

Abstract

Eliminating Seclusion/Restraint in Recovery Oriented Crisis Services

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The use of seclusion and restraint is viewed as a practice incompatible with the vision of recovery. The deliberate transformation of community mental health agencies to a recovery orientation means the elimination of seclusion and restraint in agencies' crisis services.

Objective: To describe the barriers, change strategies and results as a mental health agency (META) moved to a zero restraint/seclusion policy in their crisis services. *Methods:* Strategies included strong leadership direction, policy and procedural change, staff training on specific issues, consumer debriefing, and regular feedback on progress. *Results:* Seclusion/restraint was virtually eliminated in both crisis centers run by META; in 15 months in the smaller crisis center, and in 41 months in the larger crisis center. *Conclusions:* Strategies do exist for the elimination of seclusion/restraint as agencies transform into recovery oriented services.

Eliminating Seclusion/Restraint in Recovery Oriented Crisis Services

Seclusion and restraint (SR) remain an important part of psychiatric practice (Lind, Kalitalia-Heino, Suominen, Leino-Kilpi & Valimake, 2004; Tunde-Ayinmode & Little, 2004), and are typically administered when other less restrictive strategies have been unsuccessful (Wynaden, Chapman, McGowan, Holmes, Ash & Boschman) Various definitions of SR exist (Busch & Shore, 2000; Exworthy, Mohan, Hindley & Basson, 2001; Hoekstra, Lendenmeijer & Jansen, 2004). As reported by Busch & Shore (2000, p. 262) the Health Care Financing Administration (HCFA) defines seclusion as, “involuntary confinement of a person in a room or an area where the person is physically prevented from leaving”, while physical or mechanical restraint is characterized by “physical or mechanical interventions that restrict movement or control behavior”. SR’s therapeutic benefit remains questionable (Exworthy, Mohan, Hindley & Basson, 2001). Furthermore, SR interventions may stimulate further aggression (Donat, 2005) and are associated with increased cost (LeBel & Goldstein, 2005). Interviews with people who have experienced SR recount its many negative experiences (Frueh, Knapp, Cusack, Grubaugh, Sauvageot et al., 2005; Holmes, Kennedy & Perron, 2004; Olofsson & Jacobsson, 2001; Robins, Sauvageot, Cusack, Suffoletta-Maierle & Frueh, 2005; Sorgaard, 2004), and it has been questioned (Ashcraft & Anthony, 2005) as a practice that is compatible with the vision of recovery (Anthony, 1993) espoused by the President’s New Freedom Commission (2003). Along these lines, Charles Curie, the administrator of the Substance Abuse and Mental Health Services Administration (SAMSHA) has stated, “To reduce the use of seclusion and restraint is part of a broader effort to reorient the state mental health system toward a consumer-focused philosophy that emphasizes recovery and independence.” (Jorgenson & Geisler, 2002, p. 9)

Attempts have been made to reduce the use of seclusion and restraint (Donat, 2005; Schreiner, Crafton & Sevin, 2004; Sullivan, Bezmen, Barron, Rivera, Curley-Casey & Marino, 2005). Concern has been raised as to whether the reduction of SR would lead to more staff injuries, but this does not seem to be the case (Smith, Davis, Bixler, Hung-Mo-Lin, Altenor, 2005). Yet the need still exists for more information about successful strategies that can be used to eliminate SR entirely (Busch, 2005; Busch & Shore, 2000; Curie, 2005; Holmes, Kennedy & Perron, 2004; Schreiner, 2004).

The present study describes an initiative at two crisis centers designed to completely eliminate SR from the crisis center operation. Many of the strategies used in this study to achieve a zero SR outcome are similar to the six strategies endorsed by the National Association of State mental Health Program Directors (Glover, 2005).

Setting

META services is a mental health agency which provides a range of mental health recovery-oriented services. At the time of this study two crisis services (two sites) were operated by META serving about 14,500 people each year, including nearly 4,600 people who are brought to the crisis centers involuntarily. META Services is accredited by the Joint Commission on Accreditation of Healthcare Organizations, certified by Medicaid for Title 19 reimbursement, and licensed by the State of Arizona Department of Health.

People served

During the period in which attempts were made to eliminate SR entirely, people with a wide range of issues and situations stepped through the doors of META's crisis programs every day. The involuntary clients (32% of the total admissions) were brought by police and others who believed them to be a danger to themselves or others. The voluntary clients came because

they were frightened by their own thoughts and feelings and needed reassurance, support and/or medication. Some of the voluntary clients came because they didn't know what else to do. Some were homeless, hungry, with no other alternatives. Many were self-medicating with street drugs and alcohol (12.3% had a primary diagnosis of substance abuse and another 32.8% had a secondary substance abuse diagnosis).

Due to their life circumstances, people who used the crisis services were often disheveled, poorly dressed, and had issues with personal hygiene. They were often angry due to being brought in against their will. They were overwhelmed, frightened, in pain, confused and disconnected from themselves and their reference points. They exhibited the very characteristics that our culture devalues and disrespects. Table 1 describes the ethnic and gender characteristics of the people served in a one month period (June 2005).

Table 1: Ethnic and gender characteristics for people served (June 2005)

Ethnicity	Male		Female		Total	
	Number	%	Number	%	Number	%
White	441	35.9	374	30.5	815	66.4
African American	67	5.5	52	4.2	119	9.7
Hispanic	116	9.4	64	5.2	180	14.7
Native American	9	0.7	11	0.9	20	1.6
Asian	15	1.2	6	0.5	21	1.7
Not Reported	31	2.5	42	3.4	73	5.9
Total	679	55.3	549	44.7	1228	100.0

Sorting out primary and secondary diagnostic issues is always challenging when seeing people for the first time, and in a crisis state. The following chart is an approximate representation of a diagnostic profile for this population

- Schizophrenia 1%**
- Schitoaffective 9%**
- Mood disorders 19%**
- Bipolar 8%**

Major depression 8%

Psychotic 5%

Substance abuse 12%

Other 38%

Crisis center staff

A total of 95 staff worked in the two centers serving an average of 40 admissions a day.

Table 2 identifies the disciplines of a typical shift at the higher volume crisis center.

Table 2: Staff disciplines on a typical shift at the higher volume center

Discipline	Number
Shift Manager (Masters Level)	1
Psychiatrist	2
Registered Nurse	2
Masters Counselor	3
Behavioral Health Technicians	4
Peer Support Specialists	2
Unit Secretary	2
Total	16

While it was not uncommon for staff to catch a glimpse of the recovery process taking place in people who were in a “crisis” situations, it was often missed – overshadowed by the chaos that accompanies this state of being. Also, the way staff were responding to people who were in a “crisis” mode often added to the confusion by adding more “crisis” to the mix. Staff tended to operate in a crisis mode of management, reacting instead of responding to each situation. They were often overlooking the person’s inherent strengths and resources by focusing primarily on the problems. This left them trying to solve problems instead of promoting a response of recovery. While people’s reasons for coming varied dramatically, they were more or less treated the same – with medication – usually one that sedated and calmed them.

“Moving people on” often seemed to be the goal of crisis services, and the staff’s conversation often included “clearing the room”, so staff could get ready for the next group of people coming in. Did people leave with a renewed sense of hope and self-determination that could add meaning and purpose to their lives? Did they learn how to better manage their life circumstances so they could avoid this experience in the future? Did staff learn anything that could increase their skill in serving people? The leadership of META answered each of these questions in the negative.

Identifying the barriers to transformation

As META restructured itself to reflect a recovery orientation (Ashcraft & Anthony, 2005), the leadership realized that one of the most glaring demonstrations of a non-recovery environment was the use of seclusion and restraint in META’s two crisis centers. Accordingly, agency leadership focused on what the barriers were to transforming the crisis centers into a recovery orientation. They observed and listened to both staff and the people served. The five barriers identified were: previous staff training; fear, hopelessness, personal prejudices; and attitudes toward new peer staff.

1. Previous staff training. Caregivers who are faced with a person in crisis often respond with an urge to “fix” the situation as quickly as possible. Because the problem looms larger than the person, they tend to see the problem instead of the person. Most have been trained to take charge and take care of the problem. They may feel responsible for “fixing” the problem, which causes them to continue to overlook the person in favor of the problem. Another serious problem was that prior to META’s transformation, none of the staff had any training in recovery practices and principles. Essentially, most staff had learned, either explicitly or implicitly, that people with severe mental illnesses had a chronic condition from which they did not recover.

2. Fear. Often the people who come into crisis services, especially those who are brought in against their will, are fearful, angry, and /or upset; some are demonstrating behaviors that are threatening and intimidating. While this could be a very normal response to the circumstance they are experiencing (being brought to a strange place against their will, locked in a room with strangers, and waiting long periods of time for answers) their behavior often elicits fear from those who are trying to serve them. Fear can be a normal response from caregivers, but once it becomes the determining factor in how people are treated, the staff's effectiveness is seriously compromised. Fear seemed to be one of the reasons for restraining or secluding people. The more afraid the staff were, the more likely they were to consider this option.

3. Hopelessness. Most crisis center staff did not believe in recovery. On a daily basis they witnessed what, on some level, they considered "proof" that people rarely recover, because people only came to them when they needed significant help. Thus, crisis center staff rarely saw people who were in recovery. This narrow perspective, reinforced by daily exposure, led staff to see people as hopeless, helpless, non-credible and needing to be fixed. Perceiving people in need of help as hopeless can create an expectancy that hinders people's chances for recovery.

4. Prejudices. Since most people coming into a crisis program have multiple issues it is easy to fall into the trap of making judgments about them due solely to their appearance. If they are dirty, disheveled, intoxicated, or out of control, staff may, without thinking, begin assigning negative connotations to people that create barriers to helping them recover. Staff particularly seemed to hold prejudices toward people who return repeatedly for crisis services.

5. Attitudes toward peer staff. One of the strategies planned to transform crisis services was the use of peers (persons who had experienced a mental illness) as crisis center staff. Unfortunately, many of the staff working in the crisis programs had strong feelings about adding peers to the staffing pattern. There were concerns about peers getting hurt, staff getting hurt because peers couldn't do their part, and the belief that peers would compromise the quality of

service delivery. Many of the staff felt that the work was too stressful for peers and that being in this setting would be too much stress for the peers and be detrimental to the peers own recovery.

Transformation strategies

The question for META was how does an agency overcome these barriers and develop a crisis center operation that is consistent with a recovery orientation? META's strategies included: strong leadership direction, policy and procedural change, staff training on specific issues, consumer debriefing, and regular feedback on progress.

Strong leadership direction

The CEO of META met with staff and very clearly and strongly informed them that META would no longer be using seclusion and restraint. This was a huge culture shift for META, especially since the use of seclusion and restraint had always been seen as a necessary part of their business and was routinely practiced. Staff threatened to quit. Some threatened to call OSHA because they believed the company was putting them at risk. Some claimed that the company didn't care about them anymore. The CEO held his ground. Because his genuine beliefs and concerns were evident, staff had the courage to try this with him, even though many still didn't believe it would work. Here's how the CEO describes his leadership on this issue:

I was enthusiastic and excited about the possibilities of our new recovery mission. I wanted the people we served to really have the opportunity to recover. Stopping the violence of takedowns and restraints in our Crisis Centers seemed like the place to start. That could begin to shift our beliefs and attitudes and jumpstart the transformation of our culture. I made a public declaration for "zero restraint". That got us busy. We educated ourselves, developed new policies, redesigned our training, and measured our progress. Now, whenever there is something to do that is really hard, we remember that we have already done the impossible. "Zero Restraint" has become our metaphor for transformation. (Gene Johnson)

Once it was clear that the CEO had taken a position on which he was not going to compromise, staff began to reconsider their resistance to eliminating restraint and seclusion. While, for the most part, they didn't believe it was possible, most of the staff were willing to try, even though they continued to worry about their own personal safety.

Policy and procedural change

META had the usual array of policies and procedures, but as is often typical, they were not used by staff to direct practice. Rather, staff were making decisions based on their personal and professional beliefs and values. So, the challenge was to find a way to teach staff new values and beliefs about recovery. Then, the decisions they made every day could be guided by the new recovery beliefs and values rather than the rulebook. Any new policies that were developed for any part of the agency were based on the following principles:

1. Practice and procedures should be value based, not rule based.
2. Following the principle that recovery is a personal and individualized process, policies should be guidelines, flexible enough to allow practice and procedure to be individualized to each situation and circumstance.
3. Policies should be person-centered, not business-centered, and examined in the context of what will support the recovery of everyone served and everyone in the organization.
4. Rather than liability and risk management being the focus, policies should encourage the organization to find ways to support each other as risks are taken to create new solutions.
5. Policies should be friendly, easy to understand, and easy to remember.

As the way of doing business changed, META also had to find a way to work within accreditation standards and licensing regulations. At times leadership had to be "advocates" with the regulators, but so far the regulators and META have been able to find a solution that honored the vision and values of recovery.

Staff training on specific issues

Staff training commenced to overcome the previously identified barriers of fear, hopelessness, prejudices and negative attitudes. Before staff could be convinced that a crisis center could operate without restraints and seclusion, a foundation needed to be developed that supported the belief that recovery was possible. A required training program on recovery was developed that consisted of four hours on basic recovery information, including research findings that documented the concept of recovery. This information was accepted by a few staff, but just tolerated by most. Those who were interested in learning the new material began to point out that the training was unclear on how to actually practice recovery principles. In response, another 8 hours of training was implemented on the “how-to” of recovery. The more training the staff received, the less resistance there was to practicing recovery principles. A prevailing theme throughout the recovery training had to do with power and responsibility. Since the person served is the one who needs the power to recover, staff was trained in practices that would empower each person instead of striving for compliance and control. Training that emphasized giving people as much responsibility as possible for their lives and their behavior was a key to eliminating seclusions and restraints. If staff took over, the people served would soon see that staff had no confidence in their own ability to manage their behavior and would often lose confidence in them. At times the outcome would be out-of-control actions that were dangerous to themselves and staff and resulted in restraint.

The previous training that had been used to train staff in crisis management was continued since a nationally accredited program was required by our license, but we began to teach it with an emphasis on avoiding it. We also developed our own set of recovery material (still in draft) to accompany the training that emphasized building relationships and stay in the conversation. Since training in the proper use of restraints is a licensing requirement, this was included in the new META training but was described as a very last resort, and use of it was considered a “treatment failure”.

Managing fear is a key ingredient in eliminating restraint and seclusions. The underlying fear of staff is that they will get hurt by the people that came to the crisis center, whether voluntarily or involuntarily. The underlying fear of the people coming in is that they will not be listened to, that their preference will not be honored, and they will be forced into something they don't choose. When the fears of staff and the fears of the people meet, the "fear factor" increases exponentially. Managing fear became a priority in META's quest to eliminate restraint. Since the staff were worried about being hurt, the past record of injuries was reviewed; the records showed that most of the injuries occurred during the process of restraint. The implication was the less restraint was used, the less likely people would be subjected to injury. This information gave the staff courage to move ahead with the plan to achieve a zero restraint goal. The leadership also reviewed the history of restraint to see if there were certain times during a person's stay that restraints were most likely to be used. While there was no clear time pattern of restraints happening, two other findings helped META make adjustments to meet their zero restraint goal:

1. The longer people had to wait for answers, the greater the possibility for restraint. The crisis staff addressed this by making wait times as short as possible, and if in certain situations it was not possible, staff continually reassured people that they were working on it. Staff were taught to validate the discomfort of waiting as a normal reaction, not a psychiatric problem.
2. The second thing META learned from the records was that some shifts were more likely to use restraint than others. Additional training was provided to those shifts in order to support them through the change process.

As mentioned previously, the staff working in the crisis program usually only saw people who are in a non-recovery state – people whose lives are in some form of "break-down". This narrow perspective that staff were subjected to on a regular basis confirmed their beliefs that recovery was not a possibility for most of the people they saw. Their prejudices about recovery

were also validated on a regular basis when they saw some people repeatedly in crisis. To counter these prejudices stories of recovery were added to the training. People who had been served in the crisis program come back and talked about their continuing experience of recovery. Adding peers to the team seemed to have the most significant impact on this lack of personal experience with people in the process of recovery. When staff began to accept peers as co-workers, and began to rely on them as a crucial part of the workforce, attitudes toward recovery changed significantly, and the tendency to use restraint became more and more remote. However, the initial reaction toward including peers in the workforce was not positive. Nevertheless, the peers themselves began to point out that they could be a tremendous help if given opportunities to intervene in situations that may have previously resulted in the use of restraints. The most powerful message peers brought to people in distress was “I know how you’re feeling. I was once in here as a patient myself.” This almost always got the person’s immediate attention, and from there a conversation that was relevant to the person’s perspective followed, resulting in a better outcome. Staff learned they could call on peers to contribute hope for people who were feeling hopelessly engulfed in their illness and/or circumstances, especially related to overcoming relapse with illness and/or substance abuse. Focusing on hope seemed to help people hang on to their strengths instead of falling further apart. Another impact the peers had on the use of restraint was to make it clear to non-peer staff that being in restraints was the worst thing that ever happened to them, and that it had set their recovery back significantly. Also, for staff to see former users of crisis services who were in recovery was further evidence that people in crisis do recover; this helped staff see people in crisis as having the potential for recovery.

Debriefing

The viewpoint of the consumers who were using the crisis centers was obtained and utilized throughout the transformation process, particularly the perspectives of those who had

been restrained. Consumers were asked what staff could have done to avoid restraining them; what the consumers themselves could have done to avoid this; and what staff could do in the future to keep this from happening? For example, from the debriefing staff learned that some people need to be physically active when they are in distress. This is the way they manage the internal agitation. If staff could give people room to pace and even rant, they could work off some of the negative energy. Prior to learning this, staff often saw this behavior as “escalation” and moved in to restrain. Staff also learned to listen closely to people and whenever possible to give them what they were asking for. This kept staff from getting into power struggles over relatively meaningless issues like cigarette breaks, phone calls, and so forth. As staff learned more from the people staff had been trying not to restrain, META included these points in their crisis intervention/de-escalation training manual (REF).

Feedback on Progress

In an effort to continually educate staff on the importance of avoiding restraint and seclusion, META’s Director of Quality Improvement began sending weekly information to all staff on the dangers of using seclusion and restraint. This included information on the number of deaths related to these practices, as well as the problems of re-traumatization. She also gave regular reports to staff showing them how they were progressing toward the goal of eliminating restraint and seclusions. This process of measuring for results became a key factor in reaching and maintaining the goal.

Results

Figure 1. Quarterly indicators of seclusion and restraint for both crisis centers

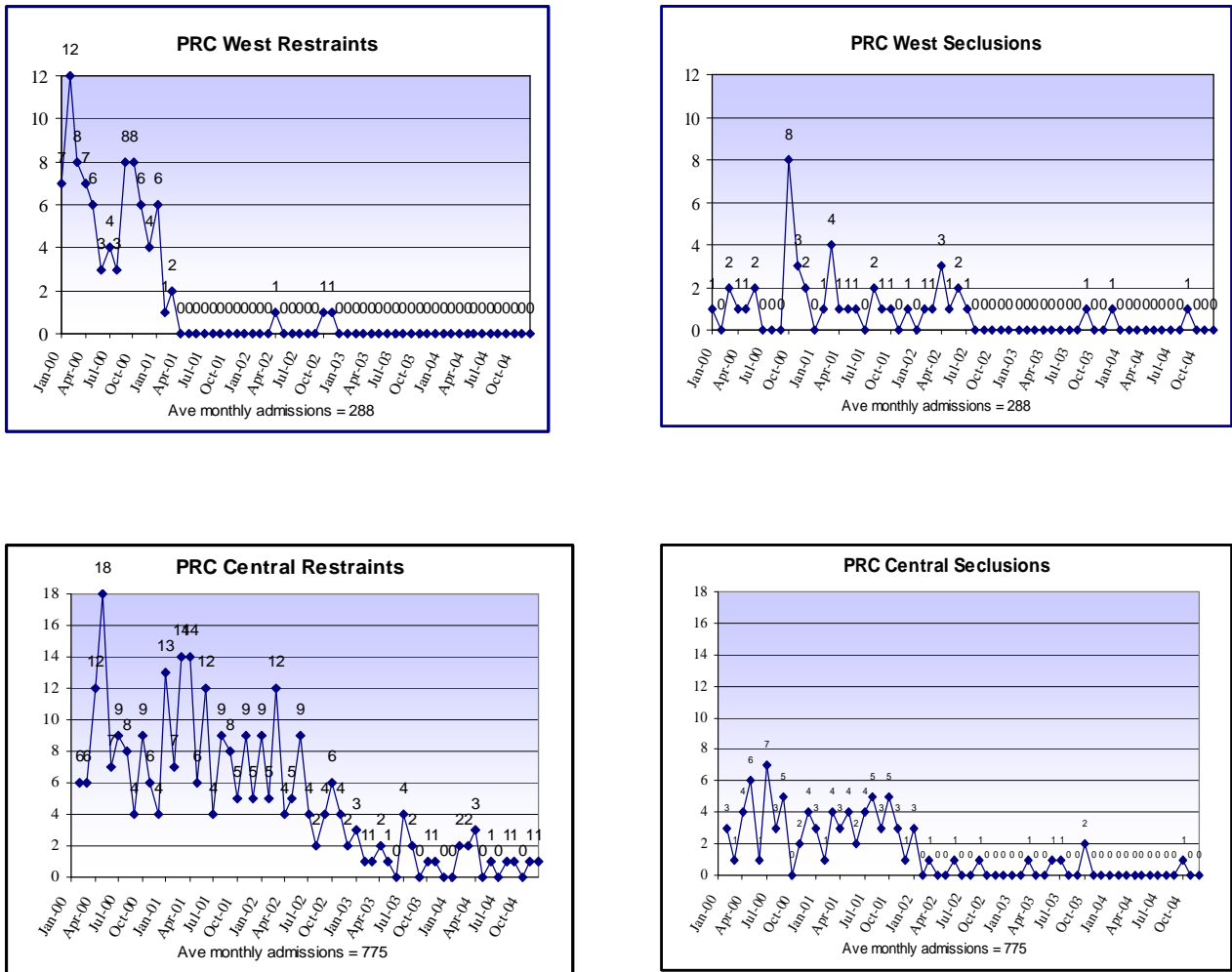


Figure 1 illustrates the quarterly figures for seclusion/restraint for each of the crisis centers operated by META. The larger center (Central) took 27 months until a quarter registered zero seclusions, and 41 months until a quarter recorded zero restraints. The smaller center (West) achieved their first zero seclusion quarter in 3 months and their first zero quarter restraint quarter in 15 months. Staff injury data for the same period shows that the concerns about an increase in staff injuries due to the virtual elimination of seclusion/restraint practices varied between the centers as well. Table 3 shows that as the use of SR decreased over time, the larger

center (PRC Central) did not have the continual decrease in reported staff injuries as did the smaller center (PRC West).

Table 3: Number of staff injuries in each center

Year	Number of Staff Injuries			
	PRC Central	PRC West		
2000	9	15		
2001	8	6		
2002	19	9		
2003	8	7		
2004	8	5		

We can speculate on the reasons why the smaller facility was able to achieve and maintain the goal of “0” restraint long before the larger facility could. First, the smaller facility, while not ideal, was much more functional and appropriate for this service. It was not overcrowded, as was the larger facility, and the layout and furnishings were more comfortable and accommodating. Also, because it was smaller, staff were under slightly less pressure to move people quickly through the recovery steps, so the atmosphere was more conducive to helping consumers relax and reflect on their options. Furthermore, the larger facility was co-located with the County hospital facility, which may have had an impact on the level of physical involvement of the consumers (i.e. people with physical involvement may have been taken to this facility since it has medical help near by).