Seclusion Video Transcription:

My name is Kevin Huckershorn and I am currently the state director for substance abuse and mental health in the state of Delaware as we fondly know as the first state. I'm also going to speaking with my colleague Gale Blueburg and since both of us grew up in Florida and spent decades there I'm sure that we probably know some of you that are joining us today so hello.

What Gale and I've been asked to talk to you about is preventing violence, trauma, and the use of seclusion or strain in behavioral health or other related settings. And what I'm going to talk to you about today is about the United States initiative to reduce conflict and violence in settings where people get served, that include not only mental health and substance abuse but also can be very easily adapted for police officers, emergency departments, nursing homes, and other similar types of settings. Including schools, we're just starting to get involved ____ for kids.

So I want to start out a little bit with the brief historical overview of this effort. For those of you who work in mental health and behavioral health settings, we've been using seclusion and restrain for decades, I mean hundreds of years actually, and although a few times in history people have made an ___ effort to reduce the use of these interventions. It never really took. So most of us were trained after we got out of school in the use of these pretty violent interventions when we took our first or second jobs. Back in 1998, a child died in Connecticut. He was a small boy by the name of Andrew. And Andrew was sitting at a breakfast table having fun with his friends in the residential treatment center and they started horse playing and he was ordered to get up and move to another table by the staff. And he refused and he ended up being crushed to death by a number of adults, he was suffocated and he died. That information got out to the public in Connecticut, very local, and the Heartford Current which was the local newspaper, got very interested because they could not understand, just as most of the late people in that area, could not understand how a small boy who go to a residential treatment center where he was supposed to be getting help and services and end up being dead. So the Heartford current sent out a team of four investigator reporters back in 1998 and they went through the entire country interviewing state holders, policy makers, joint commission, HIFA, now the Center for Medicare/Medicaid. They talked to professionals, they talked to family members, they've talked to everyone they could think of and they came back about a year later and they released a series of six newspaper articles that they entitled "Deadly Restraint". In those articles, they talked about the fact that seclusion and restraint was wide spread throughout the country, it was used in a number of different settings, it was very unregulated, the use was variable, the reasons for use were not consistent, and that people were dying and not necessarily being that those deaths were necessarily being reported to anyone.

Very quickly in a matter of months, this issue caused such a public human cry that it got up to the United States congress and the government accountability office. About the same time a number of professionals, our colleagues, went to congress and told them that this was all blown out of proportion, that seclusion restraint was normal and typical for a variety of settings at the Hartford Current had greatly exaggerated the issues and that everything was fine. So congress decided to ask the Government accountability office to go out and follow what the Hartford Current had reported on to find out if this information was indeed true. So the government accountability office sent their teams of investigators and lawyers and they pretty much followed what the Hartford Current had done, interviewing even

more people and gathering information across the country and they came back and released their report in 1999. And they again supported everything the Hartford Current series had reported but they did something that was also very important. They reported on a number of model programs that they had found throughout the country that had been able to reduce the use of seclusion and restraint without a lot of fanfare, without the extra money, just the people that had determined in small hospitals, in a couple big hospitals, Pennsylvania was a key player in this, the whole state. Just had decided because of leadership in those programs and states that they were not going to use seclusion or restraint anymore and they reported on those efforts. So they started to build a knowledge base of groups of people throughout the country taking care of youth, children, adults, nursing homes, people that are geriatric on what works and what didn't. Following this fairly quickly the federal rules changed, and for those of you who have been around for a while, the feds put in the one hour rule which said that for anybody who's secluded and restrained there needed to be a physician on site within one hour to review that restrain or seclusion and to document whether or not it was appropriate and whether or not it should continue. In 2001 also we at the national technical assistance center in Washington, D.C. started to receive a lot of request from states for help in reducing seclusion and restraint. In some cases we heard about some pretty serious situations where state administrators or hospital administrators just basically told their staff to stop using seclusion and restraint and people started getting hurt. Because when you take away a tool, which is exactly what seclusion and restraint had been for years, and don't replace it with something people can get hurt. Back then at NASHMD, the National Association for State Mental Health Program Directors, which ran a national Technical Assistance Center. We started to look around and try to figure out how we could help states to reduce violence and coercion in the use of seclusion and restraint. In 2007 the feds put out their final rule on seclusion and restraint which Is the same rule that we're all functioning under in terms of hospitals and Medicaid providers we're functioning under now. And then going back to 2002, that's when NASHMD created the training model that we are using today, although it's been updated every year. And that training model's called the Six Core Strategies to Reduce Violence Coercion and the Use of Seclusion and Restraint and that is the bulk of what I'm gonna, Gale and I are gonna talk about today. In 2003 the new freedom commission which was the first mental health commission that had been appointed since the carter administration released their report on best practices in providing behavioral health services to the country and in that they talked very clearly about the need to reduce trauma and coercion in health care settings and in any setting that is serving people with mental illness, substance abuse disorders or any other kind of behavior disorder. The feds then, SAMHSA, which is the Substance Abuse and Mental Health Services Administration then funded a research project for a number of years and the evidence coming out of that research supported the effectiveness of the six core strategies and then in 2012 the national registry for evidence based and promising practiced approved the six core strategies as an evidence based practice. So just a little brief overview so you kind of see where this evidence is coming from. This was the largest United States seclusion and restraint reduction study that has ever been done to date it was from 2004 till now. And this particular study included eight states and they received incentive grants from the feds to identify alternatives to reduce the use of seclusion restraint and that's a list of the states that were involved in that first research project. Data that was gathered was also analyzed by an independent evaluation group in Cambridge, called the human resource institute and a group of consumer expert researchers and the results of that study supported again the six core strategies. The background of the study, the facilities in these 8 states all started at different levels, implementing, some that have been trained in the six core strategies, some have not been trained,

some facilities really wanted to do this, other facilities didn't even know that their hat had been put into the ring until they got a phone call that we were coming in to talk to them and implement the six core strategies so they weren't even aware that they were involved in the research project. And at the end of the day only facilities that implemented the six core strategies and reached stabilization were included I the final data. These are the variables that we measured. We measured to variables each for seclusion and restraint, we measured hours per 1000 treatment hours of use and we measured percentage of consumers restrained or secluded. Of the 43 original facilities in those 8 states, two never really got off the ground, 7 implemented but never stabilized, 28 met stable implementation, 5 implemented, stabilized, and then decreased their results and then 1 implemented but then discontinued and as you'll recall a number of these states were effected by hurricanes in those two years so they had a lot of difficulty moving forward. In summary the interventions for the reductions of these seclusion and restraint were successful of the 28 facilities that met stable implementation, over 70% reduced seclusion hours and the percent of consumer secluded and in terms of restraint, over 53% reduced restraint hours and 57% reduced the percentage of consumer restraints and for those of you who know anything about this type of research those are extremely high numbers, they are very significant. Also we know noted that in states where the state department, the state office of mental health and substance abuse or just mental health were involved they achieved even greater success. And for example in Massachusetts 11 hospitals were involved and they decreased by 65% of episodes of restraint and 48% of the number of people restrained. In Illinois 9 hospitals reached 48 and 28% reductions and hospitals that received on site consultation by a number of the experts at least 3 times a year, in Massachusetts for instance for 2 hospitals went beyond a 90% reduction in both episodes and number of consumers restrained and in Illinois one hospital also did.

In terms of other data that we gathered, there were zero reports of increased injuries from any of these sites. The significant step of this first study provided more than enough evidence for us to apply for a best practice. This was a very big step in changing the United States threshold for what is called usual or customary practice, which is what we all use to measure what's minimally acceptable in terms of what we do every day in whatever work we are doing and successful hospitals all demonstrate significant changes in core beliefs and values, in other words they transformed their culture in the journey of doing this work. So what we do know now, is that we know that the prevention of conflict and the prevention of seclusion and restraint use is possible in all mental health settings and is possible in many other settings when it's adapted. We also know that facilities throughout the U.S. have reduced use considerably without additional resources so this is not a best practice where you need a lot of money. But we do know that this kind of culture change takes tremendous leadership, commitment, and motivation by everybody that's involved in it from the leadership at the very top to the all the way down to vast direct care staff that are working with the clients every single day or whoever is working with the people you are attempting to create this change with. What it does again, requires a culture change and hat culture change is primarily surrounding staff, language, the way you interact with people, what skills your staff have, an understanding of what recovery is about, how to build resiliency, how to help people learn to manage their own illnesses and a good understanding of negotiation and mediation. However what we've also noted throughout the country for over the last 10 years is that system wide change is very slow and difficult for a lot of reasons, mostly because we all have fulltime jobs already and this is actually most likely like another fulltime job when you try to do it. Sometime ago we met in D.C. with a number of stake holders including a number of peers, persons in recovery, and talked a little bit about a vision of behavioral health in the future for the United States and these are some of the constructs that

were talked about and widely supported. The families of former clients are employed in every setting, and make up about 50% of the staff. That treatment planning is actually directed by the customer whether they are an adult, a child or an adolescent, and/or include the family and when family is not possible, that persons chosen surrogates are able to assist including peer specialist. That conflict and violence has been reduced by 90% in our health care settings, that staff language is always person centered and nondiscriminatory and that treatment settings are sanctuaries so that people actually want to go to a treatment setting for help if they get triggered, if they fall, if they falter in their recovery process, if they get ill again which many of the illnesses of the people that we serve have are chronic in terms of there's no cure so they do have episodes at times where they need pretty much to go in and have their meds looked at or just take a time out. And then evidence based practices are the norm and I don't mean just evidence based practices but also promising practices; that things that we know work that have outcomes whether those are qualitative or quantitative. And that those outcomes are judged by the people that are receiving the services not just the staff or the professionals giving those services. And that some of those include non-coercion, standards for the use of medication, controls in place to avoid the use of polypharmacy, that consumers and families get the education that they need. And that there is this treatment focus on illness self-management; teaching people not to be dependent on our health care system but learn to manage their illnesses on their own knowing where to ask for help if they need help. So the development of six core strategies curriculum this came about through an ongoing review of literature, this also came about because back, if you remember I talked about the governmental accountability office and their report, they identified a number of best practices in the states, so that we at NASHMD, a number of us who put together a small committee we were able to reach out to these other states and get in contact with these other programs that had headed, seen this great success and ended up bringing them in for a series of brainstorming sessions to identify what measures they had used that they thought had been successful in reducing violence and coercion. Service, ___ and staff, we also spent a lot of time interviewing people with lived experience of mental health or co-occurring disorders or substance abuse, about what it felt like to be restrained and we talked to staff about what it felt like for them to go to work and actually have to get involved in what would look on the street as an assault, some pretty violent events sometimes, its staff is being asked to participate in. We held focus groups and those core strategies emerged in themes over time, in other words at the end of the day when we sat down and talked to everybody about what they had done that worked, even though people in some cases were calling these strategies different names, it came down to they had all pretty much done the same kind of thing consistently. One of the other issues that we had to identify early on too, was kind of a philosophical foundation for what we were going to base this work on to reduce seclusion and restraint and prevent violence and coercion that leads to seclusion and restraint. Just a brief comment on that, what we realized early on was that if you don't have any conflict and violence and people arguing and people unhappy you don't use seclusion and restraint, so remember that concept because that's a really important piece. So when we looked at leadership principles because we identified pretty quickly that when you start to undergo a culture, a transformation of your facility or organization, this is not something that's a grass roots initiative although the grassroots have to be very on board. This really is something that goes all the way up to the top to the leaders who are leading those systems because they got to be on board for a number of reasons. The public health prevention approach which I'll talk about in a minute. An understanding and a belief that people can recover and people are resilient and can learn to be even more resilient, that we must devalue consumer and staff, our staffs reports on what it feels like to work in our settings and to

use seclusion and restraint, that we understand about trauma and trauma informed care and that we understand about continuous quality improvement because we all are going to make mistakes in this kind of work. And we all need to understand yes we're going to make mistakes, we need to learn from those mistakes and then close that feedback loop by making whatever changes we need to make in our system to try to avoid those kind of mistakes in the future.

The public health prevention model is a very interesting model that was identified by the NASHMD medical directors back in 2001, when they wrote their first report on seclusion and restraint. There were a number of psychiatrist who had come out of the public health system, they were very familiar with epidemiology and they recognized that the public health prevention approach might be exactly the ticket for approaching this problem of seclusion and restraint. The public health prevention model is a model that's used across the country for disease prevention and health promotion and they saw it as a logical fit. What the public health approach does is it looks at threats to the population health and then identifies contributing factors and tries to figure out how to prevent, minimize or vindicate the problem if it occurs. The public health field often looks at things like the bird flu, or HIV or Hep C, the things that people can catch you know, large numbers of people can catch and have very serious outcomes from. And then so they try to figure out, what can we do up front so to minimize someone getting these illnesses and if they do get them, how do we make the illness as least problematic as possible. The medical directors also saw this public health approach as being really important to refocus us on prevention while trying to maintain safe use in the field. So primary prevention, which is now called universal precautions which all of you recognized are interventions that are designed in seclusion/restraint in the seclusion and restraint field to prevent conflict from occurring by anticipating population risk factors. Universal precautions are things like hand washing, use of vaccinations, use of condoms to prevent sexual transmitted diseases, so in terms of seclusion and restraint we're talking about primary prevention interventions designed to prevent conflict so that we never use seclusion and restraint. Secondary or selected interventions are early interventions that are used to minimize or resolve risk factors as they occur, so now we've moved past the point where there's no conflict in terms of seclusion restraint and we're starting to go into a situation where you can hear someone's raised voice, you could hear someone's upset, you could hear someone is yelling or pacing or pounding their fist on the wall and early interventions to immediately intervene and seek to deescalate that situation. And then in terms of public health, these are things like the person is already a drug addict so we provide them with clean needle exchange services to avoid them from getting HIV or Hep C, so that we haven't prevented the drug abuse, that's already occurred, but now we're going to try and remove the risk of even more serious illnesses. Um osteoporosis prevention like things like that Fosamax or reclass where a women generally has already started to see bone loss but in a way, as an attempt to prevent fractures you get put on medication so that the fractures, which is the deeper end problem does not occur. And then tertiary preventions which are indicated interventions for a much smaller part of the population are post in terms of seclusion and restraint; what do you do after a seclusion and restraint event happens, we missed the boat, we missed the signs, we didn't know the client well enough, they were intoxicated, whatever so what do we do after we've had to use seclusion and restraint, which is pretty again violent intervention, to vindicate the effects to try and to undo the traumatization that may have occurred, to try and undo the damage that may have been done to the people that were watching this event occur and take corrective action and figure out how we could have avoided that going forward in the future and in this case, in public health these would be things like good diabetist treatment regimes, good hypertension and treatment regimes, and ongoing cancer care.

Trauma informed care is the emerging science, based on the high prevalence of traumatic life experiences that the research shows that the people we serve are at high risk for. Kim Yuser, at Dartmouth back then in 1998, did a number of studies that show that up to 98% of people in the public mental health and the behavioral health field have experienced significant traumatic life experiences that can greatly complicate mental health or other problems, health care problems and serious complicate prognosis. Systems of care that are trauma informed recognize that coercive interventions cause trauma again, we re-traumatize people which goes directly in the face of do no harm and are to be avoided and that to do this we need to adopt universal precautions approach to everybody walking in our doors, assuming that they have had traumatic life experiences and that you don't want to do that to a person again. Trauma informed care is both a philosophy and includes specific activities, it's an umbrella over everything we do going forward, we want to adopt this kind of approach, the concepts are not complicated, what we're talking about it is implementation of trauma informed care. It really has to start the reduction of seclusion and restraint because that's one of the most violent, traumatizing interventions that many of us still use in our facilities, so if you're going to be trauma informed you really have to focus on seclusion and restraint reduction first. And then trauma informed care is provided in a trans-disciplinary model where no team member is more important or higher than anyone else and the customer's voice is always the most important.

So the six core strategies are leadership, court organizational change, using data to inform practices and that's very important it's 2013 and we should all be managing by data, developing our workforce, implementing seclusion and restraint prevention tools, full inclusion of service users or what we call peers, families in all activities, especially families for youth and kids, and then finally our only tertiary prevention strategy is making debriefing rigorous.

New research on violence, causality and the role of the environment, just to step back for once second into research that we looked at as we were developing the six core strategies. What we noted in the research is that violence in health care settings have been blamed on the patient for years and years and years. And that for most of the studies that had been done prior to the last decade were basically done on patient demographics and characteristics, for instance if I'm running hospital ABC and I'm having a whole lot of violence occur, I hire a researcher and they came in, take all my medical record and they go through my medical records and they come out with a picture of the client who is violent. And there are, hundreds of these studies were done and what was pretty much identified was the young males, often a minority, African American or Latino, depending on which part of the country you were in. People that had command hallucination or serious paranoid schizophrenia, people that had been involved in the foster care and legal system for years and people that use substances. And so these pictures were put together in nice little packets and said these are the people that are violent, these are the people you need to worry about. But at the end of the day a number of ___ research studies were done where all these studies were taken together and reviewed for commonality and consistency and what happened at the end of the day was that the findings from the study were completely variable and inconclusive, and leading us to now more recently to look at violence which is a complicated issue, a complicated phenomenon, look at violence in context of the environment and where it happens, including the kinds of staff person interaction patterns that are occurring. So it's not just the patient, it's not just the staff, it's not just the environment of care, it's all of those put together.

So what follows is my attempt delay about a one and half day training into about a one hour presentation. This work is in the public sector, its free to use, we strongly encourage you to not to try

and train this work if you don't have trainers that have done this work first hand but there's lots of people that could be helpful about that. With healthcare reform looming, I think that we're all very aware that we're going have to become better and better providing evidence based outcome based care and that frankly some point down the road there's going to be a lot of providers that are trying to serve a number of customers and those customers are going to back to the places that they feel they were treated with dignity, respect, compassion and best practices.

Um leadership sets clear goals based on a vision. These goals are clear and unambiguous and do things like specify for the staff or the group that's working on this, that we're only going to use seclusion and restraint in the face of imminent danger to self or others and that we're gonna make it very time limited and that we're gonna analyze all events so we can prevent use in the future through a performance improvement process. Now it's important for leadership, whether you are working in a substance abuse program where you don't use seclusion and restraint probably but you do see some violence and conflict that your goal might be to reduce the episode as a violence and conflict and ___ for clients. For schools, use a lot of holds, don't necessarily use a mechanical restraint but often use holds and seclusion, so you have to customize your goals. But one of the things, you have to make your goals, the leadership has to make the goals very clear and unambiguous to the people you're expecting to change their practices because otherwise people will get confused. And we often talk about when you do this work its to take the six core strategies and use that to develop a strategic plan that you can follow by changing each of the six core strategies into its own goal and then have a number of objectives underneath and then there is a fair amount of information on that we can send people. You need to include a statement in your mission or vision about your expressed goal to reduce or eliminate violence and coercion in trauma that is not only for the people that you serve but for the people that are serving them. What we found over and over again is that many agency staff are pretty traumatized themselves and some even have PTSD or what could be almost up to the threshold of PTSD from being involved in very violent work for many, many years. Um you need to link your goals with your agency philosophy and you need to understand that you're going to have to train your staff and this does not happen quickly and it doesn't happen through one or two day training and it happens not only with formal training, but a lot of mentoring and role modeling. The power of leadership is within the leader's control but leaders need to use their powers, they don't use it or they delegate it down it does not generally result in any kind of effective organizational change. Myself and many of my colleagues have seen this over and over and over again and we went into states and for instance we trained all four hospices, safe mental hospitals and one was successful. When we went back in to review what had happened and why. What we found pretty much consistently was that the hospital was effective it was because the leadership was completely on board, did not drop the ball, kept the ball in the air for a number of years until those changes became integrated into the actual, I guess you could say, soul of that hospital and the other facilities just either because they were distracted, because they had staff turnover, because the joint commission came in and found a lot of problems and that became the priority they weren't able to keep the reduction of violence and coercion on the horizon and they couldn't move forward. Um leadership on all levels and that includes informal leaders that are in all your programs is considered the most important and fundamental resource in any kind of project that looks for organizational change or culture change. The essence of effective leadership is the ability to motivate one's staff to action around a shared vision. In this case, what we're looking at is preventing conflict coercion and violence, creating nonviolent and non-coercive treatment cultures, implementing trauma informed systems of care that feels safe and warm to customers, that's just a couple examples, um depending on what you do on a

daily basis you would adapt to that. Um effective leaders build their organization around exemplary performers, you want to recognize your staff's best practices and especially want to make an effort to encourage reports or actual observations of staff making changes and how they practice because that takes some courage. Um you want to make sure that knowledge is transferred and sustained in your policy and procedures and practices, so when you start to change practices that's reflected in your policy and procedures and you continue to tweak those over a number of years. And that staff are very involved in performance and improvement around these issues, know what's going on and that when mistakes are made people aren't punished unless its egregious error, you know like hurting a client without real reason, which rarely happens, but people make mistakes and they're going to. It should just be treated as a learning opportunity. Um this again, work needs to start the clear documented prevention of conflict goal, needs include performance improvement principles, it's often very helpful to create a team of leaders and middle managers and direct care staff and however your particular organization lays out. To participate in this team and develop this formal plan, it needs to include peers, people you're being served and that sometimes you can do that out with people you're serving on site, sometimes its people you're gonna invite in from the community or people that you know of, that you work with that come into your agency or organization, people on your board of directors that are advocates and you know, don't forget or don't misunderstand, harm that's still being perpetrated on people in many of our settings, is still widely pervasive. Um there is almost not a couple weeks that go by that I do not get a report on someone who was kill, being restrained or very seriously harmed because of the way they were behaving and police doing what they had to do. And kids in schools that are restrained and secluded in a very high risk situation because at least in hospitals we have nurses and doctors around and in schools we do not. Next, using data to inform practice, providers need data to analyze what happens when they have an event or a near miss, which means you almost use seclusion and restraint and it got really close and you managed to avoid it but you want to go back and figure out how could've prevented that issue from happening in the first place. So what you want to do when you first start out is get a baseline, go back over the last year and basically get all the data you can on every event, adverse event that you might have recorded in your organization. And again if you're a hospital or a behavioral health center that might be seclusion and restraint events. If this was a facility or organization that really doesn't use seclusion and restraint, but does see adverse events resulting from conflict and violence, people being unhappy, then you're gonna want to look at your violent events and injury rates as a way to reduce, that's your goal to try and figure out how to reduce incidents. So what you want to look at in terms of these events whatever they are for you is that unit, the day, the shift, the time, these happened the average duration that these events are taking in terms of time. If its seclusion/restraint you want to measure how long people are in seclusion and restraint until they can be let out. You want to look at the people that are being involved in this, the customers, age, gender, race. It they're in a hospital you're gonna look at the date of admission, what we found in a number of hospitals is that the first three days of admission were the highest rate and the most dangerous time because we didn't know the clients well enough, they were coming in often from the emergency rooms or coming in from police, they're already upset and if we didn't do some really good upfront orientation work chances were that within that first two days where they finally realized they weren't going to be allowed to leave possibly, they're going to get very angry and get violent. Uh we want to look at diagnoses, um just to have that information, I've not know to shoot date any diagnoses that really high risk than others, except for paranoid schizophrenia and co-occurring disorder where substances are being used, especially when you're admitting or dealing with people that are intoxicated. You want to

look at the attending physician, you want to look at the pattern of individual staff involved in the events, what we discovered was that because for years we just accepted that fact that we were going to have violent events on our units we often hired big men and we rewarded them for being out safety people; our in staff security guards if you will, or our big people that we wanted to work. All of you probably in behavioral health know how many times you've either complained that we didn't have enough men on staff or you wanted to have john work with you because you felt safer with him. And so over the years these same staff got rewarded both formally and informally by being really good at taking down people and getting them into the seclusion room or the restraint bed and so when we start to change this culture and we start to value de-escalation skills and mediation skills, and negotiation skills, sometimes the staff get the feeling of what they were doing was all wrong, or they get very unhappy because they think they don't have a role anymore. And in some rare cases they just continue to do what they've always done and you can identify that because you'll have only a certain number of people involved in these events. And now what that indicates is that people need more training. Number of grievances, precipitating events, what seems to have happened, the what why when where how, why did the person get so upset, there's almost always precipitating events the rate of people spontaneously exploding is incredibly rare, there are almost always warning signs and it's up to us as the behavioral health experts to be able to know our clients well enough to be able to see subtle changes and sometimes not so subtle changes in their behavior. And then safety issues that justify why seclusion and restraint was the only response, some number of issues we found around the country over the last 12 years that was just customary practices you know someone picks up a book and hurls it against a wall that is nowhere near any staff and doesn't hurt anyone but the book that's not imminent danger. Someone gets up and slaps someone across the face and then walks into their room, not good but not imminent danger. Really need to only use hands on when you're talking about imminent danger, risks, not these kinds of one time only issues, pure property destruction, yea that's not great but that's not reason to use seclusion restraint. If someone kicks over a chair or breaks off a water cooler off the floor and unless they're picking up the water cooler and trying to throw it at you, that's just not imminent danger to anybody, its messy and its troubling and it cost money but that needs to be handled at the treatment scene.

Going on to use data ____informed practice leaders must use data to monitor their progress, discover best new practices in house, I can tell you in South Florida State Hospital we had a very interesting situation where we had four units that were all 50 bed units, three of those units provided care to a very similar population, they weren't specialty units, they were general population units. Of those three, when we started gathering our data, we noticed that two used a fair amount of seclusion and restraint and one never used seclusion and restraint. So we went down to that unit and we talked to the charge nurse, the nurse manager, and we found out that she had kind of on her own, she came from out of state, she didn't like seclusion and restraint, she didn't understand why people were using it. She gathered right away that most of the time it was being used because people were getting into arguments about rules and restrictions, so she just changed the rules on her unit. Now she didn't tell anybody and her staff didn't tell anybody because they thought they would get in because they weren't following the policies of the rest of the hospital. What happened was once we found that out, we grabbed her, made her a champion, and had her go into the other two units and explain and role model how to start to avoid conflict and violence by basically stopping saying no to everything, lightening up on the regulations on when you can use the phone or when you can take a shower or when you can go to take a nap or what kind of TV you can watch, um those kinds of things. Um this will also help you

identify staff champions, you want staff champions and they will come forward in every level of your staff. Include them on committees, have them be your spokespersons, target certain units and staff for training that use a lot of seclusion and restraint or don't seem to be getting the philosophy. In Pennsylvania and Massachusetts they did a fantastic job of creating this kind of healthy competition. In Pennsylvania back then they had about 10 state hospitals and about every month those 10 state hospitals had to send the commissioner their progress on use of seclusion or restraint and as a result they started getting awards, the lowest used facility and people got really into it and they now have a number of facilities that haven't use seclusion restraint pretty much for years. In Massachusetts in the children's program, same thing, and they still have yearly conferences where everyone comes together, shares best practices, talks about what's going on so that everyone's kind of up to speed. And it's a huge initiative in Massachusetts which has led the way in the kids programs.

In terms of work force development, this is the 3rd core strategy, staff need begin training on the following high risk issues. First of all they need to get training on aggression and risk violence and we don't have a lot of research on this, we're very bad at predicting violence or aggression, a lot of research has been done and if you take a hundred nurses or a hundred doctors and put them in a room and show them the same thing yet it's like 50/50 if they pick the correct answer of who's going to become violent. So what we want to do is train staff about what a complex issue of violence and aggression is and understand that these are very complicated combinations of individual, environmental, and situational risk factors. And then also physical and medical risk, we want staff to know, if you're involved in hands on work that every time you put your hands on someone, someone can get hurt and sometimes very seriously. People go into fight or flight, they get very terrified, and sometimes they have flashbacks from PTSD, prone restraint especially needs to be severely restricted in everybody's agencies. People could not be taken down, face down on the floor for more than 3 seconds, people can die very quickly in a prone restraint for a number of physiological reasons. Death can occur within 5-6 minutes and you won't necessarily know it because people can talk and ask for help, even when they can't breathe well enough to get enough oxygen exchange. It's a myth that if people are talking they are getting enough oxygen, that's a complete myth. We also need to know the risk of people that have preexisting medical conditions like asthma and obesity, and staff need to understand that we'll never know all the risk when we put hands on people, I mean people can die and do die. Work force development going on staff needs to be informed on those three models of violence, patient characteristics, and environmental factors and situational which are a combination of the above. Attention to only the patient or the setting ignores the multidimensional relationship, it is complicated and there are no simple answers to complicated questions. Situational risk factors that are negative or neutral are things that you need to fair it out, to figure out what is adding to the violence that is taking place in the work place and this kind of factors that need to be monitored including violence levels, management structures and styles of leadership policies, physical environment, quality of life factors, the type of treatment interventions that you uses, there's multiple variables there. The key goal here is to prevent the risk of conflict and violence because as without that neither seclusion or restraint are likely to occur, people are not likely to get violent if they're happy if you will although I know that sounds a bit Pollyanna. But if their needs are getting met, if they feel they're being heard the chance of violence is much lessened. These are a number of studies I just put up for you to see; there's been a lot of research in this last decade on these issues in terms of mediation, negotiation, and de-escalation, reduction of seclusion and restraint and what has worked in terms of both the six core strategies and then people that drilled down even more.

Prevention tools, what you want to look at is the first prevention tool, is to create crisis or safety plans on admission for people coming into your services, now obviously that's not going to work if you're a police officer, but it certainly works in emergency rooms, it works in any kind of facility including substance abuse, mental health, it could work in special schools where you're gonna know which kids are going to have some behavioral problems. What you want to look at is identifying what triggers that person or kids, stress, what are the early warning signs which is these we call them the ABC's, and then what are calming strategies that you use that work for that individual and those are all over the map, they're different for everybody. That's just a joke for those of you old enough to remember Roy Rogers Forrest. No not that trigger, these triggers. A trigger is something that sets off an action process of series of events in this case we're talking about fear, panic, upset, or agitation, it's also referred to as a threat cue. And this could be, all of us have these and all of us have different responses to these and the clients we serve sometimes have very violent responses to some of these threat cues or triggers, bed time. We've had a number of situations where kids, usually females, young females, got violently aggressive at bed time when they were told to go to bed and shut the door and in several of those cases what we found was because they had been severely raped by a family member in the evening so bed time meant really bad things for them. Feeling shamed, room checks, large men yelling, people too close, being told no, yes we have to say no sometimes but there are ways to say it without saying no. No turns out to be a huge human trigger. Not being listened to, I'm not going to read all these to you, feeling pressured, people yelling, loud noises, being touched, especially being touched unexpectedly, being talked down to, having no contact with family or having contact with family. Second identify the early warning signs. Early warning signs for human beings run the gamut, fairly common, we've all seen this ringing hands, shaking, crying, giggling, pacing or running, eating more, can't sit still, using a loud voice, restlessness, swearing these are early warning signs and each individual person in care needs to work on developing with the staff members their identification of what their body does when they get triggered and its different for everybody. And then calming strategies, these are probably the most difficult part of this crisis safety plan because many people have never even thought about this so they'll give you the answer they think you want to hear or something that sounds good but when first comes time to use it, it doesn't work. That doesn't mean the plan doesn't work, it just means you don't know the client well enough and the client doesn't know themselves well enough and you need to go back and work more with them to figure out what really helps to calm them down. These are just some common calming strategies that work for some people, going for a walk, having a one to one with staff in a quiet place, working out, lying down, listening to music, reading a book, pacing, taking a shower, some people like to meditate, some people like to write in a journal. Whatever it is sometimes you have to practice with the person to really make it their safety plan, their crisis plan. Sometimes talking to a peer is the most helpful intervention possible, so again leading to the whole issue of needing to have peers on staff, very important. If a person is getting agitated don't forget to use HALT, I'm sorry, HALT is they hungry, angry, lonely or tired. This is often the common triggers for people especially new admissions. Common attributes of these kinds of prevention tools and prevention plans reflects the persons trauma history, uses available resources, encouraging staff and client creativity and especially in this case staff can be very, very creative if you set them free to be creative. Incorporate sensory interventions and underscore that the needs of the people we serve need to pretty much be more important than the general rigid rules of the institution, so we need to be able to be flexible. Sensory modulation is another prevention strategy, this is work where you begin to understand the sensory experience, incorporate knowledge of sensory input, use the expertise of occupational therapy. Occupational therapist know very well about

sensory diet, we each have a sensory diet, we each have sensory seeking and sensory avoiding behaviors that we probably don't even know that we probably haven't even thought about. We can use this information as physiological human beings information to figure out how to use sensory modulation to help teach people how to manage their emotions. Sensory input, we all know what the 5 regular senses are and 2 hidden senses, which are proprioceptive senses and vestibular input. Proprioceptive is basically where you are in your environment and vestibular input is kind of your balance, then the rest sight, sound, smell, touch, and taste. These are some of the sensory based approaches that have been found to be helpful, grounding physical activities, holding weighted blankets, are and hand massages, pushups, body socks, walk with joint compression, wrist and ankle weights, aerobic exercise, and sour or fireball candy, things that like make you wake up, those can be very grounding for people. Calming activities again, hot shower, bath, wrapping in a heavy quilt, decaf tea, yoga, drumming which is exactly what it is drumming, using instruments or even just your hands and bean bags to drum and that is meditation. Some calming and grounding alternatives, this is the seclusion room and Gale is going to talk about that in a minute, these are just some examples from across the country the cuddle swing with the rock climbing wall and a mini trampoline, this is a kids program. Here's another kids program, the fish bowl, at Ft. Lauderdale hospital; this is Western State hospital in Tacoma, Washington, this is an adult comfort room with a mural on the wall. The fifth strategy which Gale is going to be talking about is including peers and families in the change processes like in culture change like we're talking about today. Just a word about the new freedom commission, another strong statement the new freedom commission called for which was complete inclusion of consumers and family members as providers, advocates, policy makers and full partners in creating their own plans of care so that the surgeon general's report as far back as 1999 and the institute of medicines report both in 2002 and 2005 and I'm gonna let Gale talk about this but the value of peers in the work force, in the community, and as advocates cannot be overstated, they are the most valuable tool that we have found, or that they have provided us since any medication that we've ever known about. The last core strategy is rigorous debriefing and just a definition of debriefing, it's a stepwise tool used to rigorously analyze a critical event, some of you know this in its formal process as a root cause analysis which is used in health care, its used in marketing, its used in making cars and its used in air traffic control. Root cause analysis is a very stepwise evidence based practice to analyze an adverse event or a critical event where you want to find out what occurred, what factors led up to that event so you can figure out what to change in your system so it doesn't happen again. There's a fair amount of information out there on rigorous debriefing and on root cause analysis what we do and what I've always done in the facilities I've worked in is a simplified root cause analysis because you don't have time to an actual root cause analysis on every single seclusion and restraint when you're first starting out. What debriefing will do for the leadership and the staff was answer these questions in terms of an adverse event, who was involved, what happened, where did it happen, why did it happen, and what did we learn and usually these debriefings an actually last over a couple of weeks when you have a number of meetings bringing in the right stats, other times it can be done, pretty much as you get good at it, in an hour or so. Um debriefing goals, number 1, reverse or minimize the negative effects in the use of seclusion and restraint, so that's immediately what you want to do, you want to basically make sure that everybody's okay and safe and if the people that were involved in the staff, the client and any clients watching are talked to afterwards, try to litigate an trauma that they may have experience and don't forget the events of observers who often don't know what happened only that their friend, as far as they know didn't do anything is now being dragged on the floor and then being put in the bed and strapped down. It's very scary for people

to watch that. The second goal is to prevent the future use of seclusion and restraint by finding out what had led up to the incidents, talking to the customer themselves and asking them what we could have done differently, in some cases we have apologized when we misunderstood what they were trying to tell us and somehow things got out of hand. It's fine to say "I'm sorry that this happened". We're not accepting blame, we're not you know saying that someone did something terrible, we're saying we're sorry this happened. Determine if all alternatives were used, if you had time to implement alternatives. And then the last debriefing goal was to address these organizational problems and make appropriate changes. You can do all this work and you can do all these debriefings but if you don't take what you learned and feed it back into your policies and procedures and work for training, you've basically wasted your time. Formal debriefing, um what we usually say is to do an acute debriefing immediately after the event on the unit, get whoever the nursing supervisor, whoever is the onsite lead person in the facility if you have one, most hospitals do have somebody floating that's kind of the administration in the off hours, get them on the unit and do a quick and dirty debrief. What happened? Is everybody okay? And fill out the paper work. And then the next stage is the formal debriefing where you basically run it through the treatment team, get the written documentation from last night or whenever it happened so that you have good information. Get the consumer, if they can, to discuss from their perspective what happened. And if they can't or they're too upset this is where peer serving in a debriefed role can really help be an advocate for that client. And so finally I just want to end with

has to provide input into their care and services will also understand the power of this initiative. Okay.

Trying to get used to the mouse, here.

Definitions of, I think it helps folks to know what some of the basic definitions are. There's now so many – Kevin has used a variety of words – and I'll mention them, but the first word is consumer – consumer being a person who is a current or former patient diagnosed with a mental illness.

A peer is a person who has equal standing with another, or others, and has had similar experiences as another.

A peer specialist is the most common term used for self-disclosed consumers who deliver recovery-oriented services. Most often, they have specialized training, and sometimes a certification.

The word consumer is probably our least favorite, although it's probably the most known, andI find that people living in our various facilities or as clients are frequently most familiar with this term, and for them it's okay.

But for others, people are preferring to call themselves persons with lived experiences or persons in recovery.

Terms will also vary in terms of where a person, what the role is for a peer specialist, and where they're working.

For peer specialists, there's also a variety of terms, and again, depending on the location or the setting that they're working in. One of them is peer-bridge – that is specific for helping people prepare for discharge. They work both in-patient and in the community.

And the term client liaison in Massachusetts, I'm going to mention that role again because it was created specifically around the use or the issue of seclusion or restraint.

Definition of peer support – peer support is not like clinical support, nor is it just about being friends. Peer support helps people to understand each other because they've bene there, shared similar experiences, and can model for each other a willingness to learn and grow.

Shery Mead is very well-known in the country for defining peer support and doing training on these issues and much writing, as well as Cheryl McNeil. She is a – she also talks on other subjects, particularly on peer-run crisis alternatives and developing alternatives around trauma-informed care.

Rationales for peer involvement in mental health settings. One of the most important rationales is providing empathy. One of the key benefits of peer support as opposed to other forms of mental health services is the greater perceived empathy that peer specialists have for the people they support.

Sally Clay, one of our early peer- specialist pioneers way back in the '80s defined it this way:

Since we have been "crazy ourselves, we feel passion for the condition of others rather than the fear of their mental illness, and we strive to offer unconditional respect for those that are in the same boat that we are."

Another important aspect of peer support is the helper's principle, which means that when we act for the benefit of someone else, we are also acting for the benefit of ourselves. Consumer survivors believe that working for the recovery of others- especially one's peers – facilitates recovery for both.

All peer-run services are based on peer-to-peer relationships as part of the helper's principle.

Other rationales is that peers can serve as role models, communicators, mediators, advocates, teachers, and legal protectors. Peers provide support from the perspective of experiential rather than professional authority. First-hand experiences provide unique insights and interpretations of situations, and peers hired as staff at all levels promote movement towards an organizational culture shift.

Adding peers to a mental health agency will make an immediate difference in the way staffing and the way the behavioral health services are provided. Trained peer staff will add a dimension to the very treatment, how it is delivered, and peers will often serve as role models to staff as well as the clients they serve.

Typical peer specialist duties. Peers participate in recovery or treatment team meetings at the request of a client. This is probably one of the major roles probably in agency, including in-patient settings. Peers facilitate peer support groups and recovery groups.

Recovery groups are interest groups that would be of interest to the client and the peer doing the workshop. That probably could be called "workshops" in various interest activities.

Peers provide individual one-on-one support. They address minor complaints and grievances. This is a very important role that peers can provide because when they address complaints at a low level, you will find that you will reduce the number of the actual formal grievances. We did that here in Delaware, and practically reduced our forma grievances to nothing. And we've pretty much turned over the whole issue of complaint taking.

Peers can help develop hospital policies with language that is sensitive to recovery. By that, I mean that clinical terms would be minimized, and it would be easy to understand in lay language.

Duties and responsibilities will vary in each facility, even between hospital facilities within the same state. This is because some facilities provide different types of serves and may be short term or longer term. They may also vary depending on the peer's level of skills and experience.

Other responsibilities may include involving service recipients – people that are being served – in all levels of decision making, including hiring new employees.

Administrating consumer satisfaction surveys. Assisting in orientations and assisting new employees. This would include peer staff as well as provider staff, and serving to mentors to people they serve with rights protection.

The possibilities are endless.

Actually, I wrote here that this was specific to in-patient peer support roles, but I really think this could be in other agencies as well. There could be a position created as a peer admission specialist. Kevin just mentioned something about HALT – and that's a term I wasn't familiar with – hungry, anxious, lonely, and I forget what "T" was –

Kevin: Tired.

Speaker: But my definition for T is terrified, and I think people that are being admitted really are very anxious and very terrified, and an admissions person that's there to be the first person to meet somebody and greet somebody is very helpful to the individual.

Hope Totes is something that we created but are basically comfort bags – things that are given to people that help them feel comfortable at the time of their admission. It's important that things that are put in the Hope Tote are screened for safety. And then we also have discharge bags, which are large, or I'll call them "goodie bags" for a person that's being discharged that can really contain all kinds of toiletries and socks. We include socks.

Helping people advocate for themselves, documentation, which is minimized under and used only under certain circumstances.

The other thing about documentation that we talk about with peer support is that we sit down and show people or work with people in terms of what we are recording, and what we are going to put on the record. And it's only, again, under certain circumstances that we would actually document – not as standard progress notes.

Probably all of you are familiar with WRAP. WRAP has been around for a while. It's our first peer-evidence based practice. It was started by Maryellen Copeland. One core function of peer specialists is facilitating wellness recovery action for anyone in WRAP, a personal monitoring program in which an individual develops techniques and strategies for reducing symptoms as well as ongoing management and prevention of symptoms.

There's now a conference that takes place annually which not only is national, but is also international and the website is listed here – Maryellen has written a number of different programs related to WRAP.

Crisis intervention – and this probably would relate most to the issue of seclusion and restraint. Peers will very often be the first level of de-escalation or to prevent or to work with an individual who is

beginning to be in crisis. The training for crisis intervention for peers should be extensive and ongoing with role play situations and also we do our own debriefing of situations that do come up.

Debriefing has been often thought of as after seclusion and restraint, but it's also important past an incident that occurred to also do debriefing.

Peers can work on personal safety plans, which is something similar, in a way, to the WRAP plans, but specific to in-patient facilities. Focusing on trauma – frequently people that are being served are more open to talking to somebody about their trauma histories than they might be sharing with others.

They do intensive work with individuals. Cultural differences need to be considered. And then I listed here last – comfort rooms, which is a prevention strategy, not an actual place where people go when they're in crisis. It's a place that they can relax and it's also a place where a peer can sit down with somebody when they're anxious or in stress.

Well, I noticed that Kevin had one of the photographs here of Western State Hospital. A comfort room, and I must say that neither one of these represent an actual, more simplified comfort room, although they're both beautiful. And one of the things about comfort rooms is that they do express beauty. They are a place where they're decorated with murals. I'm not sure about a futon, and the one on the right – Ft. Lauderdale Hospital – when I last checked haf 5 different comfort rooms, including one for children. This was the most sophisticated, and was used for several different reasons.

1:17:00

There is also training that we do on comfort rooms and materials related to how you develop and use a comfort room.

Some of the individual benefits to peers is empathy and support, or sharing stories; sharing what works and strategies for recovery, which can include resources. Frequently, peers know resources that other peers do not know about. Empowerment – giving somebody a voice, really, not that we give them a voice, but that we promote or we help them to own their own voice, and we've seen many changes from people that don't talk or didn't talk to now being quite vocal.

Holistic non-medical purchase. What people are looking for in communities in terms of holistic care is also what people want that are being served want. They're interested in yoga, massage, spirituality, nutrition – all of the different things and they're eager to learn.

Knowing their rights – it's also easier to related to somebody who has been there.

Some of the benefits for staff is that peer roles have a potential to be a force for positive change. Educating mental health professionals about living with a mental illness and potential for recovery. Peers on treatment teams are a valuable asset. Often times, staff attitudes toward clients become more positive, and interestingly enough reduced workload.

One other thing that I thought about is that we're finding also that staff are feeling more open to disclosing their own histories of mental illness, and I think we'll be seeing more of that.

Challenges to success. Staff aren't trained adequately. Staff are used as tokens during transportation or sometimes menial tasks. Peers filling traditional roles, which is something they frequently fall into, because they're not actually used to being a peer specialist themselves, and they find it very easy to fall back on what a traditional role is. Often, staff are afraid that peers will become ill. We have an answer to that, and the answer is that just the way any other person is out sick or ill – it's the same way that we treat our peer specialists, probably with a little more care. I think we do talk a little bit more as peers with each other and try to help each other when we notice that we're becoming stressed.

Often, and this is very common, is that a peer overworks and does become stressed because they're so excited about what you're doing. Boundary issues can be another challenge.

Some of the specialized peer positions are peers working in an in-patient drop-in centers. Those are common in several states, starting in Florida with South Florida State Hospital. I mentioned the term "client debrief" and "client liaison." In Massachusetts, Denyque Hotis is probably the first person in Massachusetts, I think they already started other positions that was specific to debriefing. I know that she's still working there years later and that her work has become more in the prevention area than in the post-situational debriefing.

Role. Peer bridgers work with people both while they're in the hospital, but work to transition them to community settings. Peers in eemergency rooms is being very much implemented and very needed because people often wait for long periods of time in emergency rooms. In several instances I know about, peers have been able to prevent an actual admission because of their presence.

Crisis alternatives. Peers are now starting and working in their own developed crisis alternatives. Trauma peer specialists. Admissions discharge, which is what I mentioned before.

Forensic peer specialists – there are also peers working in VA hospitals and probably in many more places with roles that I may or may not know about.

Qualifications. The first qualification we look for is somebody that's self-disclosed and self-identified as a previous recipient of mental health services, or someone who has been diagnosed as someone with a serious mental illness. We mean someone who was not just going to counseling or worried well.

The reason for the need for self-disclosure is the fact that the peers tell their stories or tell parts of their stories both to individuals and also in public settings. We ask that people or we look for people that have been stable in recovery for over a year. One way of doing that is were they hospitalized in the first year. We would generally speaking not want to hire somebody who is still in their early recovery. Bachelors degree is preferred. This is probably becoming more common than it was before, because again, you're asking people to do some very sophisticated duties, and in order to do that, people really need to have skills. They need to have excellent communication and writing skills. Previous work history that we also look at and successful completion of peer specialist training and certification when possible. In states, both the curriculum – the training that people get – and how the certification is given will vary.

Peer hiring process. I'm recommending, and it may again, this may be changing because, again I think it's very important that you get the right person in positions. So we have discovered that, first of all, we have an application that is fairly extensive where people answer some questions about their recovery so we might look for a cover letter, a resume, the application filled out, and the answer to narrative questions. We sometimes do an informal first contact on the phone. We have a secretary that does that.

I would recommend it. Sometimes we do an informal second interview. Then there is a formal interview that has at least 3 interviewers on the committee or the panel that interview with interview questions.

Stage 4 is reference checks and background checks. So I can't emphasize enough that you develop your criteria, your hiring process, a job description, and know who it is, what you're putting a peer in so that you can adjust that to the amount of interviewing that you need to do.

Creative strategies are something that I've worked on for a long time, and others, artists in our country, have become prolific. So I think that one of the important peer roles is creativity. This can be arts, humor, alternative healing. It may be introducing journaling which can be purchased at the dollar stores. Recovery videos – Maryellen Copeland has a variety of these, but they're also available in other places through SAMSA, for example. Reading materials. There are many more books being written by consumers, by people with lived experience, autobiographies and biographies of their experiences. The pillowcase project is painting on pillowcases on different themes and put out at art exhibits. Pet therapy, Horticulture, Talent shows. A display of clients artwork for enhancing the environment.

Some of the lessons learned is that preparation of staff is critical. Staff need to know before you hire somebody, they need to understand the meanings of recovery and they need to know more about what the peer role is going to be.

Job descriptions developed prior to hiring – one of the other aspects of that is that the job description has to be flexible because sometimes you'll hire somebody you'll find out that while their job description was developed one way, they really have a niche or a talent for another area. We've been sort of in luxury because we've been able to do that, and it really allows some people to succeed where they might not have been able to succeed in their original job description that they had.

Positions should be placed at appropriate levels of supervision. Whenever possible, supervisors should be peer, and I think we're going to see more of that if, not always, peer supervisor is available or managers, but most important that supervisors , if they're providers, be very aware, very sensitive, and very informed of both recovery and the peer support role.

Support groups available. For our peers, also for staff, another important point is that more than one peer specialist should be hired for any given setting. To put one person in a setting is very, very difficult for that person.

Just a couple of quotes from the drop-in center in Florida, now we're back in Florida... Which by the way we were hot here, but we were cold yesterday. Very hot, and very cold yesterday.

"For as long as I've been here since 2002, there have been no safety incidents. We have 100-150 people come every day who claim it is their favorite place,"

Gayle: And I can remember that. I worked there.

"They can play pool, watch TV, use computers and have choices about what they want to do."

Gayle: And that was written by Alicia Smuckler. I think she's still there.

A mental health provider prospective… "Peers have helped us transform our organization making it recovery-oriented in design and in service delivery. Our peer employees have helped us achieve and maintain a new way of dealing with people that does not require seclusion and restraint interventions."

Gayle: And that's from Rory Ashcraft from Recovery Innovations.

From Tony Richatelli, who is Denyque Hootis's briefer – her director.

"What is most important is that the person hired is a good fit. Good fit is the capacity that any employee has to navigate a work environment in order to maximize their effectiveness."

Gayle: I think that's about it for me. Oh, the next slide shows two materials that we have available. You can look at this later, and request them from us if you would like. And I think they'd be very helpful. The second one is an actual guidebook on hiring peers.

Kevin: Just move over and I'll sit down.

Okay, I'm Kevin. I'm back. We get questions, so we're going to start going through those questions, and my assistants went and checked to see if there's any more questions, because we have about 23 minutes so we should have plenty of time.

Just kind of going through the list.

Peter asks - have there been any attempts to implement the six core strategies in criminal justice facilities like prisons, jails, competency restoration facilities, and any reason not to try?

Well, the answer to the second question is no, I think that these strategies can be easily implemented if you can get the leadership of whatever facility you're talking about to take this on and to really understand the importance and how it will change their facility. I will tell you that prisons and jails, because of the constant collision, if you will, of 'are we there for punishment or are we there for rehabilitation' can be difficult, and that would be in place where you'd have to really spend some time with staff looking at trying to really get them on board and understand that the less violence and the less conflict means less injuries that are going to happen in prisons and jails.

Now competency restoration facilities, especially if they're forensic hospitals like we have here and you have many in Florida – you have at least, last I looked 3 in Florida – it's easier to do there because they're hospital settings because they're treating people with forensic involvement. I can tell you here in Delaware, our forensic hospital, which basically serves people that are incompetent to proceed, or not guilty by reason of insanity, is one of the safest forensic facilities that many people have ever seen. Rarely have any incidents – we just had joint commissioned here in the physician surveyor who is a forensic psychiatrist was really impressed with the staff over there.

I also can tell you that we are also working, my staff, some of my staff are working on implementing trauma-informed care principles in a large women's prison. That's the first prison in Delaware that has stepped forward and really indicated a focus and interest in implementing trauma informed care, so we're starting training with the leadership, and then we will be training the correctional officers.

Jenna asked – what has been the success of implementing the six core strategies in school settings, and obviously specifically schools that are for students with special needs like emotional and behavioral disabilities, autism, and those kinds of things.

There has been some work done in the country. The Secretary of Education, Arnie Duncan, and you can Google this, just put out a large document or report to schools to the Department of Education all over the country on the importance of reducing the use of these interventions in schools, and a fair amount

of really good information in that document that kind of provides information for schools that might want to get on board. I can tell you that my personal experience it's been hard to get into the school system. It's like, in Delaware, it's a completely separate department, and it's just hard to kind of insert yourself in that, so that generally needs to go up the ladder. For instance, my cabinet secretary who's been talking to the cabinet secretary in the Department of Education – we have some plans, but we haven't really moved forward on that, but if you Google that, I'm sure there are states that are far ahead of Delaware in working with schools.

Sandra asks – and this was with regard to Larkin Community Hospital in South Miami - that they started trauma-informed care in the behavioral health units, and that facility's now a hospital-wide trauma-informed care facility, congratulations, Sandra. Her question is: have you found a way to appropriately spread trauma-informed care form behavioral health to other areas of a hospital.

Yes, that's also been done. I know of a few small hospitals where that has been done. The best way to do that is to pique people's interest by offering some free one-hour lunchtime CEUs, and do it over a presentation, like an overview of what trauma-informed care is. I know that the National Association of Nurses that work in emergency departments have looked at this issue. So has the American Psychiatric Nurses Association, trying to get into hospitals, and sometimes the best way to get in is to go through the emergency department.

Dennis asks – is there one form of crisis prevention intervention that I, or we, recommend and are there any methods that focus on the reduction of power struggles.

That is a really good question. There are, at last count, about 42 private vendors who provide training to staff in behavioral health settings that are generally called de-escalation trainings or restraint and seclusion training. What I recommend strongly is, no matter how long you've been at your facility, if you're in a leadership role, go to your next training with your new orientees, your new hospital employees, and sit through it and participate in it. Yes, it's usually 3-5 days, but I cannot tell you how important it is to find out exactly what your staff is being trained. We're all human beings, and even if that training started out being pretty close to fidelity, from what the original trainers basically provided your staff, things can drift. I can tell you that at least 3 facilities that I have personally done this in, I found out immediately that the focus had shifted back instead of de-escalation and negotiation and learning how to work with clients in a trauma-informed care manner, that things had shifted back to spending an awful lot of time on quasi-marshal arts holds, and fancy footwork, and that is a very mixed message for staff, because they will not be able to remember how to do those moves if they don't use them all the time. What we generally say is that whoever you have coming in to train your staff if you're using an outside vendor, to have 55-75% of the time in that training to be on de-escalation, human behavior, typical signs and symptoms of mental illness. Even more important than signs and symptoms is just becoming an expert in human behavior and being able to scan the environment, know your clients well enough to see changes on them on a day-to-day, hour-to-hour basis, being able to figure out the milieu that feels different that day, manage noise levels, manage tones of voice, how you speak to people. Naturally, what those kinds of trainings should focus on. Unfortunately, none of these training vendors have really been able to produce data that shows that their particular training is better than anybody else's. There are probably 5 or 6 main trainings depending on what part of the country you're in, so again, I think you're the best judge of what you want your staff to get, so go to that training, and if

you're not happy with it, change it. Call facilities that have been able to reduce seclusion and restraint and ask who they use. (1:38:50)

Um, Sandra also mentioned patients being blamed for violence. "What has been your experience with staff's repressed violence transferred to patients?"

You know, I think staff – we're all human. And if you've got an unhappy staff that are angry or feel mistreated or feel un-listened to or unheard, that's gonna roll downhill, and that tends to mean that the clients are going to get the brunt of that. I mean, it's really important to train staff about their own triggers, their own emotions, the fact that a professional staff member is part of your job and to keep that stuff at bay, to take care of yourself, to really decide if you work somewhere for a long time and you don't' like coming to work anymore, then it's not a good fit, you may want to look into going somewhere else. This is where supervisors become very important, so that you can really see what your staff are doing, making rounds through the units. Yale's staff here – you know they work very closely with our staff. The regular staff, and they notice when people, certain staff are really being compassionate or ignoring people, or just not having a good day, and if that is a pattern, they will report that, and they will go in not to punish anybody, but to talk to them, see if they need more training, see if they need to take some time off. Any facility is only as good as its weakest link.

Lisa has asked do we have a resource for de-escalation skills, negotiation skills and conflict prevention.

We have some information, but really those issues are their own fields. There is a ton of information on the internet and people that are very skilled in doing this – I mean there are whole mediation curriculums. In addition, any of those vendors- those seclusion and restraint training vendors – have a lot of information that they've been using for years that have some fidelity that I would look at and I would – if you have trainers that are coming into you facility to do this work or you've got a vendor who's model that you're using such as CPI or Vance or Heart or there's a million of them, TCI, Cornell, Navi. I would talk to them about what they're using, where it comes from, and really ask them to emphasize that training, and even maybe come in and retrain your trainers.

But we don't have – we don't hold ourselves out to be experts in that, although we have done some of that training ourselves.

Gloria – hi, Gloria, from SFSTC, Gloria, says "we've had some discussion here on using mechanical restraints for patients who are self-injurious. Some physicians feel that the restrains make patients feel safe. How do we feel about that, and also what about patients who like to be in restraints? Aren't restraints contraindicated for patients who enjoy the restraint?"

I'll start at the bottom – yes, absolutely, and I always find it very sad when staff will say "well, Joe likes being restrained," because what that is an indication of is a terrible syndrome called institutionalization syndrome, which means that we have created this problem with this client. We have created a situation where they are using that I would consider a maladaptive strategy to calm themselves down. In this case, I would bring in an occupational therapist who is very knowledgeable in sensory modulation. There are weighted blankets and weighted vests that can really provide a very safe and comfortable feeling for someone who may be telling you they like to be in restraints. The person really needs to be weaned off of that, but something needs to replace it. You can't just say "no" if that's been used to calm them down. I would try some of those other strategies, because people – that's a set up for someone never

getting discharged because they're not going to be able to be put in restraints in the community. It won't be safe. So that needs to be managed through a treatment team mechanism and a specific treatment plan. You might even want to get someone in from your DD or your ID field.

Gayle: I think there – I just want to add that I think peer support can also be very helpful in that area. We're not doing seclusion and restraint here, so we don't have people that I know of that are asking for it. We do have people, I know that, get involved in repetitive patterns and, for whatever reasons, and I think peers are very often able to get that cycle by diverting them. We have a drop-in center, so I think there's a number of answers to that, but peer support would be one.

Kevin: Yes, I agree. In terms of using mechanical restraints for persons who are self-injurious, you really have to do a risk-benefit analysis. For instance, we had – I worked with someone in Virginia who was a boxer, who had traumatic brain injury, and who was fairly short, very strong, nice guy who was Hispanic, only spoke Spanish. The hospital had hired staff that could speak the language, but he had – he was very dangerous, because he was one of the few people that could be just talking to you and all of a sudden punch you, and he put a nurse in a coma. He broke a couple people's arms, and he wouldn't even remember it 10 or 15 minutes later. So he – they ended up, for a period of time – using wrist to waist restraints with a 2:1, because they also had to protect him, and when you do that to someone, you've got to protect them from other clients, especially if they've hurt other clients before, you've kind of created a victim if they can't defend themselves, but that was a way to get him out of his seclusion room, which actually was a suite they created for him. So I think that you can do that, I would say, for minimum amounts of time while you try to figure out what the triggers are that cause the person to be self-injurious. Clearly, anything you can do to create any kind of less-restrictive intervention, then actual restraint, you know, mechanical restraint or being locked in a seclusion room is better than nothing. But it doesn't really answer the question until you can get to the point of figuring out either the medication, or distraction, or getting them interested in something. Again, peers in that kind of situation can be very helpful to try and work with the client, whether it's PICA or just a behavior they've developed over time. We've had a number of issues with people like that here in Delaware.

Gayle: Can I add just a little to that?

Kevin: Of course.

Gayle: When I think of self-injurious behavior, I think of people who cut themselves. I also think of people swallowing – Kevin and I can remember a client or person who had a very serious problem with this. And after doing some research, I found that all of the things that were done that were all kinds of suits, restraints, two-on-ones, everything that was done, to not really alleviate the problem, and finally, the answer to what was getting her right back into treatment and into the – what did we call her treatment team –

Kevin:[unintelligible]

Gayle: And actually, it did wind up getting her back into her clothes and treating her normal. Then, the other answer is that frequently, in-patient hospitalization is not the answer for people that are self-injurious. {name} in Ohio does training on that issue and is excellent, so if anybody would like to know more about her, we have that information too.

Kevin: Thanks Gayle. Paul asked – is any organization using body language or facial recognition cues to see if the person is getting more upset?

I would hope so, because that is really what we used to call in my day, therapeutic use of self. What you're talking about, Paul – these are core competencies. If you work in behavioral health, one of your core competencies is that you need to be an expert in human behavior. Part of being an expert in human behavior is being able to read both verbal and nonverbal cues, and also to know your clients well enough to see if there are changes occurring, and to immediately be able to engage a brand new admission, and to spend enough time with them so they can feel safe and not as terrified as what Gayle was talking about before. That's why it's so important to have peers on the front end to really help the client orient to the facility. I think that one of the strategies that we often encourage people to teach their staff is that at the beginning of every shift, have everybody walk around – it doesn't have to be together – and say hello to every client. It's their home while they're there, and go and introduce yourself, tell them that I'm going to be there for the next 8 hours, if you need anything let me know. And at the end of the shift, go around and say goodbye or goodnight or "I'm off tomorrow, I'll be here the next day."

And that also gives you a chance to do a quick and dirty aspect check, so you can basically see if people are changing, how they're doing that day. That can give you a lot of cues if you may be having an issue later.

Cory asked – should policies, procedures and practices be modified at times to meet a customer's needs?

Kevin: If it will prevent aggressive behavior, you bet. That's pretty much what we did at South Florida. That's what Gayle went out to the units – we had asked her to go out to the unit's way out in 1998 and said "come back and tell us why seclusion and restraints are being used." She came back in less than two weeks and said "they're being used because people aren't getting their needs met. People are ignoring them when they ask for stuff. They're not able to talk on the phone when they want to. They're having to stand in lines all the time to wait for stuff, so they get upset. There's not enough to do. Some staff are rude. There's too many rules."

People that we serve are adults, some are kids, but they've lived on the outside. They've many times gone to school, had a job, gone to maybe even college – they had husbands or wives or sisters or daughters or parents. And we bring them into our facilities, we lock the doors, we take away all their usual abilities to meet their own needs, and we wonder why people get upset. So absolutely, we change tons of rules and regulations. Get the signs off the walls that say "do not do this. Do not do that." Change your environment of care.

Jenna – considering the restrictions of consent and policy in schools, what is the best way to include students, young children, in the process of reducing seclusion and restraint?

Include their parents, and that's really – if you're talking about young, under 5 or 6, include their parents and get your occupational therapists in to do a lot of sensory work and use of the arts. Massachusetts has done a lot with young kids, and I can certainly put you in contact with Janice LaBelle or Beth Caldwell or Tina Champagne to get in touch with. They have a lot of experience there.

Dana asks “since the 2009 revisions to the CMS reporting system regional offices now exercise discretion in activating on-site investigations or not. That’s also a trigger for another find – the Federal Protective and Advocacy System, which then can conduct primary and secondary investigations. Since the 2009 changes, reports to the P&As have plummeted in Florida. None have been reported and we do have courtesy in the date use agreement. Do you have any observations about that? Do you know if any external entity is looking at this reporting system?

Kevin: I do not. I would hope so. But what we usually recommend is that people use their own hospitals and their own baselines and track themselves against themselves. Depending on who you get as a surveyor whether CMS or joint commission, they can be all over the map. And so I don’t really depend on our accreditation agencies that really are just looking at minimal best practices to really focus or push us toward best practices. So I really expect that we need to do that.

Esther asks “has the term “consumer” replaced “patient.”

Gayle: Interesting question. 1986 is when the word “consumer” came into being, and it was our first alternatives conference. At that point, nobody could agree on what to call themselves, and where consumer came into being to meaning sort of the advocacy or the people would be advocating for them. Since then, people have interpreted it in many other ways.

The most important thing about the word consumer is that I think it’s more important to address people with their names that whenever possible you use the word “people” in documents. And only use whatever term I like – I like to use a variety of terms, and I notice that Kevin did that in the way that she presented. So yes, your question is – I would say – consumer did and has replaced the word patient. There are places that they’ve actually – and in Massachusetts one facility did a survey, and the found out that people really wanted to be called patients so… whatever.

Kevin: This next question is “what type of training is provided for individuals interested in becoming peer support staff? And are there any program areas in Florida that are currently participating in the peer program?”

We can’t really answer this second piece because we’re not in Florida, but in terms of what type of training is provided for individuals interested in becoming peer support staff, there are a variety of curriculums in the country. I’ll let Gayle kind of talk about that.

Gayle: Every state has their own certifications, standards, or own requirements for peers to get certified. In many states, they’re bringing in a couple of standard trainers that might be Larry Fricks. It might be [unintelligible, speaking over each other] and Recovery Innovations. We here in Delaware created our own peer specialist curriculum, and we did our first training this summer with 20 peers. It was very successful, and the only reason we did it – or the only reason that I wanted to do it, which I’m not sure about now – was to add the creativity piece to it, and people were very excited about that, and that was one of the things that we got very high marks on.

In terms of what I know about Florida, and there’s probably people out there that know this answer, but last I knew there is peer certification through the state board, and that there was, I think but it’s not just one curriculum that was accepted, but somebody could come and if it met the requirements, then they could do the peer training, but there’s probably some updates on that that I don’t know about.

Kevin: Next question, “what has experience been with peer employees through the same market area as the facility who acquired acute inpatient treatment.”

I’m just going to say one thing about that and let Gayle talk about it. When you hire peers, you need the discussion pieces is what their own safety and recovery plan is. And what they want to happen should they become ill. Generally, in a locale or a county or, you know, in Delaware which is as big as a county, we have 4 acute patient facilities, so we would probably recommend that that person’s treatment be not where they’re working, but we have made exceptions where the staff at the facility were perfectly comfortable and the client was perfectly comfortable. The danger there is role confusion and boundary issues because, you know, i if you’re trying to work as a side-by-side as peer professionals as staff with regular professional staff, you may or may not want them to see you when they’re ill, and that’s really a personal choice.

Gayle: Well, I kind of want to answer that a little differently. Basically that is the answer, but I really personally wouldn’t make many exceptions about that unless it was somebody that, many years ago, had had treatment in that facility and were not currently getting treatment. And I think here’s other reasons to steer away from that is that they’re records there, there’s staff there that know this person that if they get ill, when they get ill, then there’s a, what do you call it? An automatic response to that... They know this person in two different ways, and it’s kind of unfair.

Kevin: It can affect respect. It can affect the way the consumers, the peers treated afterwards, whether paternalistically or just not with trust, it can create issues. I agree. But we have done that once with everybody’s agreement.

Alvaro asks “what do you have to say to mental health facilities trying to implement 12 hour shifts within a stressful environment at work.”

I would look at what’s so stressful about the environment first. 12 hour shifts, I mean, the literature shows that it’s okay to work up to 12, maybe not beyond 12 hours, and it does give you a number of days off, often in a row, which can certainly be healing for people working in stressful environments, but I think someone needs to look at the stress in the environment and really drill down on that as a performance improvement project and see what could be done to reduce that stress and if the stress is being caused by really noise and too much activity and violence and those kinds of things. I would get some people in there to help you start to decrease those kinds of issues.

And the Dana asks “do you have any advice for doing reality testing-type exercises required for responding to internal stimuli?”

The research on that is pretty similar to the newest research on people with dementia. Reality testing, where you just ask someone if their oriented or not and find out if they are or not, trying to talk someone out of thinking that they’re hallucinating – that a hallucination isn’t real or a delusion isn’t real can really cause someone a lot of anxiety. There are other strategies to use in terms of redirection, distraction, and in many cases people with serious mental illness live with voices, live with delusions, but need to learn how to manage them by thought blocking, listening to music, telling the voices to go away. There’s stuff called cognitive enhancement therapy out of Cleveland that we’re just beginning to implement in Delaware, so that old stuff – and I was taught that too to tell a person that you don’t see that and that’s not what’s going on – have not, I personally have not found that to be real helpful. But

again, it's probably semi-individualized, and it also has to do with what type of alterations in perception a person has because if it's from detoxification, if they're in DTs, it does help to try and reality orient people because they actually kind of know that they're hallucinating or are having a delusion, which is very different from serious and persistent mental illness.

Gayle: Can I just talk on that one too? There's also a lot of work being done in the peer world, so to speak. Pat Teagan is specifically working on this issue. There are also support groups for peers for people that are hearing voices. There may even be a new term that they're creating that kind of softens that that people should acknowledge the voices that they have, that they should not be frightened by them, and I think the more they do that, and I think the more they do that where you give credence where you validate a person's experience – I think that passing effect, I can't honestly – I'm not an expert on this – I think it has the effect of a person being able to let go or to live with it. I think that's the message that's being given through the peer world. There's a lot of work from peers on this.

Kevin: That's the end of the questions that we have. There is a question about listing the six core strategies, but that, I think are going to be posting this PowerPoint, and our contact information is on that, so if anybody didn't get their questions answered, please feel free to contact either Gayle or myself, and we will get back to you in a timely to try and answer your question, and if you want some more information, we can certainly send you that.

Gayle: I just want to say that (unintelligible) is not peer, but it includes a picture of Henrietta. It's a character that I created, an alter ego if you want to say that, which I've recently – oh, there it is! There's Henrietta – so, but the meaning of that is really to take ourselves lightly, to have a sense of humor. And that's another technique, I think, that frequently gets lost, that we take ourselves so seriously whereas if you turn that around and say "oh my gosh, how ridiculous, how silly, how wonderful it is that we're experiencing something that look at it in terms of a path or a journey and think," that's the meaning of recovery.

Kevin: And now we do have two more questions, I know we're over time. We could just have those two people write us or if you want us to go ahead and answer them.

Rod: Well Kevin, thanks. We could let people know that since we've gone over that they're free to leave if they want and they will still get their credit for watching this, and if you'd like to stay for the questions, they're welcome to do so as well.

Kevin: One question is from Sandra and one is from Dana. Sandra's question is "our facility works aside different parts that have different views on how to deal with psychiatric patients. I mentioned that women's detention center using trauma informed care. Do you have any feedback on incorporating guards in trauma-informed care philosophy in our facility?"

Well, the first thing that I will tell you is that this is not going to be easy. This is an actual women's prison that houses about 300 and something women at level 5 or higher. What the most important first step is to make sure that the warden is totally on board, because this is, again, remember the first core strategy is leadership in implementing and directing change. You've got to have your senior leaders on board. If they're not on board, this will not happen because what's going to need to happen is that staff needs to get trained. Their job descriptions are going to be adapted. You're going to have to start looking at staff workplace outcomes that indicate that the culture is changing from a punishment to a rehabilitation

facility and all that needs to be leadership work. Check back in a year and I'll let you know how it's going here, because we've really just started a training program.

And then last, Dana asks, "do you feel that when needed, there's a benefit to chemical restraints vs. mechanical restraints."

And I have to tell you again, when you talk to your customers about their safety or crisis plan, that's a question that you need to ask. There are consumers and peers that will much rather have a temporary mechanical restraint than be drugged for the next 6 hours by a medication that makes them feel terrible and has bad side effects, and vice versa. But I'm also going to as Gayle to respond to that because she's had a lot of experience with that.

Gayle: Well, I basically just want to piggyback on what you've said, and I think that it's an individual. I would just really go back to the very first step is that there's ways in which you can prevent the situation that is causing a person to need either mechanical restraints or chemical restraints. I personally have seen situations where people have been put in restraints and have felt like it was necessary. I mean, chemical restraints, to me, means that they're getting more medication than what they need so that therefore the word restraint, I'm not sure neither is appropriate or desirable.

Kevin: Yeah

Gayle: But sometimes do you need to do that?

Kevin: When we miss the boat, when you don't know the client well enough, the client has just come in and you haven't had enough time to engage them, sometimes we need to use seclusion and restraint because there's no way to keep people safe, but hopefully you can quickly go in, figure out what happened, get them out as soon as possible – there's no reason for people to be in restraints and seclusion longer than minutes. We're down to half an hour, 15 minutes, on the rare occasion we use it. So you really need to look at that. And also, what Gayle said at the beginning is figuring out how to prevent using either in the first place.

Kevin: Thank you everybody. It was an honor to be able to present to you today. Again, feel free to write or call us, and good luck!

Gayle: Thank you!