, and hospital staff
- Ability to communicate effectively verbally and in writing
- Basic computer skills

**Questions:**

Describe your experience(s) as a primary consumer of Mental Health Services, how it relates to this position, and its duties, responsibilities and skills. Talk especially about those experience(s) related to a psychiatric setting.

What does Recovery Mean to you?

Please describe your experiences in sharing your story of recovery.

Describe any experiences that you have in developing, organizing, and implementing Peer Support workshops for consumers or any other type of workshop.

What strengths and weaknesses would you bring to this position?

Tell me about a project you have been responsible for and how you organized the necessary paperwork, tasks, goals, etc.

This position will serve as back up to the Peer Support Supervisor in providing training to New Employees. Please describe your experience, as well as your comfort level, training groups of people.

We all make mistakes. Tell me about a mistake you made that you would do over, if you had the chance. What would you do differently the second time?

The Peer Support Department is focusing on helping consumers develop a WRAP plan. Please describe your knowledge of (WRAP) –Wellness Recovery Action Plan.

In this position you will have to work with multiple disciplines. Talk about your comfort level when working closely with professional staff in developing therapeutic programs or in a treatment environment. Describe your experience with working with professional staff.

You are assigned to go on the unit and visit with clients. A client approaches you and states that he/she does not understand why they have to be in the hospital. They want to be discharged and feel that they are being held here against their will. The client is not physically or verbally

aggressive but is viewed as being uncooperative with his/her treatment and the treatment team. Describe how you would respond to this client and what type of support would you offer.

We are making progress at moving from a medical Model of Treatment to the Recovery Model of Treatment. Please tell us about your knowledge of the Recovery model of treatment and how Peer Support fits into this model of treatment.

Tell me any other information you think is important for me to know in considering you for this position.

## Recovery Self-Assessment

This survey was developed to help you assess how often you use recovery skills in your daily work. There’s nothing scientific about the assessment; it’s simply a tool you can use to determine which areas you are really good at, and which ones you could improve on. You can reassess your work on a regular basis and celebrate your improvement.

	No t at all	-	-	-	-	+	+	+	+	At all tim es
	1	2	3	4	5	6	7	8	9	10
I often ask the people I serve to give me some ideas on how to be more effective at doing my work (a way to practice openness and mutuality; a way to keep the person in the drivers seat)										
I step out of my comfort zone regularly and risk making mistakes in order to learn and grow (role										

models moving out of our comfort zone which is what we ask the people we serve to do; keeps us in touch with how this feels)										
I understand how my thoughts can effect the way I do my work. I know how to manage them and make them work for me. (Managing negative self-talk can keep help us stay focused on the person's strengths)	1	2	3	4	5	6	7	8	9	10
I stay focused on the person instead of being preoccupied with their problems. I understand how powerful it is to just be present with someone. (Keeps us from getting overwhelmed with the problem and helps us focus on the person's strengths)	1	2	3	4	5	6	7	8	9	10

	No t at all	-	-	-	-	+	+	+	+	At all tim es
	1	2	3	4	5	6	7	8	9	10
I use recovery language that is non-judgmental when I am talking to a person being served, and when I am talking about them. (The language we use actually reinforces the thoughts we think. Using positive language can help us stay focused on strengths).	1	2	3	4	5	6	7	8	9	10
I often feel a sense of compassion for the people I am working with.	1	2	3	4	5	6	7	8	9	10
I know how to hold hope for people who seem to have none of their own.	1	2	3	4	5	6	7	8	9	10
Choice is an important part of the recovery process. I understand this and give people as many choices as possible	1	2	3	4	5	6	7	8	9	10
When people make choices that I don't agree with, I try to help them carry them out while minimizing the risks.	1	2	3	4	5	6	7	8	9	10

Self-determination is a key part of recovery. I have many skills for helping people become self-determining.	1	2	3	4	5	6	7	8	9	10
I am good at not taking power away from people. I encourage them to guide their own recovery process and make their own plans.	1	2	3	4	5	6	7	8	9	10

	No t at all	-	-	-	-	+	+	+	+	At all tim es
	1	2	3	4	5	6	7	8	9	10
I have good listening skills. I ask questions instead of making assumptions.	1	2	3	4	5	6	7	8	9	10
I know how to validate and reinforce people's strengths and abilities.	1	2	3	4	5	6	7	8	9	10
I understand the power of a recovery environment and do my part to keep our environment clear of gossip, negativity, and criticism.	1	2	3	4	5	6	7	8	9	10
I do my part to make our environment welcoming and friendly so people feel safe to enough to begin their recovery journey.	1	2	3	4	5	6	7	8	9	10
I am skillful at helping people learn to advocate for themselves.	1	2	3	4	5	6	7	8	9	10



I have no trouble staying in a mutual position and relate to people as people instead of clients or consumers.	1	2	3	4	5	6	7	8	9	10
I understand the importance of valuing uniqueness in people and honor different cultures.	1	2	3	4	5	6	7	8	9	10

	No t at all	-	-	-	-	+	+	+	+	At all tim es
	1	2	3	4	5	6	7	8	9	10
I am pretty good at staying connected to my authentic self and can help others find and connect their authentic self.	1	2	3	4	5	6	7	8	9	10
I am good at establishing collaborative relationships and work toward partnering with those who use our services, as well as other agencies.	1	2	3	4	5	6	7	8	9	10
I have a good understanding of how to pull forth the strong and well parts of others. In other words. I know how to bring out the best in people.	1	2	3	4	5	6	7	8	9	10
I have no problem being with people who are in a highly emotional state and I am good at being with them in a way that helps them manage their own feelings and behaviors.	1	2	3	4	5	6	7	8	9	10
I know how to deal with conflict in ways that deepen rather than damage relationships.	1	2	3	4	5	6	7	8	9	10

I am good at resisting the urge to fix people and their situations, and instead support them so they can find their own solutions.	1	2	3	4	5	6	7	8	9	10
I have a good understanding of how to be with people who have challenging symptoms.	1	2	3	4	5	6	7	8	9	10

## ***Recovery Inventory***

## ***ASH Peer Support***

The purpose of this Recovery Inventory is to find out how we can best support your recovery.

Name:

Date:

1. Do you believe recovery from your mental illness is possible?
2. What does recovery mean to you at this time?
3. What are your strengths and interests?
4. What are your goals?

a) Where I want to live:

b) Where I want to work:

c) For my family and social life, I want:

d) For health and recreation, I want to be able to:

e) In the community, I want to be able to:

f) I want my follow-up care to include:

5. Which goal(s) do you want to focus on right now?

6. What barriers to those goals do you identify?

<input type="checkbox"/> Primary support group(s)
<input type="checkbox"/> Friends and Family
<input type="checkbox"/> Education

<input type="checkbox"/> Employment
<input type="checkbox"/> Housing
<input type="checkbox"/> Finances
<input type="checkbox"/> Access to health care services
<input type="checkbox"/> Working with treatment team
<input type="checkbox"/> Interaction with the legal system
<input type="checkbox"/> Medication Issues
<input type="checkbox"/> Drugs and/or Alcohol Use

7. Which recovery tool(s) is most appropriate at this time?

<input type="checkbox"/> Wellness Journal
<input type="checkbox"/> Recovery Support Group (RSG)
<input type="checkbox"/> Community Resources
<input type="checkbox"/> Substance Abuse Services

☐ Experiential Knowledge of Successful Recovery

8. Do you believe recovery from your mental illness is possible?

9. What does recovery mean to you at this time?

10. What do you like about yourself?

11. What hobbies and interests do you have?

12. What do you imagine yourself doing in the future?

13. What I want my life to be like:

a) Where I want to live:

b) Family:

c) Friends:

d) Health and recreation:

e) What I need to maintain my wellness when I leave the hospital:

14. Of these topics, which do you want to focus on right now?

15. Which recovery tool(s) is most appropriate at this time?

<input type="checkbox"/> Wellness Journal
<input type="checkbox"/> Recovery Support Group (RSG)
<input type="checkbox"/> Community Resources
<input type="checkbox"/> Substance Abuse Services
<input type="checkbox"/> Experiential Knowledge of Successful Recovery





“Intentional Peer Support” Model (<http://www.power2u.org/downloads/From%20Relief%20to%20Recovery.pdf>)

Peer Specialist certification ([www.viahope.org](http://www.viahope.org))

Peer Support Specialist position description

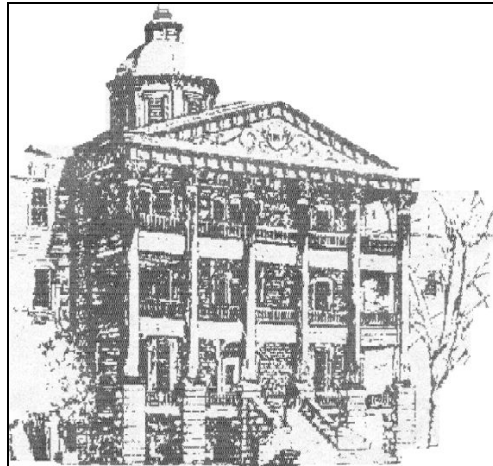
Interview Questions for Peer Support candidates

Recovery Inventory—questions for structuring the Peer Support-Patient relationship

3 Paradigms

**What is Peer Support?**  
***Vision, Mission, and Goals***

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**Austin State  
Hospital**

**Partnering to  
find Solutions  
toward Wellness**

**What are people saying?**  
**Austin State Hospital**

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**Peer Support Program**



What does a Peer Specialist do?

