Safe and Appropriate Behavioral Interventions: *Changing the Culture of Care*

A publication developed from the proceedings of the Thirteenth Robert Lee Sutherland Seminar

Hogg Foundation for Mental Health
SERVICES, RESEARCH, POLICY & EDUCATION
THE UNIVERSITY OF TEXAS AT AUSTIN

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Acknowledgements

Many individuals and agencies played a role in the development of the materials contained in this publication. The vignettes were developed for the December 2-3, 2004 Robert Lee Sutherland Seminar and the thoughts and insights of many participants were crucial to the analysis of the vignettes. The materials in the appendix were also compiled in preparation for the Seminar by Hogg Foundation staff and several conference speakers.

The Seminar was successful due to the insight and dedication of the Steering Committee members who volunteered many hours and worked tirelessly to ensure that the Seminar truly encouraged Texas agencies to minimize any reliance on the use of seclusion and restraint. The Steering Committee members included:

Albert Felts, Region XIII Education Service Center
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Tom Little, Texas Youth Commission
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A larger Advisory Committee served as a resource to the Steering Committee and provided valuable guidance in the process of developing the Seminar. The Advisory Committee members included:

Emily Abbott, Rio Grande State Center
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Sandy Rioux, El Paso Center for Children
Juan Sanchez, Southwest Key Program, Inc.
Sam Sipes, Lutheran Social Services of the South
James Smith, North Texas State Hospital
Theresa Tod, Texas Network of Youth Services
Tom Valentine, Texas Health and Human Services Commission
Frances Wise, National Alliance for the Mentally Ill – San Antonio

The Foundation would also like to thank Janess Sheets and Susan Stone for their thorough review of the draft publication.

Of course, the Foundation accepts full responsibility for any errors contained in this publication.

Introduction

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Executive Director, Hogg Foundation for Mental Health

All of us are concerned about the safety of individuals with mental health needs and the staff that serve them. As a result, the use of seclusion and restraint is an important issue because such use presents serious risks to both individuals in crisis and service providers. Clients and staff can be physically injured or some even die as a result of these dangerous practices. The use of restraint can be psychologically disturbing and can re-traumatize clients and staff who previously had bad experiences. In addition, it can expose agencies to workers' compensation claims and legal action.

Though seclusion or restraint may be necessary in some situations, de-escalation strategies are preferable to physical contact. Communicating effectively and understanding the dynamics of power and control issues can be crucial to resolving situations in a safe and appropriate manner. Sometimes situations can be prevented long before any physical conflict occurs by careful administrative attention to updated assessments, treatment planning, staff training, procedural reviews, and incident debriefing following events.

The Hogg Foundation developed this project in an effort to facilitate communication across agencies and settings related to seclusion and restraint. The goal of this DVD is to improve practice and prevent situations necessitating these dangerous interventions whenever possible. This information is an outgrowth of the Thirteenth Robert Lee Sutherland Seminar, where professionals from many different types of agencies facing these issues on a daily basis discussed seclusion and restraint and offered insight into scenarios involving clients of various age groups and circumstances.

These vignettes should supplement a facilitator's efforts to explore these issues in more depth. We hope that you find common themes throughout the scenarios that are appropriate across all agency settings. By exploring the use of seclusion and restraint in your agency, you can help to keep clients and staff safe and to provide a more therapeutic environment for the individuals in your care.

Note for Facilitators

The Hogg Foundation for Mental Health, in response to numerous requests to study the use of restraint and seclusion, presented the Thirteenth Robert Lee Sutherland Seminar on "Safe and Appropriate Behavioral Interventions: Changing the Culture of Care" in December of 2004. The first day of the seminar showcased experts from federal, state, and private organizations addressing concerns related to the increased use of restraint and seclusion in various settings. On the second day of the seminar, work groups discussed various hypothetical scenarios and detailed best practices in situations requiring intervention to change risky behavior. This publication and the accompanying DVD are a culmination of the two-day seminar. Due to the increase number of reports publicizing deaths attributed to the use of seclusion and restraint and the growing concerns for patient and staff safety, the Foundation is providing additional information to assist mental health professionals in reducing the use of seclusion and restraint through preventative measures by addressing training needs.

The video introduces each scenario and shows the progression of the scene up to the point of restraint. Although many of the scenarios presented result in restraint, the scenes illustrate cues that are overlooked that could have led to de-escalation, making the restraint unnecessary. This format was chosen to allow facilitators to introduce their institutions' methods, procedures, and policies.

Each scenario has a series of questions that follow to initiate discussion, and the scenarios and questions can be used independent of the DVD and are accompanied by an analysis that may help to frame the discussion. The written materials for each scenario come in two parts: 1) the scenario and questions to distribute prior to the discussion, and 2) the questions with analysis to distribute after the discussion.

The video clips of each scenario summarize the written scenarios included in this manual. The written scenes provide additional facts that are not included in the video. The additional information was included to illustrate how situations leading to restraint often contain missed opportunities to handle the situation differently, avoiding seclusion or restraint. In the same spirit, possible additional fact variations are included at the end of each section of analysis in order to provide facilitators with a springboard for further discussion.

The individuals in all of the scenes are student actors and have no affiliation to any particular training system or facility. The scenarios were developed from real situations that have occurred in facilities across Texas, as described by Texas service providers.

Though the Hogg Foundation is aware of the multiple training curricula that are available and used in various settings, the Foundation does not endorse or support any particular training or restraint technique.

We hope that this publication will be helpful for mental health practitioners and providers in creating a culture of care that minimizes the use of seclusion and restraint.

Scenarios

Juvenile Facility Classroom

James, a 16-year-old boy, was placed in a juvenile facility after having been adjudicated for Terroristic Threat. Since his arrival, James has displayed some aggression toward staff, which staff have ignored in an attempt to extinguish the behavior.

James was in class with other residents, a teacher, and a juvenile detention officer. James became frustrated when he did not understand the assignment. Though the teacher was a special education teacher with considerable experience teaching juveniles in a secure setting, she failed to sense James' frustration until it boiled over. Without warning, James threw his assignment on the floor and exclaimed, "I'm not going to do this crap!" The juvenile detention officer assigned to the classroom reacted according to facility policy and administered a "Behavioral Time Out," restricting James to a seat away from the rest of the class. James responded to the Behavioral Time Out directive with a torrent of profanity, and he refused to cooperate with the juvenile detention officer.

The juvenile detention officer attempted to verbally de-escalate the situation by engaging James in a dialogue, but James' anger continued to increase and he still refused to comply. The officer then attempted to escort James out of the classroom, but James flailed his arms in an attempt to strike the officer. Other residents in the class began yelling and encouraging James to hit the officer. The juvenile detention officer called for assistance on the radio. Two other officers responded immediately and began to restrain James physically. However, James continued to be angry and aggressive after being physically restrained, so the officers placed him in a mechanical restraint with shackles, handcuffs, and a waist belt. They transferred him to his room until he was calm. A physician arrived and medically assessed James to verify that he was not injured. James rejoined his class that afternoon. Both officers completed an incident report that was ultimately forwarded to the counselor responsible for James' treatment program.

Teaching Questions

Prevention

1. What information should staff have gathered at the time of his intake that would have enabled James' teacher to more effectively tailor assignments for James or communicate the guidelines for assignments?

2. In what ways could the facility respond to James' early aggression to prevent his behavior in class that day?

3. How could James' teacher have made James more comfortable with asking questions and communicating with her about his difficulties with learning?

Intervention

1. How could James' teacher and the detention officer have responded more effectively when James threw his assignment on the floor?

Follow-Up

1. What follow-up should occur?

Additional Discussion Topics:

Would these additional facts change your analysis? What if:

1. James' IQ is 64 and he reads at a second grade level.
2. James was sexually abused by his step-father beginning at the age of 5 until his mother divorced his step-father when James was 9.
3. James attacked the juvenile detention officer with a pencil.
4. James attacked another resident.
5. The incident took place in a public setting while on a community field trip.

Juvenile Facility Classroom

Teaching Questions and Analysis

Prevention

1. What information should staff have gathered at the time of his intake that would have enabled James' teacher to more effectively tailor assignments for James or communicate the guidelines for assignments?

   Like many students, James seems to have some special needs in the classroom and is probably sensitive about his abilities. Facilities could take steps to get as much early insight about clients as possible. When James first arrived, the facility could have arranged for James to communicate with staff (including his teacher) about his strengths, weaknesses, and preferences, and for him to be involved in planning his curriculum and overall treatment process. This would give James an opportunity to provide input and to exercise some control over his treatment, which could lead to a greater investment in the treatment process. The meeting could also help James gain insight into the ways he can strategize to overcome limitations. The meeting also could give his teacher valuable information that she can use to design curriculum to reach James in the most meaningful and effective way. Further, it could be a first step in teaching James how to communicate with authority figures before he starts to escalate, and it would set the tone for James' entire experience in the facility as a process truly focused on him as a person rather than focused on the ritual of treatment or the appearance of progress without genuine advancement.

   This intake discussion could also be used to communicate clearly the rules and expectations of the facility. This can be done in conjunction with an effort to empower James, so as not to appear too onerous. A firm array of consequences for behavioral problems, for example, could be given to James in writing, so he is certain about what to expect. While sixteen-year-olds will verbally resist structure, in reality it gives them a sense of security and safety.

2. In what ways could the facility respond to James' early aggression to prevent his behavior in class that day?

   A number of issues may have been contributing to James' aggression. In his earlier aggression toward staff, James may have been trying to find the boundaries of conduct that would be tolerated at the facility, and gauging whether he can manipulate staff or he could have been communicating distress. Rather than ignoring the behavior, staff could have sent a clear signal such as a polite verbal warning to let James know that his behavior would not be tolerated in the facility. The simple verbal warning might have avoided the subsequent escalation. It would be important to adhere firmly to the list of graduated consequences described to James at intake.

   When children are truly distressed, if they receive no response or a scolding response, they may feel alone and abandoned. They may escalate inappropriate behaviors to get attention. When staff ignored James instead of exploring his feelings, they risk continued negative behaviors. Ignoring him places James at additional risk along with other children and staff in the area. By responding to James' misbehavior at an earlier stage, staff could take advantage of an opportunity to address his distress and, if possible, do something about it before it escalates. Additionally, a mental health professional should assess whether the facility can meet James'

needs. Clients often use misbehavior to communicate and staff should respond to the misbehavior, never ignoring the child unless a mental health professional has suggested that they do so.

It is also important to evaluate the emotional sources of the behavior. Children often do not know how to, or want to, communicate their levels of anxiety or the source of that anxiety. In James' case, it appears that his anxiety may be academic (i.e., not wanting to appear "stupid"), but it also might be situational (e.g., family problems at home, fear of the consequences of his detention). In other cases, these types of behaviors might reflect boredom, in which case the teacher could provide additional intellectual stimulation. If it appears that loss of control is a primary problem, James could be given an important task in the classroom.

3. How could James' teacher have made James more comfortable with asking questions and communicating with her about his difficulties with learning?

   Even while studying other material, children in a classroom are learning to interact appropriately with authority figures. A teacher can set the tone in a classroom by signaling that students' questions are welcome. She could explain that everyone gets confused sometimes when the directions are not clear, and if they don't understand something, please let her know, either in class or privately. In a treatment setting, she should help them understand the process and manage their environment, encouraging them to communicate with her by asking for alone time when it is needed. Also, by carefully examining each child's behavior at the start of the day's class, she might identify a child's distress early and use more care or ask if he or she needs extra space or attention. The fact that James' teacher failed to respond to his outburst and opted to let the detention officer respond may have further confused James. The classroom environment, where one expects to be able to ask questions and dialogue about viewpoints, all too quickly reverted to a "detention" environment, which may have further alienated James.

<u>Intervention</u>

1. How could James' teacher and the detention officer have responded more effectively when James threw his assignment on the floor?

   Similar to his earlier aggressive behavior toward staff, James' inappropriate conduct was an attempt to communicate. Both the teacher and the detention officer needed to assess whether James was trying to manipulate them, trying to establish the boundaries of tolerated conduct, or trying to communicate true emotional distress. The most effective response depends on the child's motives. Engaging the child in a discussion about their behavior can usually provide a better sense of the child's perspective. This preferably should be done away from the rest of the class, so that the child does not "lose face" among his or her peers. The detention officer acted appropriately in trying to talk to James, although the teacher should have intervened initially. Once a detention officer gets involved, the child may feel more pressure and may respond by escalating rather than cooperating.

Follow-Up

1. What follow-up should occur?

   Medical and mental health follow-up with James is appropriate to treat any physical injuries due to the restraint and to review whether James is appropriate for this particular treatment program. His reading and academic skills should be reassessed to ensure that the classroom activities are at the appropriate level. A debriefing should take place with James, once calm, to assess his impressions about how things might have been handled differently, both by himself and by staff. Additionally, follow-up with the other students who encouraged James' behavior should occur to acknowledge their role in the incident. Finally, a debriefing should be held that includes the teacher and the detention officers involved. Current procedures should be re-evaluated and each person's involvement should be discussed to ensure that staff are doing everything possible to prevent restraint before it occurs.

Additional Discussion Topics:

Would these additional facts change your analysis? What if:

1. James' IQ is 64 and he reads at a second grade level.
2. James was sexually abused by his stepfather beginning at the age of 5 until his mother divorced his stepfather when James was 9.
3. James attacked the juvenile detention officer with a pencil.
4. James attacked another resident.
5. The incident took place in a public setting while on a community field trip.

Foster Home

Sally is a quiet, 8-year-old child with a history of banging her head when she becomes upset. Sally has been in her most recent foster home for approximately one week. She was moved from a shelter and there was minimal information known about her. The worker placing the child with the foster parents stated that she had been removed from her home due to neglect, that there had been unconfirmed allegations of abuse by her biological parents, and that Sally might be autistic, but the worker failed to provide the foster parents with full details of Sally's history.

Sally lives with two biological children of the foster parents. One day Sally was watching them play a computer game and they asked her to play. She looked away, but moved a bit closer. They invited her again and she took the controls, but immediately messed up. She tried again, with no success. Sally started crying uncontrollably and began hitting the back of her head against the couch with increasing severity. The foster parent ran into the room and tried to pull her away from the couch. She continued trying to bang her head and was still crying and emotional. The foster parent restrained her until she calmed down.

Teaching Questions

Prevention

1. What type of information should have been made available to the foster parents when Sally first came to their home?

2. What type of training could the foster parents have received that would have helped them integrate Sally into their family?

3. How might the foster parents have been better prepared for parenting this child?

Intervention

1. How might the foster parent have intervened differently?

2. How might training have helped to prepare the foster parents for this situation?

Follow-Up

1. What kinds of follow-up with the foster parents should occur?

2. What kinds of follow-up with Sally should occur?

Additional Discussion Topics:

Would these additional facts change your analysis? What if:

1. Sally's father severely berated her if she could not master a new skill quickly.
2. Sally's mother would only console her once she escalated to the level of banging her head.
3. Sally's mother spoke only Vietnamese and his father's English was limited.
4. Sally has always been prematurely removed from foster homes in which biological children were present.

Foster Home

Teaching Questions and Analysis

Prevention

1. What type of information should have been made available to the foster parents when Sally first came to their home?

   Records including the court affidavit leading to her removal and those containing special education, medical, and health information should have been available and shared with the foster parents. In fact, it may have been prudent for the parents to refuse to take the child until they received the necessary information. Additionally, Sally should have been evaluated for mental health problems, including trauma-related disorders, and this information should have been shared with the foster parents as well. Sally should have had a better assessment to rule out autism as well as to evaluate her language skills.

2. What type of training could the foster parents have received that would have helped them integrate Sally into their family?

   The foster parents should have received instruction on caring for foster children generally, such as instruction on welcoming a new child into the home, as well as more specific training on the needs of this particular child. Any lack of preparedness on the part of the foster parents could endanger Sally as well as the biological children living in the home. At a minimum, the case manager should have arranged for the foster parents to receive training in positive behavioral support, de-escalation skills, and other alternatives to restraints. In addition, the biological children should have been prepared for living with a child with special needs. A debriefing after the incident could have benefited the biological children also.

   The events that precipitated this incident might have been avoided if the parents had taken steps to better integrate Sally into the family. In fact, case managers and foster parents should consider carefully the likely dynamics between a foster child with special needs and other children in the home. Depending on the child, it may make more sense to place a child with Sally's characteristics in a home that did not include other children

   The scenario does not mention a treatment plan for Sally. A treatment plan should be developed, and then training for the foster parents should be made available that fits with the plan. Foster parents should also have exposure to cultural sensitivity training including cultural and language topics. In this particular case, the foster parents also needed information related to caring for a child who may have autism. Placing a child with special needs into a home where individuals are unaware and unprepared to address those needs unnecessarily increases the risk of harm to the child, the foster parents, and any other children.

3. How might the foster parents have been better prepared for parenting this child?

   Though time-consuming, pre-placement visits are indispensable opportunities to prepare children and parents for placement. Several formal pre-placement visits could have better prepared both Sally and the family.

Additionally, communication with the parents about the child's background is vital in these placements and can help prevent placement disruption.

The events that precipitated this incident might have been avoided if the parents had taken steps to better integrate Sally into the family. In fact, case managers and foster parents should carefully consider the likely dynamics between a foster child with special needs and other children in the home. Depending on the child, it may make more sense to place an autistic child in a home that did not include other children.

Intervention

1. How might the foster parent have intervened differently?

   Depending on the type of couch, the foster parent could have simply placed a pillow or other soft object between the couch and Sally. The parent could have told Sally that she might hurt herself if she continued and could have asked her why she was upset in order to determine possible ways to help. Sally should have been restrained only if she presented a danger to herself and there was no better alternative. If a restraint was necessary, the foster parent could have more effectively communicated with Sally during the incident by explaining that she was being restrained for her own safety. The foster parent might have asked her biological children to leave the room for a brief period while Sally was so upset. This might have indicated to Sally the parent's concern for her while also preventing further embarrassment on Sally's part. It would also be wise for the foster parent to discuss the incident with the biological children later in order to assess their reaction to the emotional display.

2. How might training have helped to prepare the foster parents for this situation?

   Foster parent training should include appropriate responses to a child who is beating her head against a couch. Alternative intervention methods should be discussed. Using any form of physical restraint may have been unnecessary. Clearly, in this scenario Sally is reacting to her inability to play the game well. Teaching the parents to identify and address the source of her frustration and anxiety is essential. Sally has numerous reasons to have such anxiety – recent change in placement, feelings of inadequacy and insecurity, total lack of control over her circumstances, and perhaps grief over the loss of her relationship with her biological parents, even if the situation was abusive. These issues need to be addressed directly and understood by the foster parents when they design their interventions.

Follow-Up

1. What kinds of follow-up with the foster parents should occur?

   It is important for agencies to train foster parents to immediately report occurrences of restraint. Upon learning that a restraint occurred, the foster care agency should follow-up with the foster parent to arrange for medical assessment of the child's current physical and mental condition. The agency should also revisit the appropriateness of the child's placement in that particular home and explore ways to further integrate the child into the family unit. The foster parents should be made aware that restraint is a response of last resort, and that there are better approaches to resolving these situations when they arise. That being said, the agency must be care-

ful to be constructive in this follow-up process. If foster parents have the impression that a report will be responded to with punitive or critical reactions, they will be unlikely to make it.

Better efforts should be made to provide the foster parents with a complete history of the child.

2. What kinds of follow-up with Sally should occur?

   Sally should be made aware that she is a welcomed member of the family. The foster parent should explain to Sally that she was restrained in order to protect her from hurting herself. Attempts should be made to assist Sally in describing her feelings about what led up to the restraint and the restraint itself. To the extent that Sally is able, she should be encouraged to share her thoughts and feelings verbally, and specific activities and times should be set aside to encourage Sally's ability to communicate in other, more appropriate ways. If the computer game is appropriate to her skill level, the foster parent could teach Sally how to play it.

Additional Discussion Topics:

Would these additional facts change your analysis? What if:

1. Sally's father severely berated her if she could not master a new skill quickly.
2. Sally's mother would only console her once she escalated to the level of banging her head.
3. Sally's mother spoke only Vietnamese and her father's English was limited.
4. Sally has always been prematurely removed from foster homes in which biological children were present.

Psychiatric Hospital Recreation Room

Margaret is a 27-year-old female diagnosed with schizoaffective disorder. She has been hospitalized ten times, including two six-week residential treatments, and has a history of visual and auditory hallucinations.

Staff noted in Margaret's record that she had recently been attending activities with only minimal involvement, which is unusual for her. Margaret also reported to staff that she frequently found the activities offered to be frustrating and boring.

A week after making these statements, she became agitated. Despite staff efforts to calm her down, Margaret escalated to threatening to kill herself and grabbed a pencil. Two staff restrained Margaret and placed her in seclusion once she had calmed down.

Teaching Questions

Prevention

1. What actions could the staff have taken when it first became clear that there was a noticeable change in Margaret's behavior, that her involvement in program activities was only minimal, and that she was frustrated and bored with the activities?

2. How could staff have better communicated in order to avoid this situation?

Intervention

1. How could staff have diffused the situation before Margaret became agitated?

2. How could staff have diffused the situation once Margaret became agitated?

Follow-Up

1. Was Margaret's seclusion necessary once she had calmed down?

2. How can staff reflect on this situation in order to prevent situations like this in the future?

3. What kind of intervention should be conducted with Margaret following the incident?

Additional Discussion Topics:

Would these additional facts change your analysis? What if:

1. She has a history of assault on her family.
2. She is 5'5", 140 pounds. OR, she is 6', 180 pounds.
3. She has a history of assaulting staff at this facility.
4. One of the staff who restrained her is her primary therapist.

Psychiatric Hospital Recreation Room

Teaching Questions and Analysis

Prevention

1. What actions could the staff have taken when it first became clear that there was a noticeable change in Margaret's behavior, that her involvement in program activities was only minimal, and that she was frustrated and bored with the activities?

   Prior communication with Margaret about her comments about the activities would have been crucial in avoiding this situation. The staff should have been alerted to the recent changes in Margaret's behavior and could have solicited more information from her to explore the issue in a productive way. For example, perhaps the activities were inappropriate for Margaret or perhaps her medications had recently been adjusted. A staff member could have spoken with Margaret about her level of interest in the program activities. Her reaction may have been a direct result of the fact that she got no response though she reported her boredom and frustration to the staff.

2. How could staff have better communicated in order to avoid this situation?

   Staff could have monitored the situation more closely and shared information with each other. Margaret's case should have been thoroughly discussed at a staffing meeting so that all the staff would have known that Margaret was not participating in activities and that she was getting very frustrated. In this case, a lack of response to Margaret's initial statements led to an escalated level of frustration.

Intervention

1. How could staff have diffused the situation before Margaret became agitated?

   Given Margaret's reported frustration and boredom, a tentative plan of action should have been discussed by staff and put into action to guide the staff's response when they first noted that the situation was escalating. The staff could have diffused the situation by guiding or directing (or re-directing) her toward a less frustrating situation. Furthermore, because Margaret was reflecting boredom, activities that require intellectual stimulation or responsibilities could have provided the missing motivation. Some individuals do better than others with the scheduled activities in psychiatric hospitals, and it is important for facility staff to tailor the individual interventions to individual needs and suitability for the planned programming.

2. How could staff have diffused the situation once Margaret became agitated?

   Staff should have a clear system of communication with each other about patient conduct so that each knew of Margaret's reported frustration and boredom. Had the staff communicated more effectively, they would have been alert to her potential for agitation and could have monitored her more carefully. Staff could have taken the opportunity to discuss the activities with Margaret and explore her frustration. Additionally, in light of her state of mind, staff should have removed sharp objects from Margaret's reach.

There are a number of well-documented de-escalation strategies that are effective in situations like this one. Speaking quietly, using Margaret's name, positioning yourself below her eye level, and indicating your own emotional reaction to her agitation (e.g., "Margaret, you're making me nervous with all of this yelling") have been shown to assist greatly in calming individuals who are in some sort of emotional crisis. Staff should be trained in these de-escalation strategies.

Follow-Up

1. Was Margaret's seclusion necessary once she had calmed down?

   Once Margaret had calmed down, there is no apparent need for seclusion. The staff could have asked Margaret if she would like some time to herself before rejoining the group. Some quiet time might be helpful for a client who is stable enough to be left alone, but not calm enough to return to normal activities.

   Margaret is an adult, but agencies should be particularly reluctant to place a child in seclusion. Children who have recently been restrained should be evaluated carefully before determining that seclusion is necessary. Seclusion is particularly painful for children, as they often exhibit problematic behaviors based on a sense of abandonment, which is amplified when they are placed in a secluded setting. When seclusion is necessary, staff should closely monitor individuals and return them to their regular activities as soon as possible.

2. How can staff reflect on this situation in order to prevent situations like this in the future?

   A debriefing should be held following this incident to discuss preventative measures that could have been undertaken as well as follow-up. Depending on her psychiatric stability, Margaret could be present for at least part of this debriefing. A plan should be developed to re-integrate Margaret into the facility as soon as possible, carefully monitoring her level of agitation. Staff should oversee the activities in which Margaret participates based on this plan in order to determine whether those activities are appropriate for her. Further, all staff involved with Margaret should be notified of the situation and the plan so that they can react accordingly.

3. What kind of intervention should be conducted with Margaret following the incident?

   Plans developed during the debriefing should be discussed with Margaret, soliciting her feedback and input. Staff should also ask her to elaborate on her original complaint related to being frustrated and bored with activities. Margaret should be more involved in the development of programs and activities that are of interest to her.

Additional Discussion Topics:

Would these additional facts change your analysis? What if:

1. She has a history of assault on her family.
2. She is 5'5", 140 pounds. OR, she is 6', 180 pounds.
3. She has a history of assaulting staff at this facility.
4. One of the staff who restrained her is her primary therapist.

Residential Treatment Center Recreation Room

Johnny is a 9-year-old boy diagnosed with bipolar disorder who recently attempted suicide while in his fifth foster home placement. When admitted to the children's residential treatment center, he was scared and untrusting. The first evening, though, he found a personal welcome bag on his bed in his cottage. The next morning, he was asked about his interests as his treatment plan was being developed.

Several weeks into his treatment, Johnny had a very difficult day. His estranged mother had promised to visit him. She failed to appear at the scheduled time, and when Johnny realized that his mother would not be visiting, he began to punch the couch and tear apart the couch cushions. In response to questions about what was wrong, he said he wanted to die. He tried to eat the cushion stuffing and threatened anyone who approached him. Sara, a front-line staff person who had befriended Johnny, gave him three prompts to redirect his behavior and gave him the option of a time-out. When he agreed, she took his arm to guide him to a quiet end of the room. Johnny jerked his arm back and turned away. Sara firmly guided him by the shoulders to a chair across the room. Johnny sat quietly for around a minute, but then he began banging his forehead hard against the back of the chair. Sara called for another staff person.

Teaching Questions

Prevention

1. What steps could staff have taken to prevent this situation?

2. What could the facility have done from the time that Johnny was admitted to help prevent Johnny's outburst and reaction to his mother's "no-show?"

3. What could staff have done to attend to Johnny's situation and to prevent this scenario when he was having such a traumatic day?

Intervention

1. How should staff have responded differently to Johnny's violent outburst?

2. Should staff have used an alternative to the restraint used in this scenario?

Follow Up

1. How soon should a mental health professional been requested after Sara gave Johnny three prompts in an attempt to redirect his behavior?

2. How should other staff be made aware of this incident?

3. What kind of follow-up should occur with staff?

Additional Discussion Topics:

Would these additional facts change your analysis? What if:

1. There was a vacant "safe" room available with no moveable objects or other means for Johnny to injure himself.
2. Several times earlier in the week, Johnny had tried banging his forehead against furniture in order to get attention.
3. Johnny hated to be touched.

Residential Treatment Center Recreation Room

Teaching Questions and Analysis

Prevention

1. What steps could staff have taken to prevent this situation?

   Facility staff could inquire about and anticipate events of particular emotional import to children. Once staff is aware of an upcoming event, they should take reasonable steps to prepare the child for the event. This situation was exacerbated by issues of previous neglect and abandonment. When the staff found out that Johnny's mother was scheduled to visit, they could have communicated with the mother prior to the visit to make sure that she kept her appointment and to facilitate the visit. They could have made efforts to prepare Johnny for the possibility that his mother would not actually come for the visit and could have talked about possible ways to handle the disappointment prior to the visit. There is some question whether they should have allowed such a visit at all, in light of his recent suicide attempt and transition into the facility. Also, upon hearing that Johnny's mother did not appear for the visit, the staff could have discussed the situation with Johnny and provided support. Helping him to deal with such emotionally-charged situations would have helped to minimize the impact of this disappointment.

2. What could the facility have done from the time that Johnny was admitted to help prevent Johnny's outburst and reaction to his mother's "no-show"?

   An intake should always gather information concerning the child's circumstances, number of placements, negative and positive experiences at prior placements, and other important events or circumstances, because these experiences factor into a child's likely cooperation with different approaches to guidance and treatment. Additionally, during the intake, or soon afterward, information should be solicited about the child's interests and the things that inspire and motivate him or her.

   Johnny should be involved in the development of his individualized treatment plan. Being open and honest with the child is proven to yield positive results, because this involvement will create a more trusting relationship and allow the child to feel he shares in the control of his life. This will also foster a child's communication with treatment providers. Building on his areas of interest as part of his treatment plan would have given him the opportunity to realize some progress and to enhance his self-esteem. Preventing a child's exposure to unpleasant and unsafe stimuli is a basic necessity for a child's treatment. Beyond that, reasonable efforts to tailor a child's interactions with staff and the facilities around those things that are particularly meaningful to that child can support the child's therapy and minimize violent outbursts by keeping a child happy and stimulated.

   Additionally, a welcome bag was left on Johnny's bed, but additional and face-to-face steps could have been taken to introduce him to the facility and the staff. Every child should be given a warm orientation to a new facility delineating the rules, privileges, and procedures, and new children should be introduced to as many staff members as possible.

3. What could staff have done to attend to Johnny's situation and to prevent this scenario when he was having such a traumatic day?

   When they learned that Johnny was having a particularly difficult day, staff should be armed with relevant information about his history. This information would assist the staff in guiding and responding to his emotions and his conduct, which may have been provoked by this very disappointing event. Children, particularly those in foster care and treatment, often lack the defenses and impulse control to respond appropriately to overwhelming internal and external events. Communication and coordination between professionals and staff can provide each with the information they need to predict a likely problem and act to prevent it. The staff should have apprised the mental health professional of all significant events which impacted this young man, and likewise the mental health professional should have apprised the staff of how some of these events could impact Johnny. Having a very bad day, coupled with the impending visit with his biological mother, are ingredients for a negative outcome. Similarly, the staff should have been cognizant of his numerous foster home placements and his unsuccessful suicide attempt. These events combined may have precipitated an overwhelming over-reaction on Johnny's part and may have reopened some serious psychological wounds about neglect and abandonment. Having a plan to identify and respond to the confluence of these emotionally-charged issues would have benefited all of the parties involved.

<u>Intervention</u>

1. How should staff have responded differently to Johnny's violent outburst?

   When a violent outburst occurs, staffers should assess the threat Johnny poses to other children, to himself, and to the staff, as well as the likely impact of the event and the intervention on his treatment. The response should be calculated to diffuse the threats while causing the child the least amount of fear, pain, and embarrassment possible. When Johnny became enraged by the mother's "no-show", and he stated that he wanted to die while tearing the stuffing out of the furniture, the staff could have recognized that while Johnny’s conduct posed a threat to equipment, he had not yet directed aggression at a person. They also could have acknowledged that he had very legitimate reasons for being very angry. While accounting for the risk that even a small escalation would have greatly increased the danger, staff had an opportunity to address his emotional needs with a therapeutic plan to deal with his issues of neglect, abandonment, and grieving, not to mention his having a bad day at the residential center before any further escalation occurred. Using well-documented de-escalation techniques, such as sitting on the floor near Johnny (but not so close as to be physically threatening) and talking to him in low, calm tones while making sure that the other children are not watching, can be very effective in defusing such a situation. Sara, the front-line staff person who had befriended Johnny, should have called in the clinician or mental health professional to intervene with Johnny and his extreme anger and disappointment. There is no mention that the staffers called a mental health professional to consult on this case. This missed opportunity paved the way for a dangerous and traumatic but avoidable situation.

2. Should staff have used an alternative to the restraint used in this scenario?

   A staffer’s response to violence should be examined in order to diffuse the threats while causing the child the least amount of fear, pain, and embarrassment possible. An important concern when confronting an uncooperative child is that child’s response to touch. When staff choose to escalate their response to a situation from

verbal interaction to a physical restraint, which involves touch, they cross a very significant divide. Touch is a relationship-based and situation-based issue, and because the outcomes vary widely depending on the situation, it must be used with care, particularly when a staffer might be harboring anger towards the child or the child may perceive anger on the part of the staffer. According to experts, touch almost always has a bad (or worse) result when it is done at the wrong time.

A tight grip in combination with anger can have devastating results, as demonstrated in this scenario because there was a situational "melt down." When opting to use any restraint, even a low-level restraint such as a firm grip, staff needs to consider the relationship they have with a child and to know and calculate for each individual child's response to touch in emotional situations.

Follow-Up

1. How soon should a mental health professional been requested after Sara gave Johnny three prompts in an attempt to redirect his behavior?

   It was apparent that Johnny was extremely disappointed and angry that his mother had abandoned him once again. Having had a bad day overall only confounded the situation. Johnny's aversion to touch made her choice to use a restraint extremely significant for his treatment. A mental health professional should have been contacted immediately in order to address Johnny's conduct.

2. How should other staff be made aware of this incident?

   The fact that Johnny had tried banging his head against the furniture at that time in order to gain the attention of staff was a clear indication that he was experiencing some distress and that his reaction to distress posed a threat to himself and possibly others as well. This is also evident because of his previous suicide attempt. When any staffer omits to note this significant conduct and apprise the staff at large about it, the staff misses an opportunity to anticipate problems and resolve them at the very first indication that a child is distressed.

3. What kind of follow-up should occur with staff?

   A debriefing should occur to discuss the necessity of the restraint in this situation and the use of alternative de-escalation techniques. Additional staff training may be necessary in terms of alternatives to restraints to ensure that they can handle a child's outburst safely with the least possible negative impact on the child's treatment. Issues related to touch and "guiding" or "redirecting" someone in a residential setting should be an integral part of the training. Serious reconsideration should be given as to the wisdom of allowing any further scheduled visits with the mother in the near future.

Additional Discussion Topics:

Would these additional facts change your analysis? What if:

1. There was a vacant "safe" room available with no moveable objects or other means for Johnny to injure himself.
2. Several times earlier in the week, Johnny had tried banging his forehead against furniture in order to get attention.
3. Johnny hated to be touched.

Therapeutic Camp Dining Hall

Jessie is a 15-year-old who has resided at Sunshine Therapeutic Camp for the past three months. The camp has three camp sites, and 12 children reside at each site. There are 2 staff assigned to each site, with a floating staff person and a floating supervisor. Jessie is typically quiet, brooding, and often passively oppositional. She refuses to actively participate in most therapeutic activities, instead sitting on the margins watching others participate.

It is a Saturday afternoon and the children have just finished lunch. Staff are standing several feet away from most of the children, but each can observe a portion of the group from their current locations. Jessie and another child, 12-year-old Julie, are both sitting at the lunch table. A staff member can see Jessie talking to Julie, but he is not close enough to hear the conversation clearly.

The staff member steps away for a couple of minutes. When he returns, he sees Jessie punching and kicking Julie repeatedly. Julie is attempting to block the punches, but is obviously getting injured. The staff member tells Jessie to stop immediately, but she continues so he quickly yells for assistance. When another staff member arrives on the scene, both staff get behind Jessie in order to physically restrain her. The first staff member gets control of Jessie's upper body and puts her on the ground for a face-down restraint. The other staff member assists by controlling Jessie's lower half. The other two staff arrive within a few minutes and supervise the other children. After 15 minutes have passed, Jessie is still extremely combative and unresponsive to verbal redirection. The decision is made to call law enforcement, as staff are concerned that they will not be able to continue to contain Jessie.

By the time the sheriff arrives, Jessie is calmer but still very angry and oppositional. Jessie is arrested for assaulting Julie, and the sheriff takes Jessie to juvenile detention. Jessie is not allowed to return to the camp. Julie is taken to the hospital and treated for a broken nose, four cracked ribs, and a fractured arm. Julie tells staff later that Jessie was trying to bully Julie into giving her cookies to her, and Julie had refused.

Teaching Questions

Prevention

1. What kind of preventive measures could have been taken *before* Jessie acted out with aggression?
2. How could staff have better prepared for this situation in order to avoid it?
3. How did the staff to child ratio affect this situation?

Intervention

1. How could staff have responded differently in this situation?
2. How could back-up staff have responded differently?

Follow-Up

1. What type of follow-up should occur with Julie and Jessie?
2. What type of follow-up should occur with staff?

Additional Discussion Topics:

Would these additional facts change your analysis? What if:

1. Jessie was placed at the camp by Juvenile Probation for gang activity, including several incidents of assault.
2. Jessie belonged to a gang of girls who were all Caucasian, and their rival gang in the neighborhood was all Hispanic. Julie was the first Hispanic to reside in Jessie's camp site since Jessie's admission. The date of the incident was Julie's second day at the camp.
3. Jessie spoke to her probation officer the day before the incident. The probation officer told Jessie that although she was originally supposed to spend only six months at the camp, her stay would probably be extended because she was not participating or demonstrating any progress.
4. Jessie has a strong family history of bipolar disorder.

Therapeutic Camp Dining Hall

Teaching Questions and Analysis

Prevention

1. What kind of preventive measures could have been taken *before* Jessie acted out with aggression?

   The staff could have tried more diligently to involve Jessie in camp activities, instead of suggesting activities and excluding children who chose not to participate. Perhaps they could have asked Jessie to provide a list of her favorite activities and then included those at the camp. This involvement could have encouraged Jessie to create relationships with other children at the camp. This increased participation could help to prevent the future violent acts.

2. How could staff have better prepared for this situation in order to avoid it?

   The first staff member could have notified another staff member before stepping away, even for a few minutes. Because Jessie is normally non-participatory and quiet, at any indication that Jessie was exhibiting uncharacteristic behavior such as interacting with other children, staff could have attempted to move closer and observe the conversation to determine whether Jessie was being hostile or friendly. With closer observation, staff might have discovered that Jessie was attempting to bully Julie and prevented the altercation.

3. How did the staff to child ratio affect this situation?

   The issue of staff to child ratio has a direct and important effect on the relative safety of children, staff, and third parties. More on-site trained staff result in increased oversight of child behavior, increasing the chances that staff will see early signs of inappropriate conduct in time to prevent a dangerous crisis. While it is not always practical or economical to improve ratios, administrators can train staff to be sensitive to the relative strength or weakness of staff ratios and to be aware of gaps that are likely to leave portions of the camp unattended and plan their division of responsibilities in the most effective way.

   Even if for practical reasons staff ratios could not have been improved, staff meetings should highlight residents like Jessie who are the highest risk. Her non-participation and inability (or unwillingness) to communicate clearly indicate that her behavior has the potential to escalate. Staff member who are available could then pay particular attention to any changes in behavior for this high-risk group.

Intervention

1. How could staff have responded differently in this situation?

   At first, the first staff member responded correctly by attempting to engage Jessie verbally and insisting that Jessie stop hitting Julie. However, his subsequent actions unnecessarily escalated the situation. A face-down restraint can lead to physical injury or death. New legislation in Texas permits a face-down (or face-up) restraint only as a last resort and with specified protections. If verbal engagement was ineffective, one of the staff members

could have removed Julie while the other restrained Jessie from behind in a standing position. This would have ensured Julie's safety while at the same time avoiding the dangerous and potentially fatal face-down restraint.

2. How could back-up staff have responded differently?

   The back-up staff that arrived on the scene should have removed the other kids from the dining hall. This shields the other campers from witnessing any more of the ensuing events than absolutely necessary. Furthermore, it avoids stigmatizing Jessie as uncontrollable or dangerous by giving her some level of privacy during her pending arrest, if arrest is ultimately necessary. Additionally, with the other children removed, staff would likely have been able to release Jessie from the hold.

   Finally, more time should have been allowed for Jessie to calm down before the police were called. Jessie is at the camp for treatment, and immediately calling law enforcement and having her removed from the camp seems not only unnecessary, but probably harmful to her treatment and relationships within the camp. Professional counselors should have reviewed Jessie's actions and assessed her potential for future violence before changing her placement.

Follow-Up

1. What type of follow-up should occur with Julie and Jessie?

   Medical attention should be provided for Julie and Jessie to ensure that neither child sustained injuries during the altercation or the restraint. Furthermore, a mental health professional should evaluate each child's mental condition. Ideally, Jessie's evaluation should occur before the police are called to assess whether her treatment program can be salvaged and if she should remain at the camp. The decision to remove Jessie from the camp ultimately depends on how successful the staff was in preventing the attack or at least in preventing its escalation.

   Further, staff could assure Julie that she is safe in her environment and that the altercation is an anomaly rather than a normal occurrence in the camp. Staff could also remind Jessie of camp rules related to behavior and physical aggression. Staff could work with both children on developing more pro-social problem-solving strategies.

2. What type of follow-up should occur with staff?

   A debriefing should be held with staff to discuss potential changes in the way these situations are handled. Staff should be vigilant about monitoring children because even minor diversions can expose the children to risk of harm. The debriefing should also include a review of security procedures and de-escalation techniques, with particular emphasis on verbal de-escalation, effective tactics to remove bystanders from the area, and identification of the safest and least invasive restraint to use in given situations. Additional training should be added for the entire staff about de-escalation techniques and appropriate restraint procedures. Administration should also review procedures to ensure that the chain of command is clear and the floating supervisor is able to provide assistance and guidance in crisis situations. If administrative staff determine that staff members did not handle the situation appropriately, these staff members should be retrained.

Additional Discussion Topics:

Would these additional facts change your analysis? What if:

1. Jessie was placed at the camp by Juvenile Probation for gang activity, including several incidents of assault.
2. Jessie belonged to a gang of girls who were all Caucasian, and their rival gang in the neighborhood was all Hispanic. Julie was the first Hispanic to reside in Jessie's camp site since Jessie's admission. The date of the incident was Julie's second day at the camp.
3. Jessie spoke to her probation officer the day before the incident. The probation officer told Jessie that although she was originally supposed to spend only six months at the camp, her stay would probably be extended because she was not participating or demonstrating any progress.
4. Jessie has a strong family history of bipolar disorder.

In the Community: At the Mall

Pat is a 25-year-old single Hispanic female who lives with her elderly parents in an apartment complex for older adults. Pat was diagnosed with schizophrenia and mild mental retardation when she was in her teens, sometimes hearing voices that tell her to tear up things or to hit other people. She has been receiving treatment at the community mental health center since she was 17. Her parents had been able to drive Pat to her appointments until their health conditions worsened and they no longer could drive safely. Now Pat must take the bus accompanied by her mother. In recent years, Pat has been experiencing outbursts and has become physically and verbally aggressive with her parents and several of the neighbors in the apartment complex. She has been admitted frequently to the state hospital after refusing to take her medications and becoming aggressive.

On her most recent admission, Pat was very aggressive and admitted to hearing voices telling her to hurt others. She was paranoid about staff members poisoning her food and would frequently lash out at other patients. Her attending physician adjusted her medications and she had fewer episodes of aggression. Because her behavior had improved and as part of planning for her upcoming discharge, Pat was allowed to join five other patients and three staff members on an outing to the mall to see a movie and eat pizza at a local restaurant.

During the movie, staff noticed that Pat was increasingly restless, but she was able to control her behavior. She got up several times to go the bathroom or for a drink. She changed seats several times and once yelled at another patient for "stealing" her seat. During the movie, Pat began to hit one of the other patients for no apparent reason. A staff member took Pat to a different area in the theater and sat with her. The staff member tried to talk with her telling her that she would never get to go on an outing again if she didn't behave and that her parents would never let her come back home if she continued to fight. Pat seemed to become even more agitated. She became aggressive and started striking out at the staff members. Pat was restrained by the staff members to prevent her from injuring herself or others. Pat was restrained only long enough to allow her to calm down. Another staff member called for the van to pick them up, and Pat was returned to the hospital without further incident.

Teaching Questions

Prevention

1. How might additional agency processes and procedures have helped in avoiding this situation?

2. How might staff have been better prepared to monitor Pat during this outing?

3. What could staff have done to better prepare Pat to attending the outing?

Intervention

1. How might staff have reacted differently when Pat first became agitated at the movie?

2. What might have better prepared staff to handle this situation?

Follow-Up

1. What kind of follow-up should occur with staff?

Additional Discussion Topics:

Would these additional facts change your analysis? What if:

1. Pat has severe asthma.
2. Pat has repeatedly expressed an intense desire to return to her parents' home.
3. One of the staff members had taken one of the patients to the restroom before Pat began to hit, leaving two staff members and five patients.

In the Community: At the Mall

Teaching Questions and Analysis

Prevention

1. How might additional agency processes and procedures have helped in avoiding this situation?

   An assessment and treatment plan for Pat could help in avoiding this and future situations. Treatment planning for Pat should clarify whether she has the necessary skills to participate in individual and group outings. Specifically, while her psychiatric status had stabilized significantly in a structured hospital setting, a movie theater incorporates a great deal more stimulation, which may have been too much for her already fragile condition. A treatment plan should also describe the nature, frequency, triggers, and risks posed by her command hallucinations and provide instruction for the most effective measures staff can take to respond to crisis situations.

   A good assessment and plan should also take into account Pat's living situation and its effect on her behavior. Pat may have other alternatives besides living with her elderly parents and staff could discuss these options with her. The situation at her parents' home is deteriorating and her parents are increasingly unable to provide enough support to keep her stabilized in their home. This living arrangement may not be an option for her for much longer. Thus, her assessment should include plans to address her family circumstances, either by providing additional support to Pat's parents or by exploring other living arrangements. To build a solid plan, staff need to have a full assessment of Pat's living skills, because they may find that Pat can continue to live with her parents or live independently if staff arrange for special transportation and other resources for the family.

   Although agencies should attempt to minimize the use of restraint as much as possible, restraint plans may be an acceptable part of transitioning to avoiding restraints altogether. When staff tailor restraint plans to each individual, they can minimize the risk of harm. The staff could begin developing and incorporating these at admission. Note that this may require a culture shift in the agency.

2. How might staff have been better prepared to monitor Pat during this outing?

   Due to the increased risk that patients will behave in uncharacteristic ways when adjusting to different medication regimens, systems could be in place to ensure that direct care staff are alerted to updated patient medication regimens. Any assessment or treatment plan information could be communicated to direct care staff as well. When they have the best information about patient history and are trained on treatment plans, direct care staff are better equipped to interact productively with patients and ensure the safety of all involved. Additionally, staff may use buddy systems involving other patients.

3. What could staff have done to better prepare Pat to attending the outing?

   Based on assessment information, Pat's ability to attend the outing could have been evaluated more thoroughly. Patients may be unprepared to conduct themselves appropriately in an unknown public place, which requires skills that staff should thoroughly assess. Outings pose an increased risk of harm not only to patients

and staff but also to the general public and, while outings can be instrumental in helping a patient make a transition to more independent living, the decision to take a patient on an outing should not be made lightly or with inadequate information. Pat may have been capable of attending an outing with one-on-on attention, but the facts of the scenario suggest that the staff-to-client ratio on this outing was insufficient to provide adequate support.

It is not surprising that Pat would find changes in her environment to be challenging. Perhaps taking her on a shorter and less stressful outing first (e.g., to a park, to buy ice cream) would help her adapt to changes in a constructive manner.

Intervention

1. How might staff have reacted differently when Pat first became agitated at the movie?

   Being proactive in these situations is critical to effectively preventing a crisis situation. If the staff had known Pat's history, they might have been alert and watching for indications that she was not reacting well to the medications or the outing, permitting them to intervene well before she began to escalate and to call for someone to come pick her up at the first sign of distress. Instead, the staff first failed to appreciate the warning signs and then responded with comments that further agitated Pat. The outcome of the situation could have been different had the staff handled Pat's outburst differently. They might have prevented a crisis in which they had to use a restraint on Pat, which placed her at increased risk of injury or death.

2. What might have better prepared staff to handle this situation?

   The staff did not seem adequately prepared to handle the situation. They should know the relevant details of Pat's history and have clear recommendations for effective ways to respond to signs that Pat is in distress. These recommendations should be incorporated into a plan for Pat's care. At a minimum, direct care staff need training in effective tactics for de-escalating patients so that fewer crisis events require the staff to use a restraint. Certainly staff need to understand that Pat's reaction to a stressful situation would not be improved by threats such as never being able to go back home again. In addition, training staff on treatment plans would improve understanding of how to assist a person in crisis.

Follow-Up

1. What kind of follow-up should occur with staff?

   Staff should be debriefed on this situation, with discussion including the need to intervene as soon as a situation begins to arise. This debriefing should include discussion of specific behaviors exhibited by Pat (restlessness, getting up and down) that suggested that she was not handling the stimulation and change in environment. Additionally, the agency should prepare more thorough assessments of client ability to attend outings safely, taking into consideration the timing and circumstances of the outings.

Additional Discussion Topics:

Would these additional facts change your analysis? What if:

1. Pat has severe asthma.
2. Pat has repeatedly expressed an intense desire to return to her parents' home.
3. One of the staff members had taken one of the patients to the restroom before Pat began to hit, leaving two staff members and five patients.

Juvenile Justice Pre-Adjudication Facility

Stephanie is a 15-year-old girl who had been detained in a pre-adjudication facility for three months pending adjudication for aggravated assault. When she is adjudicated, Stephanie faces commitment to the Texas Youth Commission. Stephanie has been depressed because she understands that it is likely that she will be confined to a secure facility for the next few years, and it is unlikely that she will be released to her parents' custody while she awaits adjudication.

Stephanie returned from her most recent detention hearing very upset. She was detained again, precluding her chances of being released from detention prior to her adjudication hearing. Later that night, Stephanie and the rest of the detention residents were placed in their single occupancy rooms for the remainder of evening. Stephanie then tied her bed sheet around her neck and managed to stand on her bunk to reach a vent directly over her bed. Stephanie threaded the sheet through the vent and then she stepped off her bed in an attempt to hang herself. Although Stephanie's feet were not suspended, her circulation and air flow were restricted enough for her to begin to lose consciousness. The juvenile detention officer assigned to the pod was conducting the staggered fifteen minute room checks at that time and happened to look into Stephanie's room before Stephanie lost consciousness. The juvenile detention officer entered the room and attempted to release Stephanie from the ligature. Stephanie's clothing was exchanged for a paper gown and she was placed on constant watch or "suicide watch." In accordance with standards, a mental health professional was notified. However, the on-call mental health professional advised them that she would not be at the facility for another three hours.

Stephanie was still very upset, repeatedly exclaiming that she wanted to die. She began banging her head against the door with great force. The detention officer responded by telling Stephanie that she would "not be able to go to heaven" if she committed suicide and Stephanie became very upset, telling the officer that she didn't know what she was talking about. The detention officer argued with Stephanie that it was true that people do not go to heaven if they commit suicide. Stephanie kept screaming "shut up" at the officer and the officer finally said, "Then I'll just have to tie you down so you won't hurt yourself." As soon as the officer came toward Stephanie, she began hitting and the officer attempted to push her down into a chair. Stephanie fell down into the chair and began crying that her tailbone was hurting.

Teaching Questions

Prevention

1. What kinds of preventative measures could have been taken *before her detention hearing* to minimize the risk of suicide attempt and subsequent agitation?

2. How could staff have better responded *after her detention hearing* to recognize signs of the upcoming attempted suicide and subsequent agitation?

3. How did environmental conditions contribute to this situation?

Intervention

1. How could the staff response following Stephanie's suicide attempt have been more effective?

2. How may the exchange of clothing following the attempted suicide have escalated this problem? If the detention officer had been male, could that have further escalated the situation?

3. How might Stephanie's attempted suicide have influenced staff reactions?

Follow-Up

1. What medical and mental health follow-up should occur after Stephanie stabilizes?

2. What follow-up communication should occur in order to minimize the likelihood that Stephanie's acute emotional state or her urge to harm herself or others will recur?

Additional Discussion Topics:

Would these additional facts change your analysis? What if:

1. Stephanie had a history of self-mutilation and self-destructive behavior prior to being detained.
2. Subsequent to previous detention hearings, Stephanie made threatening statements in reference to harming herself.
3. After she fell into the chair, Stephanie began to gasp and turn blue.

Juvenile Justice Pre-Adjudication Facility

Teaching Questions and Analysis

Prevention

1. What kinds of preventative measures could have been taken *before her detention hearing* to minimize the risk of suicide attempt and subsequent agitation?

   The incident might have been prevented by helping Stephanie anticipate possible outcomes of the hearing and discussing coping strategies. Further, Stephanie could have been accompanied to the hearing and given assistance in preparing to communicate with her lawyer. An advisor or other staff member could have talked to Stephanie about the detention hearing before it occurred to prepare her for the hearing and discuss her worries and how she would feel and react to potential outcomes. The approach should be to validate her concerns and work through positive responses and coping ideas.

   This staff member also could have accompanied her to the hearing. Unfortunately, punitive environments often provide inadequate support for juveniles, placing more emphasis on security than on recruiting and training counselors and psychiatrists. If the facility could not spare a staff member to accompany her, they could have asked Stephanie to make a list of things she is worried about, along with potential positive responses. Staff could validate her concerns by reviewing the list with her and helping her fill in the positive responses and coping ideas. Staff could suggest that she share the list with her attorney or representative in court and so that the advocate can give her the information and emotional support she needs during the hearing. Staff could already have prepared a plan to discuss the list with Stephanie when she returns to the facility so that she knows she will have a safe space to work through her emotions after she knows the outcome of the hearing. This meeting could have allowed Stephanie to work through her emotions before her distress became acute, preventing her suicide attempt. Further, Stephanie might have described her thoughts of killing herself, permitting staff to plan for mental health intervention at that point. Staff would need appropriate training to enable them to assume these varied roles.

   Some jurisdictions incorporate mental health professionals as court resource coordinators who assist in identification and planning for juveniles with mental health issues. These professionals can be invaluable in assisting juveniles in dealing with the stresses attached to court appearances.

2. How could staff have better responded *after her detention hearing* to recognize signs of the upcoming attempted suicide and subsequent agitation?

   Staff should have arranged for Stephanie to meet with a staff member immediately following the hearing. Direct care staff should have been apprised of the outcome of the detention hearing and of Stephanie's state of mind at the earliest possible opportunity. An early assessment would have alerted staff to Stephanie's mental state. A meeting with a staff member might have assisted Stephanie to begin the process of coping with the decision as well as providing valuable insight into Stephanie's mental state. This, along with staff knowledge of any history of self-mutilation and self-destructive behavior, could have prevented the incident that led to the restraint.

Upon returning from the detention hearing, Stephanie was visibly upset, a clear indicator of her need for increased observation. Staff could have communicated with Stephanie about what upset her and what she needed. If she had disclosed that she felt like killing herself in her meeting with the advisor, Stephanie should have been placed on either 5-minute checks or constant watch, rather than 15-minute watch. While 15-minute watches have been the standard in the past, there is increased evidence that more frequent monitoring is needed for individuals at risk of suicide. Furthermore, Stephanie's behavior indicated that she needed human contact and should not have been left alone. Options would have been to open the door to the single occupancy room, or to let Stephanie stay in a group room so that she would not be completely isolated. Someone should have been communicating with Stephanie on an ongoing basis, rather than only interacting with her when she behaved inappropriately.

3. How did environmental conditions contribute to this situation?

   Prevention can be as simple as ensuring that a child's environment is safe for him or her. Stephanie's isolation in a single occupancy room, along with a poorly placed vent, provided an environment that exacerbated Stephanie's problems. Facility planning should account for environmental factors, such as the vent Stephanie used in her attempted suicide. Where administrators are unable to renovate the building to eliminate environmental risks, staff need to be aware of any possible hazards so they permit only patients posing the least risk of harm to encounter those hazards.

   In addition to improving the physical environment, a more supportive emotional environment is essential to keeping Stephanie safe.

Intervention

1. How could the staff response following Stephanie's suicide attempt have been more effective?

   The staff response in this situation was exceptionally non-therapeutic, particularly the argument about Stephanie's poor chances of going to heaven if she commits suicide. Though this staff member's primary responsibility is Stephanie's security rather than her psychiatric treatment, security officers have no less duty to interact appropriately with patients, and this officer should know how to conduct herself appropriately in the interim while waiting for the mental health professional. In fact, the detention officer could have ended the conversation when Stephanie said "shut up," rather than aggravating the situation. A more therapeutic, less antagonistic initial response could have alleviated the situation. It is important to provide significant training to correctional and security staff with regard to mental health situations. They are often in the position of "immediate responders" to crisis situations; they should be trained as to appropriate responses and strategies in these situations.

   Immediately following the attempted suicide, staff should have arranged for both a physician and a mental health professional to meet with Stephanie and thoroughly examine her. Although in the scenario a mental health professional was called, three hours is an excessive amount of time for a person in Stephanie's condition to wait. Stephanie should have been transported to a hospital to evaluate her physical condition, as well as her potential to repeat the suicide attempt. This was clearly a very serious suicide attempt, and she was

likely to have continuing suicidal ideation.

Instead, the detention officer exacerbated the situation by arguing with her and pushing her into a restraint chair, possibly injuring her. A child who has recently attempted suicide to the point of almost losing consciousness may be oxygen-deprived and should not be restrained.

Finally, the detention officer seemed to be using the restraint chair to express power rather than to protect Stephanie. Often, paraprofessionals are not involved in decisions regarding these children, and poorly trained staff may abuse the power that they have by making unnecessary use of restraints. Administrators can address this dynamic by involving paraprofessional staff in decision-making when appropriate and by training them to react therapeutically in these situations.

The staff did not seem to be trained in the basics of preventing and responding to suicide and self harm. When staff members respond inappropriately to a crisis such as a suicide attempt at a facility, policies, procedures, and training should be reviewed to identify the sources of the errors and changes needed. All restraints, suicide attempts, and other critical incidents should be reviewed by a multi-level team that makes recommendations to correct problems and prevent such incidents in the future.

2. How may the exchange of clothing following the attempted suicide have escalated this problem? If the detention officer had been male, could that have further escalated the situation?

The use of a paper gown seems unnecessary in this situation. If not immediately transported to a hospital, Stephanie should have been placed on continuous watch until a mental health professional arrived. If this were the case, the possibility that she would use items of her clothing to hurt herself would have been unlikely. The paper gown almost certainly made Stephanie feel more vulnerable and exposed. More appropriate and respectful items of clothing could be used while still ensuring her safety. In the event that a paper gown is used, staff could explain to Stephanie that the paper gown is used to keep her be safe.

The gender of the detention officer could change the dynamics of the scenario, especially when staff members make a decision to have a patient change clothes. Male staff members should almost never be supervising young women changing clothes. If this is absolutely necessary because of security concerns, a female staff member must also be present. This scenario can trigger strong feelings associated with sexuality and vulnerability, particularly when the child has a history of sexual abuse. There is significant evidence in the literature that the vast majority of young women in the criminal justice system have been victims of trauma, so this is a particularly critical issue. Thus, to reduce the risk that a patient will escalate, facilities should implement a policy that only same-gender staff attend to patients who are changing into or wearing a paper gown.

3. How might Stephanie's attempted suicide have influenced staff reactions?

Staff members are required to make judgment calls as to whether suicide attempts are serious attempts. Untrained staff may react without thinking or, fearing liability and risks to their own safety, formulate a response designed more to protect their own interests than to avoid trauma to the child. Untrained staff members place a child in an unreasonable risk of harm and expose the facility to liability. The child's safety and well-being should be the first priority and staff should be trained and monitored to follow procedures that place emphasis

on a child's safety while permitting staff to provide for their own safety. Administrators can help by arming staff with simple checklist-type procedures that address the staff fears and give them insight and strategies to respond effectively, permitting them to act in a controlled and thoughtful manner. When staff remain calm and focused, they make better decisions and also prevent the children from becoming fearful, which minimizes escalating behaviors. Well-trained staff members are an indispensable part of a safe therapeutic environment.

Follow-Up

1. What medical and mental health follow-up should occur after Stephanie stabilizes?

   Given that Stephanie lost consciousness during her attempted suicide and complained that her tailbone was hurting after being restrained, she needs to be examined by a physician and a mental health professional. Either of these incidents should trigger immediate notification of medical professionals for examination and treatment of Stephanie as soon as possible. This would optimally occur in a hospital emergency room setting.

2. What follow-up communication should occur in order to minimize the likelihood that Stephanie's acute emotional state or her urge to harm herself or others will recur?

   Mental health personnel should work with Stephanie to validate her emotions and feelings and to help her explore different ways to respond to and cope with threatening situation. They might ask her to make a commitment to being safe, although the validity of such "no harm contracts" has been questioned in the literature, so that should not be the only strategy. Ideally, the direct care staff could participate in the meeting after this private session so that Stephanie can share with them the decisions she has made to remain safe and how they can help her with her safety plan. Together, the staff and Stephanie could review the staff's responses, such as the detention officer's attempt to impose religious beliefs on Stephanie, discussing how each response was or was not helpful.

   Additionally, all staff and professionals involved with Stephanie could be notified of the situation, and she should be kept on constant watch until the risk diminishes. Stephanie should not be isolated. The facility should notify other agencies involved in Stephanie's care so that they are aware of the situation as well.

Additional Discussion Topics:

Would these additional facts change your analysis? What if:

1. Stephanie had a history of self-mutilation and self-destructive behavior prior to being detained.
2. Subsequent to previous detention hearings, Stephanie made threatening statements in reference to harming herself.
3. After she fell into the chair, Stephanie began to gasp and turn blue.

State Hospital Dining Room

It has been three weeks since Alfred transferred to the State Hospital's Special Security Behavioral Unit, a unit with a higher staff/patient ratio for patients with behavior requiring special precautions. For days he had been certain that at their next meeting, the treatment team would grant him unrestricted grounds access, a step often leading to a patient's transfer to the hospital's Transitional Program and ultimate discharge. With three exceptions, he had attended all regularly scheduled classes and therapies and had not been physically violent toward anyone since transferring to the unit. Nevertheless, at the meeting, the treatment team decided he should remain on the unit another thirty days before the granting of full grounds privileges.

Alfred began to anticipate that the meeting would go poorly when he first sat down with his treatment team. He felt alienated and frightened. Alfred's psychiatrist began the meeting with the treatment team by coldly stating, "This is a 27-year-old male schizophrenic from Dallas, Texas. He was referred to us approximately twenty-one days ago and we will be considering whether he has met the criteria necessary for full grounds privileges." Alfred refused to participate in the meeting, to the extent that he declined to answer direct questions. While Alfred exhibited no overt expressions of anger or aggressive behavior, it was apparent to all treatment team members that Alfred was seething inside. At the conclusion of the treatment team meeting, the team dismissed Alfred with polite encouragement to "keep up the good work" and the promise that if he did, there was a good chance he would soon be given full grounds privileges.

For the remainder of the afternoon, Alfred was withdrawn. Upon entering the dining room for dinner, Alfred refused to take his seat, violating a unit rule that all patients must be seated before food is served. At first, Ralph, an inexperienced mental health worker, was polite while asking Alfred to take his seat. Alfred remained adamant in his refusal and Ralph became increasingly assertive. The situation erupted when Ralph informed Alfred that he must leave the dining hall and miss dinner. Alfred became agitated and tried to strike Ralph. Ralph performed a quick take down, knocking Alfred in the mouth with his elbow in the process. Ralph then held Alfred's wrists to the floor and immobilized Alfred's legs with his legs. After Ralph had Alfred restrained, he issued a call for "all help." Alfred screamed at staff and claimed his leg was broken as he was carried to the seclusion room. As a supervising RN attended Ralph's bloodied lip, Ralph stated that he still wasn't sure how the injury or the incident had occurred.

Alfred was transferred to the local general medical facility for x-rays of his right leg and Ralph was informed by his supervisor that he should report first thing next day to the Office of Client's Services and Rights Protection to respond to an allegation that patient abuse had occurred during the incident for which the Office had initiated an investigation.

Teaching Questions

<u>Prevention</u>

1. What kinds of preventative measures could have been taken *before and during his treatment team meeting* to prevent Alfred from being overwhelmed by the disappointment that led to the physical confrontation?

2. How could staff have responded differently *after the treatment team meeting* in order to recognize and validate Alfred's disappointment and anger when he was not granted full grounds privileges?

<u>Intervention</u>

1. How could the staff respond more effectively to Alfred when he began to violate the facility's rules?

2. How may Ralph's inexperience have escalated the problem?

Follow-Up

1. What type of medical and mental health follow-up should occur?

2. What kinds of follow up with Alfred should occur to minimize the likelihood that the crisis will recur or that he will continue to act out or be confrontational with staff?

Additional Discussion Topics:

Would these additional facts change your analysis? What if:

1. At even a mere 145 pounds, Alfred had been considered a real threat to others because prior to his transfer to the Special Security Behavioral Unit, he had assaulted staff on two separate occasions, one of which resulted in the hospitalization of the injured staff.
2. Ralph is a 230-pound man who had been an all-state linebacker for his high school football team and could have gone to college on a full athletic scholarship, had it not been for his poor grades.
3. Ralph had been the most "senior" of the staff in the dining room at the time of the incident. All nursing supervisory staff was in the nursing station.
4. The hospital's staff training compliance rate was just over 83% and Ralph was two weeks overdue for his annual refresher training related to management and prevention of aggressive behavior.
5. Alfred's psychiatrist had been "coached" during his last performance review regarding general complaints from staff that he was "cold and distant" from his patients.
6. During the incident, Ralph was the only staff in the immediate vicinity.

State Hospital Dining Room

Teaching Questions and Analysis

Prevention

1. What kinds of preventative measures could have been taken *before and during his treatment team meeting* to prevent Alfred from being overwhelmed by the disappointment that led to the physical confrontation?

   Alfred expressed an expectation that he was "certain" that at his next meeting he would be granted full grounds privileges. Alfred expected that his model patient conduct would lead to the grant of privileges, and when his expectations were not met, he began to violate facility rules. Perhaps he was experiencing frustration related to an inability to control his environment. To minimize any frustration, the facility or treatment team should set clear guidelines as to when a patient will be granted full grounds privileges. They should advise the patient of these guidelines at the time of his or her arrival, thus setting realistic expectations with regards to timelines for receiving full grounds privileges. By establishing and following clear guidelines, the facility can better reward and garner the trust of patients who follow the unit rules.

   Furthermore, the treatment team could personalize the treatment meetings. Alfred admitted to feeling "alienated and frightened" during the meeting. This is not surprising given that the team referred to him as "a 27-year old male schizophrenic from Dallas, Texas," rather than referring to him by name. The team could instead refer to the patients by name and introduce themselves to ease patients fear and anxiety during team meetings. By using the patient's name and personalizing the meetings as much as possible, the facility can foster increased patient participation and investment in the meetings and facilitate the treatment process.

   The treatment team should have given Alfred an opportunity at the beginning of the meeting to express his opinions about how he has done since the last meeting. They should ask him, in a supportive way, to elaborate successes and continued challenges in moving toward a more independent status. The mental health professionals should build upon his articulated strengths and challenges when discussing their professional opinions regarding his supervision status.

2. How could staff have responded differently *after the treatment team meeting* in order to recognize and validate Alfred's disappointment and anger when he was not granted full grounds privileges?

   The treatment team admits that they realized Alfred was "seething inside" following the meeting. However, no member of the treatment team approached Alfred directly to find out what was upsetting him or to show empathy. Perhaps if someone took the time to understand Alfred's anger, they could have prevented him from expressing his anger through violation of facility rules. Such a response is fairly predictable when individuals feel that they have been doing all that is asked, but they still do not get positive reinforcement. If a treatment team member had talked with Alfred following the meeting and discovered that he was frustrated and disappointed with the team's decision, the team member could have assured Alfred that his model conduct was not in vain and that he was on the road to full privileges. This short talk could have re-motivated Alfred and encouraged him to continue to follow facility rules. Additionally, Alfred could have been referred to a mental health professional to discuss his feelings.

Intervention

1. How could the staff respond more effectively to Alfred when he began to violate the facility's rules?

   Ralph's initial response to Alfred's conduct was satisfactory. Staff should always respond to a patient's inappropriate behavior by first giving the patient a polite verbal cue about how the conduct is inappropriate and the opportunity to correct his or her conduct before resorting to other tactics. However, once Ralph began to become assertive and realized that Alfred was not going to listen to his request to be seated, Ralph could have taken actions designed to deescalate the situation. Alfred's anger was only heightened by Ralph's continued persistence and increasing assertiveness. The events in the scenario indicate that Ralph and Alfred may have been acting out power and control issues. Rather than concern for Alfred's safety or treatment process, Ralph may have acted out of a need for power. Ralph made a poor decision, forcing a direct confrontation in this situation rather than notifying the professional staff of Alfred's misconduct. Alfred could have been punished in other ways besides missing dinner. Why would a patient who refused to listen to an order to sit down agree to leave the cafeteria and miss dinner? It should have been obvious to Ralph that he would gain nothing by continuing to issue orders to Alfred. Rather, Ralph could have allowed Alfred to continue to stand while closely monitoring him to assure he did nothing that would harm himself, other patients, or staff. By acting in a less confrontational manner, Ralph could have prevented the ultimate physical confrontation and the need to use restraints.

2. How may Ralph's inexperience have escalated the problem?

   Inexperienced mental health workers may find it difficult to predict patient behavior and respond effectively, as demonstrated by Ralph's escalation of this incident. A more experienced worker might have handled the situation in a manner that would have avoided a physical confrontation. While facilities can not be expected to maintain a workforce of experienced workers on the floor at all times, they can take steps to minimize the risk that inexperienced workers will be exposed to hostile patients. The facility could instruct inexperienced workers to seek out more experienced workers at the first sign of trouble to prevent turning mere rule violations into physical confrontations. Also, the facilities could provide more training or partner all inexperience workers with seasoned employees to prevent minor infractions from escalating unnecessarily.

Follow-Up

1. What type of medical and mental health follow-up should occur?

   Immediate medical attention should be arranged for Alfred following his complaint of a broken leg. They should also arrange for a doctor to treat Ralph's injured lip. Mental health staff should interview Alfred to discuss his response to the outcome of the treatment team meeting. Further, an administrator should review the incident with Ralph to ensure he is adequately trained and has learned alternative reactions to such incidents, which will decrease the chances of future escalations.

2. What kinds of follow up with Alfred should occur to minimize the likelihood that the crisis will recur or that he will continue to act out or be confrontational with staff?

   Alfred should be interviewed to determine what caused him to abandon his pattern of good behavior and become involved in a physical confrontation with staff. During the interview, the mental health professional might learn of Alfred's disappointment and anger from the treatment team meeting and permit him to express his feelings and work through them. Additionally, a debriefing should be held to discuss the events leading up to the incident and to explore ways that this type of situation can be prevented in the future. Following the meeting with Alfred and the debriefing, the facility could explore ways in which it can improve its treatment program to prevent such dramatic swings in patient behavior in the future.

Additional Discussion Topics:

Would these additional facts change your analysis? What if:

1. At even a mere 145 pounds, Alfred had been considered a real threat to others because prior to his transfer to the Special Security Behavioral Unit, he had assaulted staff on two separate occasions, one of which resulted in the hospitalization of the injured staff.
2. Ralph is a 230-pound man who had been an all-state linebacker for his high school football team and could have gone to college on a full athletic scholarship, had it not been for his poor grades.
3. Ralph had been the most "senior" of the staff in the dining room at the time of the incident. All nursing supervisory staff was in the nursing station.
4. The hospital's staff training compliance rate was just over 83% and Ralph was two weeks overdue for his annual refresher training related to management and prevention of aggressive behavior.
5. Alfred's psychiatrist had been "coached" during his last performance review regarding general complaints from staff that he was "cold and distant" from his patients.
6. During the incident, Ralph was the only staff in the immediate vicinity.

Appendices

Selected Materials from the Thirteenth Robert Lee Sutherland Seminar

Preventing and Reducing the Use of Restraint and Seclusion through Effective Behavior Support and Intervention

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Introduction

Despite recent efforts, seclusion and restraint are still used to control client behavior. Studies have shown that these practices are harmful to clients, staff, and organizations. The Harvard Center for Risk Analysis estimated in 1998 that between 50 and 150 seclusion- and restraint-related fatalities occur annually. Regrettably, signs of distress, such as clients saying "I can't breathe," vomiting, and turning blue have been ignored. The use of restraint not only increases injury rates, but also increases the intensity and frequency of aggressive/violent behavior (National Executive Training Institute, 2003). Children, older adults, and individuals with addictive or co-occurring mental health and addictive disorders are especially at risk.

In addition to bodily harm, restraint and seclusion use can result in a number of adverse psychological effects. A federal government study showed that clients who have been restrained reported painful memories, fearfulness at seeing or hearing others being restrained, and a mistrust of mental health professionals (U. S. General Accounting Office, 1999). Additionally, seclusion and restraint can result in re-traumatization of victims and staff physical injury and mental trauma, as well as workers' compensation claims and legal action against agencies.

This information further supports the Child Welfare League of America's (CWLA) position that restraint and seclusion use should either be eliminated completely or limited to those situations in which imminent danger to either the client or others exists (CWLA, 2002). CWLA has long been concerned about the risk involved with the use of restraint and seclusion. In September 2001, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded CWLA and the Federation of Families for Children's Mental Health a substantial grant to coordinate and assist five demonstration sites across the country in reducing the use of seclusion and restraint by improving the training and supervision of staff who work directly with children and youth. The following observations are based on lessons learned through working with the five demonstration sites.

The project's title, "Best Practices in Behavior Support and Intervention: Preventing and Reducing the Use of Restraint and Seclusion," reflects the belief that the child must manage his or her own behavior and that the caregivers should be available to provide support as needed. CWLA is committed to continuing efforts to reduce and eventually eliminate the use of restraint and seclusion at facilities serving children and youth. Achieving this goal and maintaining successes requires more than staff training alone. Sustaining reductions in the use of seclusion and restraint demands a supportive leader and a shift in organizational cultural to consider restraint and seclusion as emergency procedures of last resort.

Current Rationale

While there may be situations that necessitate seclusion and restraint, studies have shown that in practice, the rationale for initiating a restraint or seclusion is often questionable. Caretakers say that the reason they must use seclusion and restraint is that clients have severe problems and often put themselves, other clients, and staff at risk. They say it is necessary to keep everyone safe. Specifically, some rationales include refusing to comply while in the time-out room or being escorted; fighting with peers; being aggressive with staff; or participating in non-compliant behavior, such as refusing to give up an object or to put on shoes, wanting to leave the designated group area, or running away. The belief that the problem lies with the clients creates an environment in which caretakers believe that there is nothing they can do to change the situation. In fact, much of the problem lies in the fact that caretakers are focused on management and control as opposed to support and teaching.

In the less critical situations described above, preventative measures can be instituted to avoid the use of seclusion and restraint. Recent studies suggest that programs serving similar children have widely varying rates of restraint, and that some program serving very difficult children have low restraint rates. In fact, many programs have significantly reduced restraint without changing their populations. Alternatives include effective communication and de-escalation, as well as an awareness of power struggles and control issues. From an administrative perspective, prevention can include thorough and updated assessment and treatment planning, detailed risk assessment, staff training, agency process and procedural reviews, and debriefing following all seclusions and restraints. Use of these alternatives can create an environment where seclusion and restraint are used as a last resort only when necessary for the safety of the client or others.

4-Step Process of Reduction

Restraint reduction is a four-step process that requires a cultural shift. First, it is important that the field acknowledges that change can only be accomplished through the efforts of service providers, not by changing the clients. Second, we must look honestly at our contributions to the problem and identify areas for change. Third, we must use the six key tools for change discussed below. And, always, we must evaluate our progress and never give up, recognizing that meaningful change can be a slow process.

4-Step Process of Reduction

1. **Admit that service providers need to change**
2. **Look honestly at our contributions to this problem**
3. **Develop and use six key tools**
4. **Evaluate progress and do not give up**

Six Key Tools for Change

The third step in the process of reduction relates to the adoption and implementation of strategies to reduce or eliminate seclusion and restraint. These strategies were derived drawing on best practices, expert knowledge, creative thinking, and sometimes trial and error to reduce seclusion and restraint. Key strategies address leadership, organizational culture, agency policies, staff training, the treatment milieu, and continuous quality improvement.

1. Strong Leadership

Strong leadership is essential. In fact, seclusion and restraint can be significantly reduced in just months through focused attention by agency leadership, prior to any significant expenditures on training or other supports. Sites have reported that when senior management was distracted by other events, such as unionization efforts or opening new units, the use of emergency safety interventions increased. The importance of strong leadership cannot be understated. Without leadership support, change is unlikely to occur or be sustained.

Supervisors and managers can provide leadership in this area by setting the tone. They should send a clear message that they support a coercion-free environment, partnerships, choice, and proactive communication, and that elimination of the unnecessary use of restraints and seclusion is paramount. The mission statement of the organization should support a violence- and coercion-free environment. Supportive and active leadership will help to identify restraint and seclusion as a top priority that is sustained by the executive leadership team.

Restraint and seclusion are identified by strong leaders as crisis events, treatment failures, and high-risk interventions. Leaders model the interest, make a time commitment, and "sell" the initiative to managers and direct care staff. They can do this by mandating that incidents be immediately reported to executive leader(s), who are on-call for these purposes 24 hours a day. If complete eradication of these practices is possible, leadership enforces an elimination-by-mandate protocol, banning restraint use or specific types of restraints and eliminating the use of seclusion rooms.

Administrators take responsibility by shouldering the burden of reducing restraint and seclusion through constant vigilance, including a maximum length of time for restraints, and ongoing training in emphasizing behavioral support de-escalation. Leaders provide training and resources that emphasize alternatives to restraint and seclusion and steps to ensure the integration of training into practice. Leaders model and coach alternative approaches. They have high expectations and time commitment, providing training resources and 24-hour on-call support. Leaders conduct debriefings after incidents occur, using these as an exercise for learning as opposed to punishment. These debriefings should also be used to gather data, discuss issues, and document timelines for changes. An oversight committee implements changes and includes executive leaders, managers, supervisors, direct care staff, family members, children, and advocates.

2. Client-Centered Organizational Culture

A positive organizational culture embraces a person-centered environment in which the needs of children and families are at the center of care and treatment. Tailoring the environment to the needs of the population served can reap great benefits in regard to reducing restraint and seclusion use and providing a range of better outcomes for clients.

The organizational culture should emphasize staff empowerment and youth involvement, as well as family and natural support involvement. Healthy relationships between staff, clients, and families facilitate support of positive behavior and help de-escalate clients in times of crisis. Healthy relationships are developed over time in a person-centered environment that puts the needs of the child at the forefront of care, uses supportive language, and avoids labels such as "manipulative" or "needy." Additionally, collaboration is emphasized over compliance in offering culturally and linguistically competent services.

Leadership and staff acknowledge that families play an important role in reducing the use of restraint and seclusion. The paradigm must shift to assure that 1) "family" goes beyond the biological parents; 2) families need to be involved and supported in the care and treatment planning of their children and 3) family representation in facility governance structures is critical to infusing the family voice throughout the policies and practices – ultimately leading to better outcomes for children and their families. Additionally, agencies must ensure that family members and staff receive focused training on family involvement within the systems of care. Family members and clients are involved in treatment planning, programming, and review teams, as well as advocacy.

3. Supportive Policies and Procedures

The use of emergency safety interventions can be greatly reduced through the implementation of more stringent policies. All facilities pursuing the reduction of restraint and seclusion first undergo an assessment of policies, procedures, and practices. Agency policies and procedures prescribe practices such as comprehensive assessment, individualized treatment planning, individualized behavior support planning, monitoring, and debriefing that contribute to the reduction of restraint and seclusion.

Comprehensive assessments record any history of aggression, as well as the physical, psychiatric, and emotional risks of restraint and seclusion. Additionally, assessments inform the behavior support and treatment plans. Treatment planning is individualized and strengths-based, and developed in conjunction with the child and their family. An individualized behavior support plan also identifies triggers, successful intervention strategies, and options for self-calming. This information should be communicated to all relevant staff and revisited regularly.

Monitoring is face-to-face and assesses the physical and psychological well-being of child. When possible, specific staff are designated to implement restraint and seclusion. Caretakers have the authority to stop intervention if signs of distress are evident.

Debriefing includes the child, witnesses, staff, and family members. Participants are allowed to express feelings about the incident and to make a plan to avoid future incidents. The debriefing does not assign blame and should be carefully documented.

There is much to learn from setbacks and failures. It is critical to have an open and honest dialog about what actually occurred and to examining the agency's policies, procedures and processes, and staff's practices, which led to the breakdown. Just as an agency is expected to shift their culture from one that blames the staff for implementing restraint and seclusions, we must also make a shift away from condemning those agencies that experience setbacks and failures, and start to acknowledge that the issues of restraint and seclusion use are extremely complex and difficult to manage.

4. Skills-Based, Ongoing Training

Though research has clearly demonstrated that training alone is not effective for maintaining low levels of emergency safety interventions, competency-based and refresher trainings have worked in tandem with other approaches to reduce restraint and seclusion use. Regular training and refresher courses ensure skill retention so that when a crisis arises, staff members feel confident and are competent to intervene appropriately. Providers must shift to an approach that strengthens the organization's preparedness.

Risk factors for client injury and fatality indicate the need for pre-testing of skills, comprehensive initial and refresher trainings at frequent intervals, and regular CPR and First Aid training. Training should be competency based, with at least 50% focusing on trauma-sensitive care, prevention, and de-escalation. Often, tones, gestures, and postures may be misinterpreted by youth. Culturally and linguistically competent services can help to avoid these issues. Frequent refreshers can minimize training drift, along with regular staff supervision, mentoring, and coaching.

5. Focused Treatment Milieu

The treatment philosophy is coercion-free and non-punishment-based. Treatment providers acknowledge that most children have experienced trauma and that restraint and seclusion is re-traumatizing. Staff who know the signs of trauma can create a culture of empathy. Behavior support such as anger and anxiety management skills for consumers can also help. Frequent role-playing can help clients practice responses to provocative situations. A positive, structured in environment is essential and requires active programming and a well-maintained environment.

The treatment milieu must be relationship-based. Agencies that are invested in reducing restraint and seclusion use emphasize positive relationships as the most important therapeutic tool, as opposed to "management and control," which often escalates into power struggles. This, along with behavior support for clients and a positive-structured environment that provides a predictable routine creates an environment that reduces the need for seclusion and restraint.

6. Continuous Quality Improvement

Continuous quality improvement can help to ensure sustainment of achieved goals in this area. Organizational goals implement quality standards. Data is collected, analyzed, and results are reported back to the organization for corrective feedback mechanisms. A program evaluation based on quality criteria identifies problems to be addressed and successes to be celebrated.

In order to reduce the use of seclusion and restraint and to sustain reductions, organizations should continually monitor and track the use of restraint and seclusion through an array of data points. In order to correct programmatic "trouble spots" and identify staff training needs, these data are analyzed and corrective feedback mechanisms are implemented. Ongoing evaluation is necessary to sustain improvements in agency treatment of clients served.

An essential component of tracking is basic consumer demographic information and program profiles. This information is especially useful when comparing reductions in the use of restraint and seclusion between differ-

ent programs. Baseline information such as referral source, family of origin issues, and clinical diagnostic information for each client involved in a restraint or seclusion episode helps identify programmatic areas of need and agency limitations that may impede reduction efforts.

Special focus on vulnerable clients such as children under twelve and females will help to ensure that continuous quality improvement reaches all clients. Both of these populations present specific challenges regarding emergency safety intervention. To date, very few studies have targeted these demographic groups, but future work can concentrate on finding innovative treatment methods to address these unique needs of these clients.

Conclusion

To reduce seclusion and restraint, policy changes must be planned thoroughly and staff prepared to respond differently. Supported and empowered staff have new tools with which to guide clients, recognizing and avoiding power struggles. Involving clients in these changes can provide additional sources of information and insight.

Once improvements are achieved, the focus on reducing restraint and seclusion must be sustained with the same vigor throughout reduction efforts. When agencies have lessened their focus on reduction efforts, restraint and seclusion use has increased. Changing the culture so that staff members view restraint and seclusion as an emergency procedure of last resort requires constant attention and effort. Of course, change is not necessarily easy. Keep in mind that it may get worse before it gets better and that changing a culture is a process that takes time. In the case of reducing seclusion and restraint use, improving the safety and well-being of clients and staff is well worth the effort.

References

Child Welfare League of America (2002). *CWLA best practice guidelines.* Washington, DC: Author.

National Executive Training Institute. (2003). *Training curriculum for the reduction of seclusion and restraint.* Alexandria, VA: National Technical Assistance Center, National Association of State Mental Health Program Directors. Available from http://tecathsri.org/shop_display_cart.asp?action=add&version=E-copy&id=98

U.S. General Accounting Office. (1999). *Mental health: Improper restraint or seclusion use places people at risk* (GAO HEH-99-176). Washington, DC: Author.

Seclusion and Restraint Website Links

For live links to these websites, please see the Hogg Foundation website at www.hogg.utexas.edu.

American Academy of Child and Adolescent Psychiatry
http://www.aacap.org/publications/policy/ps44.htm
Policy Statement on the Prevention and Management of Aggressive Behavior in Psychiatric Institutions with Special Reference to Seclusion and Restraint

American Geriatrics Society
http://www.americangeriatrics.org/products/positionpapers/restrain.shtml
Guidelines for Restraint Use

American Hospital Association and National Association for Psychiatric Health Systems
http://www.naphs.org/News/guidingprinc.html
Guiding Principles on Restraint and Seclusion for Behavioral Health Services

Institute on Community Integration at University of Minnesota
http://education.umn.edu/ceed/projects/preschoolbehavior/
Tip sheet on physical restraint developed with the aim of assisting "teachers and parents in providing the best possible educational opportunities to students with emotional and behavioral disorders"

National Alliance for the Mentally Ill (NAMI)
http://www.nami.org/Template.cfm?Section=Issue_Spotlights&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=5&ContentID=7779
Issue Spotlight on Seclusion and Restraint

National Association of State Mental Health Program Directors
http://www.nasmhpd.org/general_files/position_statement/posses1.htm
Position Statement on Seclusion and Restraint. See also three technical papers on reducing the use of seclusion and restraint at www.nasmhpd.org/publications.cfm#symposia and documents from the National Coordinating Center to Reduce and Eliminate the Use of Seclusion and Restraint at http://www.nasmhpd.org/ntac.cfm

Joseph B. Ryan and Reece Peterson, University of Nebraska-Lincoln
http://www.unl.edu/srs/pdfs/physres.pdf
Presentation entitled "Physical Restraints in School"

Substance Abuse and Mental Health Services Administration (SAMHSA)
http://www.samhsa.gov/Matrix/matrix_seclusion.aspx
Federal government homepage for information and resources about seclusion and restraint

U.S. General Accounting Office
http://www.gao.gov/archive/1999/he99176.pdf
Report entitled "Mental Health: Improper Restraint or Seclusion Use Places People at Risk"

Selected Texas Statutes and Regulations Related to the Use of Seclusion and Restraint

For live links to these statutes and regulations, please see the Hogg Foundation website at www.hogg.utexas.edu. For a direct link to Texas statues and other legislative information, go to http://www.capitol.state.tx.us/capitol.htm

Certain Health Care Facilities

Title 4 Health and Safety Code §322.001 - §322.055; Use of Restraint and Seclusion in Certain Health Care Facilities

TITLE 4	HEALTH FACILITIES
CHAPTER 322	USE OF RESTRAINT AND SECLUSION IN CERTAIN HEALTH CARE FACILITIES
SUBCHAPTER A	GENERAL PROVISIONS
§322.001	Definitions
SUBCHAPTER B	RESTRAINTS AND SECLUSION
§322.051	Certain Restraints Prohibited
§322.052	Adoption of Restraint and Seclusion Procedures
§322.053	Notification
§322.054	Retaliation Prohibited
§322.055	Medicaid Waiver Program

Schools

Title 2 Texas Education Code §37.0021; Use of Confinement, Restraint, Seclusion, and Time-Out

TITLE 2	PUBLIC EDUCATION
CHAPTER 37	DISCIPLINE: LAW AND ORDER
RULE §37.0021	Use of Confinement, Restraint, Seclusion, and Time-Out

Title 19 Texas Administrative Code §89.1053; Procedures for Use of Restraint and Time-Out

TITLE 19	EDUCATION
PART 2	TEXAS EDUCATION AGENCY
CHAPTER 89	ADAPTATIONS FOR SPECIAL POPULATIONS
SUBCHAPTER AA	COMMISSIONER'S RULES CONCERNING SPECIAL EDUCATION SERVICES
DIVISION 2	CLARIFICATION OF PROVISIONS IN FEDERAL REGULATIONS AND STATE LAW
RULE §89.1053	Procedures for Use of Restraint and Time-Out

Mental Health Programs

Title 25 Texas Administrative Code §404.167; Restriction of Rights as Part of Emergency Behavioral Interventions: Restraint and Seclusion

TITLE 25	HEALTH SERVICES
PART 1	DEPARTMENT OF STATE HEALTH SERVICES
CHAPTER 404	PROTECTION OF CLIENTS AND STAFF–MENTAL HEALTH SERVICES
SUBCHAPTER E	RIGHTS OF PERSONS RECEIVING MENTAL HEALTH SERVICES
RULE §404.167	Restriction of Rights as Part of Emergency Behavioral Interventions: Restraint and Seclusion

Title 25 Texas Administrative Code §448.706; Restraint and Seclusion

TITLE 25	HEALTH SERVICES
PART 1	DEPARTMENT OF STATE HEALTH SERVICES
CHAPTER 448	STANDARD OF CARE
SUBCHAPTER G	CLIENT RIGHTS
RULE §448.706	Restraint and Seclusion

Juvenile Justice

Title 37 Texas Administrative Code §97.21, §97.23, §97.25; Security and Control

TITLE 37	PUBLIC SAFETY AND CORRECTIONS
PART 3	TEXAS YOUTH COMMISSION
CHAPTER 97	SECURITY AND CONTROL
SUBCHAPTER A	SECURITY AND CONTROL
§97.21	Approved Restraint Equipment
§97.23	Use of Force
§97.25	Use of Force: Chemical Agent OC

Title 37 Texas Administrative Code §341.66 - §341.71; Texas Juvenile Probation Commission Standards

TITLE 37	PUBLIC SAFETY AND CORRECTIONS
PART 11	TEXAS JUVENILE PROBATION COMMISSION
CHAPTER 341	TEXAS JUVENILE PROBATION COMMISSION STANDARDS
SUBCHAPTER J	RESTRAINTS
§341.65	Definitions
§341.66	Requirements
§341.67	Prohibitions
§341.68	Documentation
§341.69	Physical Restraint
§341.70	Mechanical Restraint
§341.71	Transporting

Title 37 Texas Administrative Code §343.60 - §343.68; Standards for Secure Juvenile Pre-Adjudication Detention and Post-Adjudication Correctional Facilities

TITLE 37	PUBLIC SAFETY AND CORRECTIONS
PART 11	TEXAS JUVENILE PROBATION COMMISSION
CHAPTER 343	STANDARDS FOR SECURE JUVENILE PRE-ADJUDICATION DETENTION AND POST-ADJUDICATION CORRECTIONAL FACILITIES
SUBCHAPTER E	RESTRAINTS
§343.60	Definitions
§343.61	Requirements
§343.62	Prohibitions
§343.63	Documentation
§343.64	Physical Restraint
§343.65	Mechanical Restraint
§343.66	Restraint Chair
§343.67	Chemical Agents
§343.68	Transporting Residents Outside Facility

Title 37 Texas Administrative Code §351.40 - §351.48; Standards for Short-Term Detention Facilities

TITLE 37	PUBLIC SAFETY AND CORRECTIONS
PART 11	TEXAS JUVENILE PROBATION COMMISSION
CHAPTER 351	STANDARDS FOR SHORT-TERM DETENTION FACILITIES
SUBCHAPTER D	RESTRAINTS
§351.40	Definitions
§351.41	Requirements
§351.42	Prohibitions
§351.43	Documentation
§351.44	Physical Restraint
§351.45	Mechanical Restraint
§351.46	Restraint Chair
§351.47	Chemical Agents
§351.48	Transporting Residents Outside Facility

Child Care Facilities

Title 40 Texas Administrative Code §720.1001 - §720.1013; General Policies and Procedures

TITLE 40	SOCIAL SERVICES AND ASSISTANCE
PART 19	DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES
CHAPTER 720	24-HOUR CARE LICENSING
SUBCHAPTER O	GENERAL POLICIES AND PROCEDURES
§720.1001	Definitions
§720.1002	Behavior Intervention Precedence
§720.1003	Required Behavior Intervention Policies and Procedures
§720.1004	Less Restrictive Behavior Interventions
§720.1005	Restraint and Seclusion: General Requirements
§720.1006	Emergency Medication
§720.1007	Personal Restraint
§720.1008	Mechanical Restraint
§720.1009	Protective Devices
§720.1010	Supportive Devices
§720.1011	Seclusion
§720.1012	Behavior Intervention Training
§720.1013	Evaluation of Behavior Interventions

Nursing Facilities

Title 40 Texas Administrative Code §19.601; Resident Behavior and Facility Practice

TITLE 40	SOCIAL SERVICES AND ASSISTANCE
PART 1	DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 19	NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION
SUBCHAPTER G	RESIDENT BEHAVIOR AND FACILITY PRACTICE
RULE §19.601	Resident Behavior and Facility Practice

Assisted Living Facilities

Title 40 Texas Administrative Code §92.125; Resident's Bill of Rights and Provider Bill of Rights

TITLE 40	SOCIAL SERVICES AND ASSISTANCE
PART 1	DEPARTMENT OF AGING AND DISABILITY SERVICES
CHAPTER 92	LICENSING STANDARDS FOR ASSISTED LIVING FACILITIES
SUBCHAPTER G	MISCELLANEOUS PROVISIONS
RULE §92.125	Resident's Bill of Rights and Provider Bill of Rights

Nine Step Process in Using the Trauma Assessment, Safety Form, Health Care Proxy, and Business Cards

- to maximize client choice
- to plan proactively to avoid emergencies and retraumatization
- to develop relationships
- to treatment retention

1) Trauma Assessment Form is filled out at intake.

2) Safety Form (also called "De-escalation Form" or "Restraint Reduction Form") is filled out either: a) with the client at intake, or b) by the client on their own, returning it to the principal point person working with them (e.g., friend, peer-advocate, therapist, charge nurse, psychiatrist, case manager).

3) Safety Form is copied for client to retain; a second copy goes in the client file.

4) Treatment Plan is developed, incorporating information from the Trauma Assessment Form and Safety Form. The Plan is reviewed and signed by the client.

5) Treatment Plan is circulated to the treatment team.

6) Sample Health Care Proxy is given to the client to review.

7) Health Care Proxy is completed by client using Safety Form with help (if necessary) from principal contact person. It should be witnessed by a psychiatrist determining that the person was competent at the time the Health Care Proxy was developed.

8) Health Care Proxy is put in file and circulated to the treatment team as well as any other area providers used by client (e.g., local hospital, crisis evaluation team, primary care physician, family and/or friends designated by client).

9) Business Card is made for or by client to carry in wallet or pocket in case of emergencies to alert people (e.g., police, emergency intervention personnel, ambulance drivers, emergency room doctors) to presence of Health Care Proxy on file.

State of Maine/BDS – RPC (patient label)
Trauma Assessment (to be completed with RN within 10 days)

1. Have you ever been asked questions about abuse and trauma in you life before?
   ___ Yes ___ No ___ Don't know

   Would you be willing to answer a few questions about his now?
   ___ Yes ___ No ___ Don't know

2. Have you ever been physically hurt by another? (i.e. hit, punched, slapped, kicked, strangled, burned, threatened with object or weapon, etc.)
   ___ Yes ___ No ___ Don't know

   If yes, in the past? _____ Is it still going on? ______
   Are you able to say by whom? ___ Yes ___ No
   Details: ____

3. Have you ever been touched in a way that makes you uncomfortable? (e.g. unwanted kissing, hugging, touching, nudity, unwanted intercourse)? ___ Yes ___ No ___ Don't know
   If yes, in the past? _____ Is it still going on? ______
   Are you able to say by whom? ___ Yes ___ No

4. Have you experience an acute trauma such as a natural disaster, war, severe accident threat to life, witnessing a death or violence to someone else, or been a victim of a crime?
   ___ Yes ___ No ___ Don't know
   If yes, please give age and circumstances? ________________________________
   ____

5. If yes to any of the above, have you experienced flashbacks, nightmares, lost time, insomnia, numbness, confusion, memory loss, self injury, extreme fearfulness or terror, etc., related to the trauma?
   ___ Yes ___ No
   Is this happening currently? ___ Yes ___ No
   Please describe: ____
   ____

   How are you feeling now? ____
   ____

   Have these questions made you feel uncomfortable? ________________________________
   ____

6. Have you ever been in counseling/therapy to deal with issues regarding trauma? ___ Yes ___ No
   When _____________ Where _______________

Comments: ____
____

Signature: ______________________________ Date: ________________

MR Form 224 (3/21/00); Revised 03/2004; 10/2004

Summary Findings	**Summary Recommendations**

Signature: ________________________________ Date: __________________________

This form serves as a guide to gathering information from clients about a possible trauma history. It is recommended for use as part of the intake assessment and after clinical review, should be incorporated into the client's treatment. It should be used in conjunction with the Personal Safety Form. Screening client's for information about trauma must be done in a sensitive manner that fosters the clinical recovery of the client and continued support from the client's social network.

Review Date

Date	Initial

* *(PLEASE INCORPORATE THE INFORMATION OBTAINED IN THE TRAUMA ASSESSMENT INTO THE TREATMENT PLAN FOR THIS CLIENT.)*

MR Form 224 (3/21/00); Revised 03/2004; 10/2004

State of Maine/BDS – RPC (patient label)

Personal Safety Form (by 72 hr Tx planning session)

Our goal at Riverview Psychiatric Center is to work with you and your family members to provide a safe and supportive environment. If you become angry or upset, staff are available to talk and find ways to help you solve the problem. Ideas to help you calm down might be getting away to be alone, finding a change of scenery, talking to a family member or going for a walk. We encourage you to choose the best way of managing your anger. This document will be used in planning your treatment. We are asking you and/or your family to answer the following questions so we can provide a safe and comfortable place for you to receive treatment.

1. What makes you angry, frustrated or upset? ____
____

2. How do I know when you are angry? ____
____

3. What helps you calm down? (Check all that work for you). We may be able to help you with all of these alternatives but if we work together we can come up with a plan to help you while you are here.

___ voluntary time out in your room
___ talking with another person
___ eating something
___ deep breathing exercises
___ wrapping up in a blanket
___ watching TV
___ calling your therapist
___ exercise, physical or relaxation
___ lying down with a cold face cloth
___ a change of scenery
___ counting to 20
___ talking to yourself in a positive way (stay cool, I can handle it, take it easy)
___ voluntary time out in quiet room
___ talking with staff
___ punching a pillow
___ going for a walk with staff
___ listening to music
___ pacing the halls
___ pounding some clay
___ putting hands under cold water
___ thinking of something pleasant
___ thinking of the consequences
___ getting involved with activities, crafts
___ Other ______________________________
___ sitting by the nurses station
___ a warm drink
___ writing a diary/journal
___ taking a hot shower
___ reading a newspaper/book
___ calling a friend
___ using ice on your body
___ prn medication
___ being alone
___ relaxation exercises

4. Is there a person who has been helpful to you when you are upset? ___ Yes ___ No

Would you like them to come and visit you? ___ Yes ___ No

Can we assist you in this process? ___ Yes ___ No

5. What are some of the things that make it more difficult for you when you are already upset? Are there particular "triggers" that you know will cause you to escalate?

___ being touched
___ bedroom door open
___ particular time of day (when?)
___ being isolated
___ people in uniform
___time of the year (when?)
___ loud noise
___ not having control/input (explain) ____
____
___ other (please list) ____

Form #223 Revised 03/2004; 10/2004

State of Maine/BDS – RPC (page 2/2)
Personal Safety Form (by 72 hr Tx planning session)

6. If you are escalating or in danger of hurting yourself or someone else, we may need to use a physical or mechanical restraint. We may not be able to offer you all of these alternatives but if it becomes necessary we would like to know your preferences.

___ quiet room (unlocked) ___ 3 or 4 point restraints ___ time out in your room
___ physical hold ___ safety coat ___ seclusion (locked door)
___ other ____

7. Do you have a preference regarding the gender of staff assigned to you during and immediately after a restraint? Female staff ___ Male staff ___ No preference ___

8. Is there anything that would be helpful to you during a restraint? Please describe: ________________
____

9. We may be required to administer medication along with physical restraints. In this case, we would like to know what medications have been especially helpful to you? Please describe: ______________________
____

10. We do room checks here to make sure you are okay at night. We are trying to make these room checks as non-intrusive as possible. Is there anything that would make room checks more comfortable for you?
____

SAFETY SCREEN

1. Do you think that it is sometimes acceptable to hit/strike others? ___ Yes ___ No

2. Have you ever been involved in a physical confrontation? ___ Yes ___ No

3. Do you presently feel threatened here or at home or by someone in particular? ___ Yes ___ No

4. Have you ever utilized restraints or seclusion? ___ Yes ___ No

5. Have you ever intentionally injured yourself? ___ Yes ___ No

____
Patient Signature Date

____
Staff Signature Date

Revised 4/04

Form #223 Revised 03/2004; 10/2004

Sample of a Health Care Proxy (page 1 of 2)

developed by a woman in public mental health residential treatment
This proxy uses language from the MA Restraint Reduction & De-escalation Form.

The purpose of this document is to inform health care providers of my preferences and contraindications of treatment should I be deemed "incompetent" to make treatment decisions or be unable to communicate my wishes. This instruction directive will spring into effect the moment I am considered incompetent to make treatment decisions.

This directive may be revoked by me orally or in writing at any time, however, I must be considered "competent" by clinical staff in order to revoke this directive. Competency must be recorded in my chart prior to revocation.

Issues addressed are as follows, and in this order:

Clinical stance
Assessment/ Intake
Location
Visitors
Medications
Seclusion
Restraints
ECT
Length of hospital stay

Also enclosed are a copy of grounding techniques which are helpful, and a copy of a restraint reduction form which may also prove to be helpful.

Clinical stance:

Do present an attitude of understanding and caring. Remember I may be very afraid of you. This stance helps me trust staff and feel less afraid. Helpful phrases are located in grounding techniques.

Do not blame or chastise me. Tone of voice is critical. Do not present as angry, annoyed, or judgmental. Comments I've heard in the past such as " I guess I can't trust you now" (from acute care staff), "You make me sick when you do that" (from a nurse)," Now you've gotten what you wanted" (after being forcibly put in 4-point restraints), and " Shut Up!" (from a psychiatrist), were harmful. Do not shame and blame me because this feeds my self-hatred and frustration, potentiating self-injury.

Do not tell me I self-injure for secondary gain (attention, drugs, hospitalization, restraints/ limits). This approach is not helpful. I am not suffering and self-injuring for staff's attention.
Motivations for my self-injury include but are not limited to: the need to reduce voices, the need to express anger toward self or others/ to punish myself, the need to escape flashbacks, and to hurt myself like the voices are telling me to before "something worse" happens.

Assessment/ Intake:

Do present an affect of caring and understanding. A calm presence is effective. Allow me to remain clothed. I may feel safer and oriented prior to hospitalization in the emergency room. Offer me less restrictive alternatives than involuntary hospitalization.

Do not present as angry or judgmental. Do not ask, coerce, or force me to undress. Forcing me to undress directly replicates childhood sexual abuse I survived, the effects of which I am receiving treatment for at this facility.

Do not talk about me with other staff in front of me as if I'm not there because that behavior is dehumanizing to me and makes me feel invisible.

Location:

I prefer to go to____________Hospital in ___________, M.A., or to_________ in___________, M.A. as a last resort. I do not want to go to___________ or ___________ because I had bad experiences at these in-patient psychiatric units.

Sample of a Health Care Proxy (Continued, page 2 of 2)

Visitors:

I want to able to visit with my husband, ___________, my children ___________, ______________, and _____________. I also want to be able to visit with my therapist, __________ and my residential support staff. Enclosed are release forms for residential support agency.

Medication:

Do not prescribe Thorazine or Trilafon. In the past, Thorazine produced profound sluggishness (dose info not available) and abnormal tongue and jaw movements. Trilafon produced shakiness (which impaired my ability to write), dizziness, and blurred vision severe enough to impair my ability to read. I.M. doses should not be given if my pants would have to be pulled down or removed to administer the dose.

Electro-convulsive therapy (ECT):

ECT is not to be done under any circumstances. My proxy (if applicable) cannot authorize ECT. My previous courses of ECT have caused what appears to be permanent loss of precious memories, doing very little to alleviate symptoms of depression.

Seclusion:

I prefer seclusion to restraints. Being with lots of people when I'm experiencing voices and flashbacks can be overwhelming. However, if I'm in restraints in seclusion, staff assigned to me should be available to talk with me because talking can help me calm down and feel safer. Staff should not remain silent or refuse to talk with me.

Restraints:

Do not put me in three, four, or five point restraints. I was tied down at both wrists and ankles as part of the childhood sexual abuse I survived, the effects of which I am receiving treatment for at this facility. 3, 4, and 5 point restraints directly replicate this abuse, causing me to feel extreme helplessness and terror, not security. Bruises from being roughly restrained by staff also replicated sexual violence I experienced as a child.

Preferences to mechanical restraint are: one-on-one contact with staff with whom I have developed a relationship, time-out/ quiet room /seclusion with staff, non-violent physical holding (no gender preference), and chemical restraint.

Length-of stay:

The shorter, the better. In the past, long hospital stays cause me to feel despair, hopelessness, and potentiate suicidality and "delusional" thinking.

I don't mind being approached about consent to participate in informal/formal experimental studies while hospitalized.

I, ______________________, being at least 18 years old and of sound mind and body, attest that no coercion has been used to sign this instruction directive, and that this document should instruct health care providers as to the best, and least harmful care for my condition should I be deemed 'incompetent" to make treatment decisions or be unable to communicate my wishes. I understand the consequences for the treatment decisions I am making.

Signed: ___________________________________ Date:______________

Witness: __________________________________ Date:______________

Witness 2 (optional): _______________________ Date:______________

Business Card

Many individuals have a difficult time articulating the above information at times of crises. Therefore, business cards carried in a wallet, pocket or bag can be very helpful to alert emergency room and ambulance personnel, crisis teams, police, and others as to the presence and location of health care proxies, advance directives, and treatment plans developed in advance. In order for this to work, the trauma assessment, de-escalation form, treatment plan, and health care proxy should be on file in at least two places that can be accessed in times of crisis.

____________________________(Name) has a Health Care Proxy on file. In an emergency please contact: _______________(Agency/ Other Name) __________________________(Address) _________________________(phone #1) _________________________(phone #2)	____________________________(Name) has a Health Care Proxy on file. In an emergency please contact: _______________(Agency/ Other Name) __________________________(Address) _________________________(phone #1) _________________________(phone #2)
____________________________(Name) has a Health Care Proxy on file. In an emergency please contact: _______________(Agency/ Other Name) __________________________(Address) _________________________(phone #1) _________________________(phone #2)	____________________________(Name) has a Health Care Proxy on file. In an emergency please contact: _______________(Agency/ Other Name) __________________________(Address) _________________________(phone #1) _________________________(phone #2)
____________________________(Name) has a Health Care Proxy on file. In an emergency please contact: _______________(Agency/ Other Name) __________________________(Address) _________________________(phone #1) _________________________(phone #2)	____________________________(Name) has a Health Care Proxy on file. In an emergency please contact: _______________(Agency/ Other Name) __________________________(Address) _________________________(phone #1) _________________________(phone #2)

About the DVD

This DVD is designed to be used by a facilitator in conjunction with the booklet "Safe and Appropriate Behavioral Interventions: Changing the Culture of Care." It contains the contents of the booklet in PDF files (readable by using the program Adobe Reader). It also has video clips of each scenario described in the booklet, filmed up to the point of intervention by professional staff. The descriptions in the booklet include additional facts that are not portrayed in the video, as well as teaching questions and analysis for use by the facilitator. Thus, the video clips on their own are not designed to provide a complete learning experience.

Some of the individuals in the video clips were members of the Voices Against Violence program, a student acting group at The University of Texas at Austin directed by Geeta Cowlagi. The student actors were Celina Aguilar, Ashley Chytil, Melissa A. Haney, Tanya Robertson, Sean A. Tate, and Marianne Kay Wakehouse. Additional child actors were Erica Paige and Logan Ryan Skloss. Susan Colegrove, Ph.D., provided clinical consultation during the filming process. Many thanks to all!

System requirements: Windows Media® Player, Microsoft® Word 2000, Adobe® Reader®, 256M RAM, and minimum Pentium® 4 computer.
For freedownload of Windows Media® Player, go to: www.microsoft.com/windows/windowsmedia
For freedownload of Adobe® Reader®, go to: www.adobe.com/products/acrobat/readstep2.html

History of the Robert Lee Sutherland Seminars

The Robert Lee Sutherland Seminars began in 1978 as a living tribute to the academic, philanthropic, and mental health contributions of Dr. Robert Lee Sutherland, the Hogg Foundation for Mental Health's director from 1940 to 1970. During his tenure, Dr. Sutherland brought together people and ideas in the pursuit of innovation and cooperation for mental health initiatives in Texas.

With a small staff and an annual budget of $20,000, the Hogg Foundation set out to educate the people of Texas about the little-known concept of "mental hygiene" primarily through two activities, which remain at the Foundation's core today: communication and convening. Together with other experts, Dr. Sutherland traveled the state, promoting the positive, preventive, and therapeutic aspects of mental hygiene.

In the past, the Robert Lee Sutherland Seminars have focused upon critical issues in mental health including the needs of juveniles within the criminal justice system, mental health challenges along the Texas-Mexico border, and concerns facing mental health philanthropy in Texas.

About the Hogg Foundation for Mental Health

Since 1940, the Hogg Foundation for Mental Health has responded to its mandate "to develop and conduct. . .a broad mental health program of great benefit to the people of Texas" (Miss Ima Hogg, 1939) by funding grants for mental health service programs, research efforts, policy initiatives, and public education projects throughout the state.

The Foundation is an administrative unit of The University of Texas at Austin and accomplishes its mandate through programs and grantmaking in strategic priority areas.

For more information about the Hogg Foundation and its programs, please visit the Foundation's web site at www.hogg.utexas.edu.

Hogg Foundation for Mental Health

SERVICES, RESEARCH, POLICY & EDUCATION

THE UNIVERSITY OF TEXAS AT AUSTIN

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