MODULE 3

Creating Cultural Change

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Creating Cultural Change

"The hospital's culture dictates whether, in what circumstances, and how often seclusion and restraint interventions are used."
—Ira Burnim, Bazelon Center for Mental Health Law
*(*Networks*, Summer 1999)*

"It's not possible to solve a problem with the same consciousness that created it."
—Albert Einstein

Learning Objectives

Upon completion of this module the participant will be able to:

- Understand seclusion and restraint from a primary, secondary, and tertiary public health prevention model.
- Identify key components of successful programs that are eliminating seclusion and restraint.
- Outline the key elements of cultural change, including intrapersonal change, interpersonal change, and system change.
- Define safety from both a service recipient perspective and service provider perspective.
- Describe what consumers say would be helpful in preventing the use of seclusion and restraint.

MODULE 3: CREATING CULTURAL CHANGE

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BACKGROUND

BACKGROUND FOR THE FACILITATORS: CREATING CULTURAL CHANGE

Overview

"Seclusion and restraint are not treatment; they reflect treatment failure." —Charles Curie, former Pennsylvania Deputy Secretary for Mental Health and Substance Abuse (Pennsylvania Department of Public Welfare, 2001)

Changing the culture of violence and coercion in mental health settings is crucial to the elimination of seclusion and restraint. A working definition of cultural change is

- Lasting structural and social changes (within an organization or set of linked organizations), PLUS
- Lasting changes to the shared ways of thinking, beliefs, values, procedures, and relationships of the stakeholders (Allison Scammel, 1997)

An organization's culture is determined by its policies and rules, both written and unwritten, and by the acceptance of these policies and rules by key stakeholders. Cultural change often requires a re-examination not only of the organization's policies and rules, but of values, beliefs, and the relationships between all stakeholders (administrators, direct care staff, and consumers). This re-examination is often difficult because of the long-standing stigma and discrimination associated with mental illness.

The National Association of State Mental Health Program Directors (NASMHPD) has issued a report on the issue of the use of seclusion and restraint. It states in part, "this issue is about how mental health systems treat the people they serve. If the goals of the public mental health system are to treat people with dignity, respect, and mutuality, to protect people's rights, to provide the best quality care possible, and to assist people in their recovery, any use of seclusion and restraint must be rigorously scrutinized...In addition, using power to control people's behavior or to resolve arguments can lead to escalation of conflict and can ultimately result in serious injury or even death." (NASMHPD, 1999)

Rodney Copeland, former Vermont Commissioner, also has expressed strong views on the need for cultural change within the mental health system. According to Copeland, "Recent national exposés revealed alarming numbers of youth and adults with emotional disorders, mental illnesses, and/or developmental disabilities dying as a result of seclusion and restraint in treatment programs…I believe a major part of the answer lies in the overemphasis, even dependency, in our treatment and rehabilitation practices on power, control, paternalism, and ultimately coercion. Put another way, the mental health and developmental disabilities fields have not clearly offered alternative practices to old styles of control, which can often lead to significant levels of coercion. Deliberate examination of coercive practices viewed through

the lenses of consumers in addition to scientific and clinical knowledge can assist us in the shift away from coercion to positive practices. Consumer stories of experiencing coercion are very powerful. One only has to listen briefly to hear the pervasive chilling and, in reality, killing effect coercion has on the human spirit. None of us like coercion in any of its forms applied to us. All coercion, regardless of its forms, damages and hurts." (Copeland, 1999-2000, Fall-Winter)

Will Pflueger, a consumer from Minnesota, sums it up perfectly. "The terror of confinement, the pain of restraint and the wound to my soul made me want to stay as far away from the mental health system as possible."

Ideas for Eliminating Coercion
(Source: *Vermont's Vision of a Public System for Developmental and Mental Health Services Without Coercion* by Rodney E. Copeland, Ph.D., Commissioner, Vermont Department of Developmental and Mental Health Services, Fall/Winter 1999-2000)

- It is important that consumers have control over their own treatment and recovery.
- Educate providers and hospitals on the importance of the "partnership concept" with consumers.
- Separate the issues around medications that "control behavior" versus the ones that "make people feel better."
- One size does not fit all—there are unique paths to recovery.
- Make full use of self-determination principles that allow citizens to take control of their system of care and support.
- Make better use of each consumer's knowledge of himself or herself.
- Make full use of informal alternatives, natural supports, and family/consumer-run supports.
- Emphasize prevention and public health approaches.
- Adults with severe mental illness and developmental disabilities could benefit from a prevention approach.
- Encourage ambitious public involvement and education for the community at large regarding natural supports.
- Develop informal and, if necessary, formal systems to engage early on with citizens who have previously experienced very coercive situations in our formal systems of care. This early intervention and engagement would have the goal of preventing individuals from experiencing the formal system as they had in the past.
- Once involved with the formal system, have more choice and chance to do the consumer's own work toward recovery.
- Positively address the culture of agencies regarding professional control.
- Develop grievance procedures that have a strong procedural justice base.
- Encourage the employment of consumers at all levels, including involuntary care settings.
- Have the option of peer support and self-advocacy support coming into the formal system.

- Train staff on the importance and value of communication skills and recovery.
- Encourage self-advocates to articulate clearly where and when paternalism and control take place.
- Find examples in agencies where best practices are being followed and actively disseminate those findings to others.
- Follow the strengths-based approach with children and give children a real voice in individualized plans.

Pennsylvania: A Model for Reform

(Source: www.power2u.org/downloads/Pennsylvania_S&R_Initiative.pdf)

In 1997, the Pennsylvania Department of Public Welfare instituted an aggressive program to reduce and ultimately eliminate seclusion and restraints in its nine State hospitals. Charles Curie, former Deputy Secretary of Mental Health and Substance Abuse Services, articulated the philosophy behind the change in policy: "Most of our patients are already the victims of trauma. There is no need to reinforce that trauma, or to retraumatize." Three years later, Pennsylvania had reduced incidents of seclusion and restraint in its nine State hospitals by 74 percent, and reduced the number of hours consumers spent in seclusion and restraints by 96 percent. Its program, which includes both forensic and civil commitments, has the highest standards for seclusion and restraint in the Nation.

Pennsylvania's hospitals experienced no increase in staff injuries. In addition, its changes were implemented without any additional funds, using only existing staff and resources. Charles Curie noted that preliminary data indicates that the number of both consumer and staff injuries has decreased.

By July 2000, Pennsylvania reported that one State mental hospital had not used seclusion for over 20 months. Another had used neither seclusion nor restraints for 8 of the previous 12 months. Three hospitals had been seclusion and restraint free for one or more consecutive months and others were approaching zero use. In October 2000, Pennsylvania's Seclusion and Restraint Reduction Initiative received the prestigious Harvard University Innovations in American Government Award.

Pennsylvania began its reform project by carefully tracking the use of seclusion and restraint, and then used that 1997 data as its baseline to measure improvements. A workgroup of practicing hospital clinicians set about developing new policies and procedures, goals, strategies, and monitoring systems to design and implement the new approach. Key among these goals was developing a new philosophy of care, one that identified seclusion and restraint as treatment failure and restricted it to emergency use only.

Mental health officials cite a number of innovations that were critical to the success of the program. Among them were the following:

- Computerized data collection and analysis
- Strategies for organizational change
- Staff training in crisis prevention and intervention
- Risk assessment and treatment planning tools
- Consumer debriefing methods
- Recovery-based treatment models
- Adequate number of staff

Also critical was changing the culture of State hospitals. Pennsylvania did this by requiring open public access to seclusion and restraint data, by creating competition among hospitals to reduce seclusion and restraint, and by giving awards and acknowledgments for improvement.

Key elements of Pennsylvania's seclusion and restraint reduction policy:

- Seclusion and restraints must be the intervention of last resort.
- Seclusion and restraint are exceptional and extreme practices for any consumer. They are not to be used as a substitute for treatment, nor as punishment, nor for the convenience of the staff.
- Seclusion and restraint are safety measures, not therapeutic techniques, which should be implemented in a careful manner.
- Staff shall include consumer strengths and cultural competence to prevent incidents of seclusion and restraint.
- Staff must work with the consumer to end seclusion and restraint as quickly as possible.
- A physician must order seclusion and restraint.
- Orders are limited to 1 hour and require a physician to physically assess the consumer within 30 minutes.
- The consumer and family are considered part of the treatment team.
- The consumer advocate is the spokesperson for the consumer (if the consumer desires it) and is involved in care and treatment.
- Consumers being restrained cannot be left alone.
- Chemical restraints are prohibited.
- The treatment plan includes specific interventions to avoid seclusion and restraint.
- Consumers and staff must be debriefed after every incident, and treatment plans must be revised.
- Staff must be trained in de-escalation techniques.
- Consumer status must be reviewed prior to utilizing seclusion and restraint. Voluntary patients who did not agree to these procedures must be involuntarily committed before these procedures may be initiated.

- Leaders of the hospital, clinical department heads, and ward leaders are accountable at all times for every phase of a seclusion and restraint procedure. Accountability is demonstrated as a component of the hospital's "performance improvement" index and in staff competency evaluations.
- Data regarding the use of seclusion and restraint are made available to consumer and family organizations and government officials.

For more information, please contact:

Office of Mental Health and Substance Abuse Services
Bureau of Hospital Operations
Beechmont Building, First Floor
Harrisburg, PA 17110
(717) 705-8152

Cultural Change

In order for sustainable cultural change to occur around the issue of seclusion and restraint, all of the stakeholders must be present at the table for the discussion. No component or subset of a system IS the system…the parts interact to give it life. No one is blaming anyone for how things have been. Consumers and staff are hoping to create new ways of being together, which requires both consumers and staff to change how they interact with each other. This manual approaches cultural change from three levels: intrapersonal, interpersonal, and system change. Intrapersonal change occurs within the individual mind or self and is reinforced by the Personal Take Action Challenges. Interpersonal change involves relationships between persons, e.g., consumers and staff. System change focuses on structural changes by addressing issues of policy, of local, State, and Federal legislation, and by implementing Workplace Take Action Challenges.

In Our Own Voices

In December 2000, the National Association of Consumer/Survivor Mental Health Administrators (NAC/SMHA) developed and sent out a survey to people diagnosed with mental illnesses to better understand the experience of people who had been secluded and/or restrained. The results from the survey laid the groundwork for this training manual. People diagnosed with mental illnesses were asked to respond to four questions.

1. Have you ever been in seclusion or restraints?
2. What would have been helpful in preventing the use of seclusion or restraints for you?
3. Some people suggest that “talking to them” helps. What would you have wanted to hear?
4. What other options may have been beneficial?

Seventy-two percent of those responding reported being secluded or restrained. Here are a few of the responses, some of which are heart wrenching. "I think…putting a patient in restraints makes them feel like an animal or trapped bear in a trap."

What would have been helpful in preventing the use of seclusion or restraints for you? "I don't know what caused me being put in seclusion. I have asked for 26 years because I NEVER want to cause that again." What would have been helpful? "Not being processed like cattle." What would you have wanted to hear? "What was happening to me would end soon. It would not last forever—hope—some explaining what was happening would be helpful." What other options may have been beneficial? "To be able to cry, chemical restraints often prevent this." "Have someone sit with me for a while."

The results from the survey may elicit a wide array of strong responses from staff members. Be sure to allow plenty of time for processing all feelings—including defensiveness, anger, sadness, and guilt. Remember, putting people diagnosed with mental illnesses in seclusion or restraints is traumatic for the staff as well. This section provides an opportunity for staff to hear the consumer's perspective and process their own trauma around seclusion and restraint.

PRESENTATION

PRESENTATION

Welcome participants, review names, and make sure everyone has a nametag or name tent. It may be helpful to provide a quick review of Module 2: Understanding the Impact of Trauma.

Ask each participant to share one of the Take Action Challenges from Module 2 and report on their progress.

Go over the learning objectives.

Learning Objectives

Upon completion of this module the participant will be able to :

- Understand seclusion and restraint from a primary, secondary, and tertiary public health prevention model
- Identify key components of successful programs that are eliminating seclusion and restraint
- Outline the key elements of cultural change, including intrapersonal change, interpersonal change, and system change
- Define safety from both a service recipient perspective and service provider perspective
- Describe what consumers say would be helpful in preventing the use of seclusion and restraint

PRESENTATION

Exercise/Discussion—Module 3

"Flowers Are Red"

OBJECTIVE: Identify how behaviors in a culture become established.

PROCESS: Distribute the handout "Flowers are Red." Give the participants time to read the poem. Facilitate a discussion.

DISCUSSION QUESTIONS: Think about what it might take to change this little boy's image of flowers at this point in his life.

- What would he have to change?
- How would the system have to change?
- What would the teacher have to understand to help the little boy?

MATERIALS REQUIRED: "Flowers Are Red" handout

APPROXIMATE TIME REQUIRED: 10 minutes

PRESENTATION

Overview

- If the goals of the public mental health system are to treat people with dignity, respect, and mutuality, to protect people's rights, to provide the best quality care possible, and to assist people in their recovery, any use of seclusion and restraint must be rigorously scrutinized (NASMHPD, 1999).
- Historically, seclusion and restraint techniques have been a part of inpatient psychiatric care since the Middle Ages and are ingrained in the habits, organization, and culture of mental health facilities (Pennsylvania Department of Public Welfare, 2001).

A working definition of cultural change

- Lasting structural and social changes (within an organization or set of linked organizations), PLUS
- Lasting changes to the shared ways of thinking, beliefs, values, procedures, and relationships of the stakeholders

Treatment of Consumers

In a fundamental way, the issue of seclusion and restraint is about how mental health systems treat the people they serve. (National Association of State Mental Health Program Directors)

- Any intervention that recreates aspects of previous traumatic experiences or that uses

PRESENTATION

power to punish or is harmful to the individual involved is unacceptable.

Seclusion and Restraint are not evidence-based practices

- The research on the use of seclusion and restraint with children or adults provides evidence that the experience may actually cause additional trauma and harm (Finke, 2001).
- There is no research to support a theoretical foundation for the use of seclusion with children (Finke, 2001).
- 30 years of evidence demonstrates that seclusion does not add to therapeutic goals and is in fact a method to control the environment instead of a therapeutic intervention (Finke, 2001).
- "Seclusion and restraint are persistent national issues, even though we have known with certainty since the 1960s that their use is harmful, indeed life threatening at times." Rodney Copeland – former Vermont Commissioner

Seclusion and Restraint are not evidence-based practices – pg 2

- Most episodes of seclusion and restraint occur within the first few days after admission, and the majority of incidents occur with a very small number of individuals (NASMHPD).
- Our goal is to improve the system, rather than placing blame on any one group for how it currently exists.
- Using a Public Health Model of Prevention may be helpful for thinking about eliminating the use of seclusion and restraint.

PRESENTATION

A Public Health Model that eliminates the use of seclusion and restraint would support:

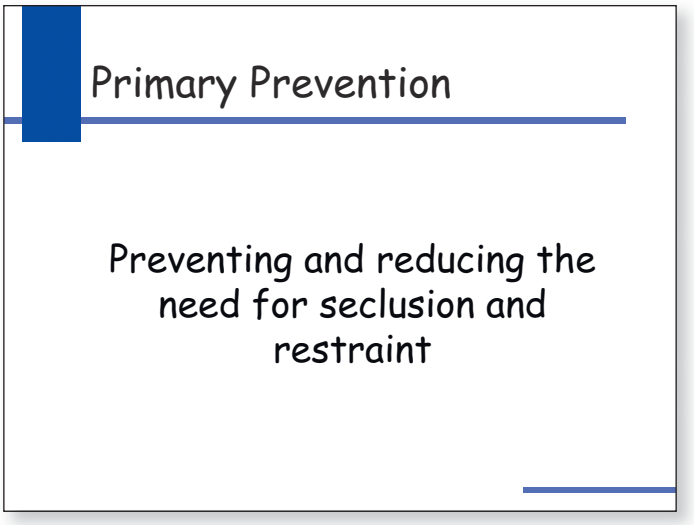
1. The selection and use of the least possible restriction consistent with the purpose of the intervention
2. Establishing a culture that minimizes the occurrence of events that might lead to the use of seclusion and restraint
3. A culture that emphasizes the importance of valuing what consumers say about what contributes to a safe environment
4. Identifying and resolving conflicts early, before they escalate

A Public Health Model that eliminates the use of seclusion and restraint would support:

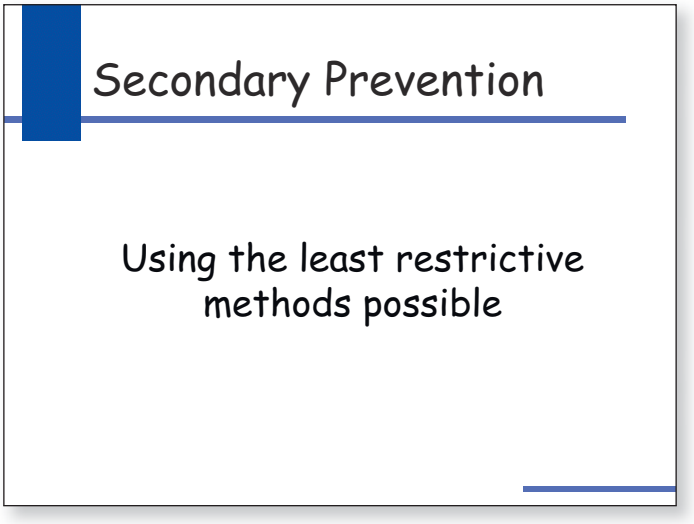
5. Training in techniques of early intervention for all staff
6. Policies and procedures that only allow safe use of seclusion and restraint on those rare occasions when it is required to maintain safety
7. Staff and consumers being fully debriefed after any use of seclusion and restraint and the information obtained would be used to prevent further episodes

- Depending on the context in which a particular tool is used, it may fit into more than one category. For example, a Wellness Recovery Action Plan (WRAP) could be used as primary, secondary, or tertiary prevention.

PRESENTATION

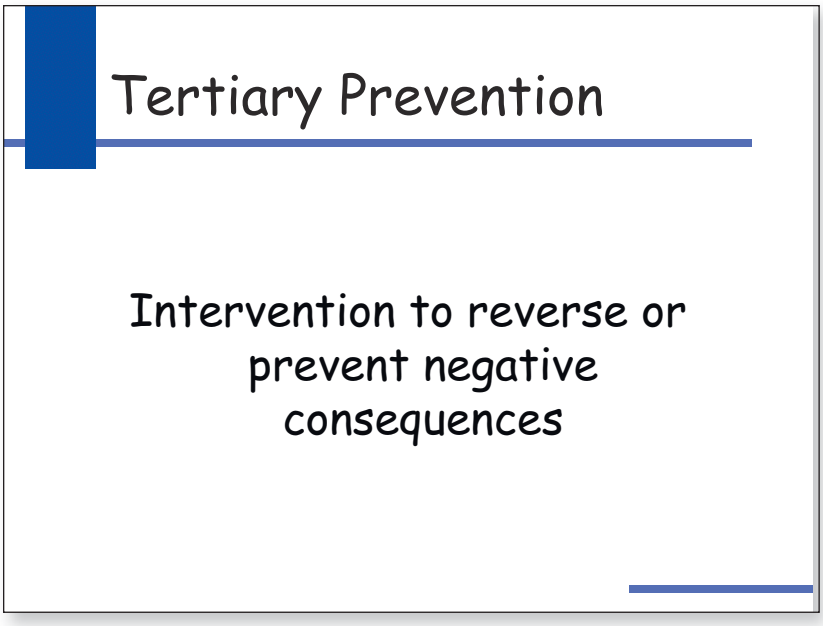


- In the context of seclusion and restraint, primary prevention would include consumer empowerment, utilizing resiliency and strengths-based models, changing physical environments, an organizational philosophy that articulates nonviolence in policy, procedures, and practice, etc.



- In the context of seclusion and restraint, secondary prevention would include use of a comfort room, a consumer referring to their WRAP, de-escalation techniques, consumer support groups, etc.

PRESENTATION



- In the context of seclusion and restraint, tertiary prevention would include exploring the precipitating factors that caused the seclusion or restraint, facilitating a debriefing session with changes to the treatment plan, using only face up restraints if they are necessary at all, and never leaving a consumer alone while she/he is in seclusion or restraint, etc.

Pennsylvania: A Model for Reform

For this segment, you may wish to use the videotape Leading the Way: Toward a Seclusion and Restraint Free Environment *by the Pennsylvania Office of Mental Health and Substance Abuse. It is 17.5 minutes long. To obtain this video, please contact Robert Davis, M.D. at robedavis@state.pa.us or at Department of Public Welfare, Commonwealth of Pennsylvania, 502 Health and Welfare Building, Harrisburg, PA 17105.*

The information for this segment was obtained from Pennsylvania's Web site, www.dpw.state.pa.us. It is also available in *Leading the Way Toward a Seclusion and Restraint Free Environment: Pennsylvania's Success Story* by Bonnie Hardenstine, Director of Performance Improvement and Forensic Services, Bureau of Hospital Operations, Office of Mental Health and Substance Abuse Services, Department of Public Welfare, Commonwealth of Pennsylvania, 2001.

PRESENTATION

Pennsylvania Model

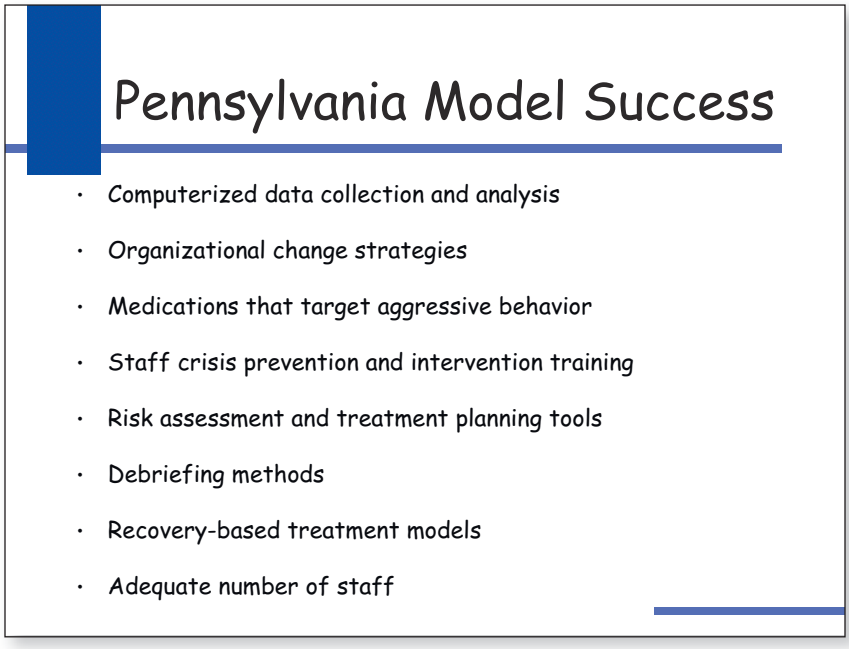
1997 – Pennsylvania Department of Public Welfare's Office of Mental Health and Substance Abuse Services (OMHSAS) announced that all nine State mental hospitals would actively pursue the elimination of seclusion and restraint.

Treatment Failure

Seclusion and restraint reflects treatment failure

PRESENTATION

- Stressing that seclusion and restraint techniques reflect treatment failure, the Office of Mental Health and Substance Abuse Services (OMHSAS) first tracked the use of these methods throughout the State mental hospital system. With data in hand, a workgroup composed of practicing hospital clinicians developed a new policy that limited seclusion and restraint use to emergency situations only.
- The Pennsylvania model policy established clear goals, policies, strategies, and monitoring systems to reduce the use of these dangerous and restrictive measures.



- Essential to the initiative's success were computerized data collection and analysis, organizational change strategies, medications that target aggressive behavior, staff crisis prevention and intervention training programs, risk assessment and treatment planning tools, consumer debriefing methods, recovery-based treatment models, and an adequate number of trained staff.
- Today, Pennsylvania has a seclusion and restraint policy that exceeds all national standards. The policy enhanced physician involvement and accountability, increased consumer safety, and limited use of seclusion and restraint to use as a last resort in situations involving imminent serious harm. The policy includes the following requirements:

PRESENTATION

Pennsylvania Model Policy

- A physician must order seclusion or restraint.
- Orders are limited to one hour and require a physician to physically assess the consumer within 30 minutes.
- Consumers being restrained cannot be left alone.
- Chemical restraints are prohibited.
- Consumers and staff must be debriefed after every incident, and treatment plans must be revised.
- Data regarding use of seclusion and restraint are made available to consumer and family organizations and government officials.

Staff Involvement

Staff members encourage consumers to creatively resolve or avoid factors that cause or escalate aggressive and self-injurious behavior

- Staff members are encouraged to pay close attention to the factors that cause or escalate aggressive and self-injurious behavior. They encourage consumers to creatively resolve or avoid these factors and to develop alternative coping strategies that reinforce consumer dignity and self-control and foster recovery and successful community reintegration.

PRESENTATION

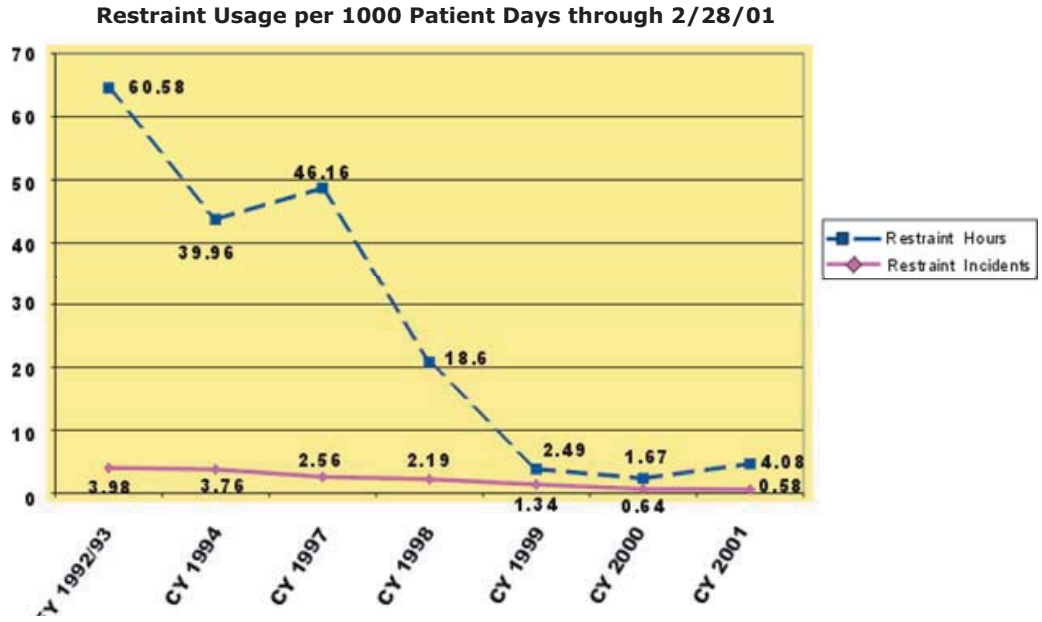
Cost Effective

Entire initiative used current staff and had no increased costs associated with it

- Pennsylvania's reduction initiative relied solely on existing staff and resources—without increased cost to taxpayers.

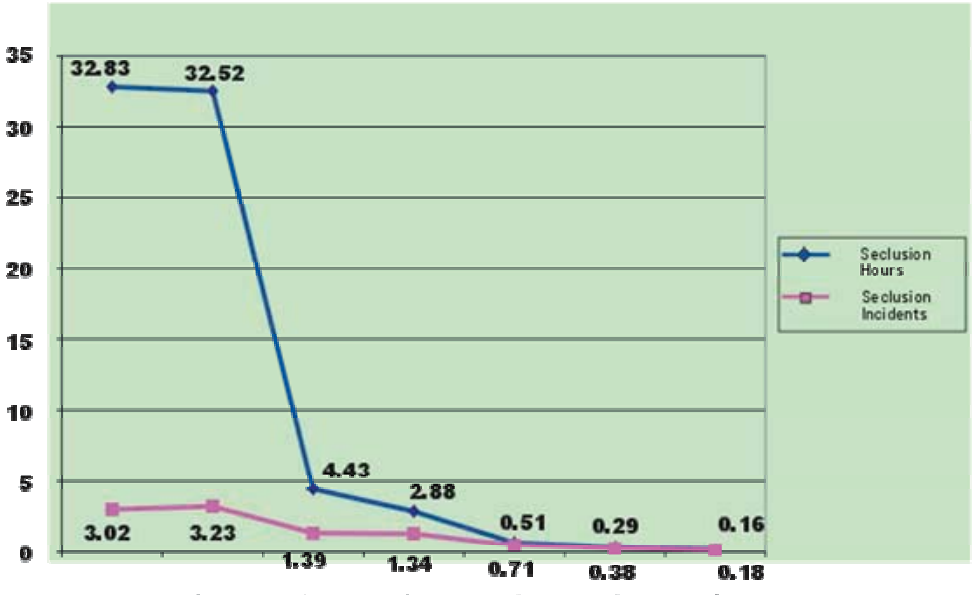
Outcomes of the Pennsylvania Model

- Since 1997, the combined incidents of seclusion and restraint were reduced by 90 percent, and the hours of use fell by 95 percent. (See PowerPoint charts below.) By July 2000, one State mental hospital had not used seclusion for over 20 months.



PRESENTATION

Seclusion Usage per 1000 Patient Days to 2/28/01



- This proactive initiative has fostered healthy competition among State hospitals to aggressively continue further reduction of seclusion and restraint use.
- "The rate of work-related injuries is higher in mental health than in the construction industry, and more staff injuries occur during the implementation of seclusion and restraint than occur from unexpected assaults" (NASMHPD, 1999).

PRESENTATION

Decreased Staff Injuries

DECREASED STAFF INJURIES!

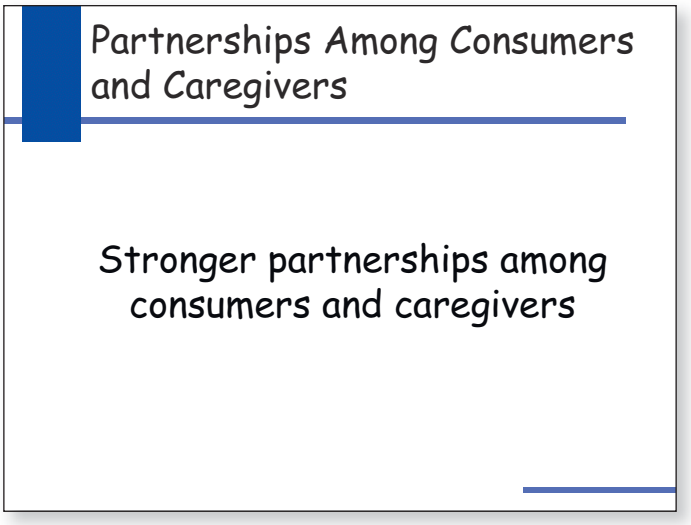
- The new policy has not put staff at greater risk. In fact, injury rates due to consumer assaults decreased with seclusion and restraint reduction.
- The initiative has produced a cultural change conducive to expedited consumer recovery, hospital discharge, and community reintegration. Seclusion and restraint are no longer considered the acceptable response to aggressive or self-injurious consumer behavior.

Cultural Change and Consumer Recovery

Cultural changes created quicker consumer recovery, hospital discharges, and community reintegration.

- Since the policy actively involves consumers in their overall treatment, it has encouraged much stronger partnerships among consumers and caregivers.

PRESENTATION



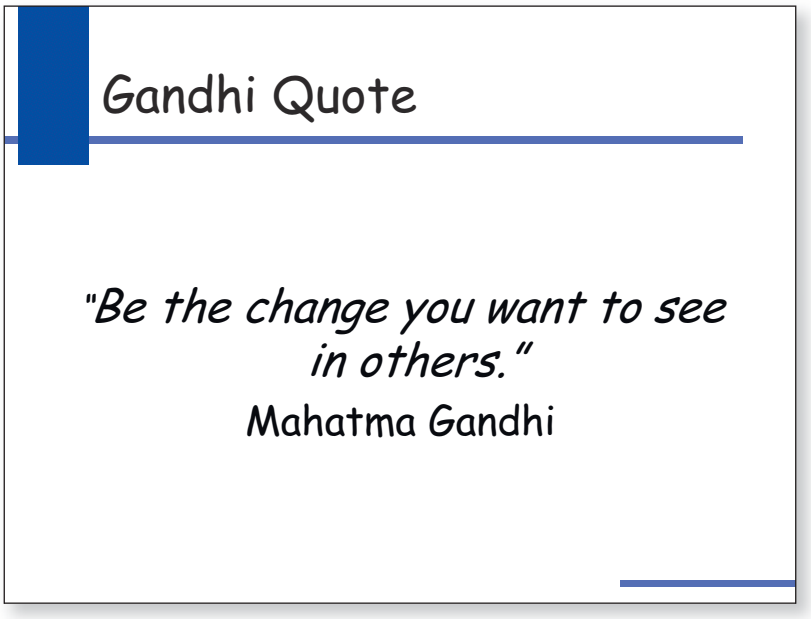
Cultural Change

- No component or subset of a system IS the system…the parts interact to give it life. No one is blaming anyone for how things have been. Consumers and staff are hoping to create new ways of being together, which requires both consumers and staff to change how they interact with each other.
- Thinking about systems is important to understand the context of the whole.
- To understand the system completely, all voices, including consumers, family members, facility management, and direct care staff need to be present
- The challenge before all of us is how to create sustainable cultural changes in the mental health system.
- Francis Meehan (1982) outlined a social justice movement model that identifies three levels of change that we will use as a framework for thinking about overall systems change.

PRESENTATION

Intrapersonal Change

- Webster's Dictionary defines this type of change as "occurring within the individual mind or self."
- This training focuses on intrapersonal change by asking you to respond in your journal so that you become even more aware of your attitudes, gifts, and blind spots.
- The following quote from Gandhi illustrates intrapersonal change.



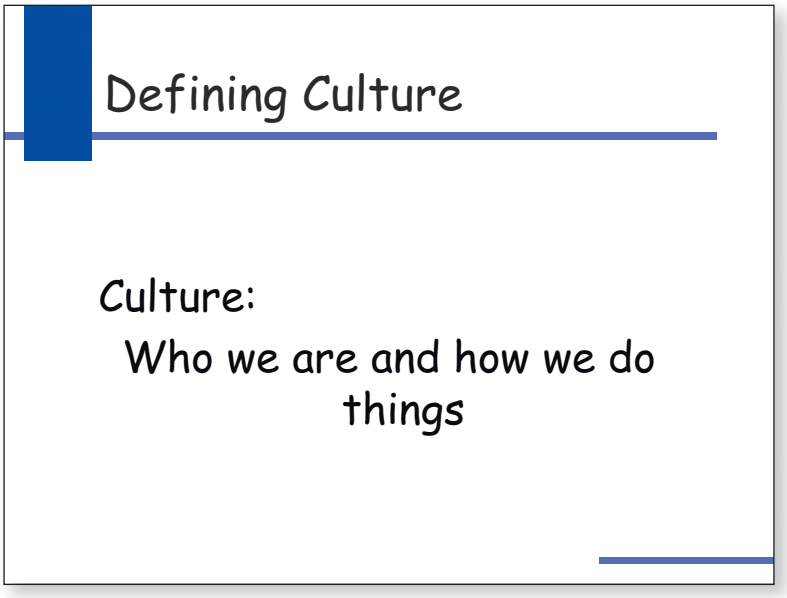
Interpersonal Change

- Webster's Dictionary defines this type of change as "involving relationships between persons."
- This training focuses on interpersonal change by offering you many opportunities to build bridges between consumers and staff, change your day-to-day work practices, and implement your Take Action Challenges.

PRESENTATION

Systems/Cultural Change

- Webster's Dictionary defines this type of change as "something arranged in a definite pattern of organization."
- This training focuses on how to make structural/system changes by addressing issues of policy; addressing local, State, and Federal legislation; and implementing Workplace Take Action Challenges.
- The primary interest is in making cultural changes that are sustainable and are adopted at every level in the institution.



PRESENTATION

Cultural Building Blocks

- Norms
- Climate
- Organizational Support
- Values

- Norms—expected and accepted behavior for both staff and consumers.
- Climate—includes a sense of community, shared vision, and positive outlook. These social atmosphere factors enable constructive individual and collective change.
- Organizational support—the system of informal and formal structures, policies, and procedures that maintain the culture.
- Values—heartfelt beliefs about the appropriate way to approach mental health issues.
- To create a change in culture, it is necessary to first identify the limiting beliefs that are holding the group back. Then identify some more positive and enhancing beliefs and start building and reinforcing those.
- The following exercise will assist in identifying underlying beliefs.
  - Let's first start with a picture of where your organization is right now—before proposing any changes.
  - Remember, all organizations have things they do well and things they could improve on.

PRESENTATION

Exercise/Discussion—Module 3

"My Organizational Culture Currently Is..."

OBJECTIVE: Participants will identify current ecology, relationships, and leadership in their organization.

PROCESS: Divide the class into groups of six. Assign one group ecology, one group relationships, and one group leadership. If there are more than three groups, two groups can work separately on the same topic. All administrators need to have their own group so others can share freely. Ask them to do an evaluation (positive and negative) of how their organization currently functions around these issues as it relates to the reduction of seclusion and restraint. Have each group report back their findings. The groups may want to write key points on the board or on a flip chart.

Ecology
- Physical surroundings
- Formal policies and rules
- Resources
- The unit culture
- Attitudes
- Cultural norms

Relationships
- Direct care staff peer relationships
- Direct care staff to administration relationships
- Direct care staff to consumer relationships
- Administrative staff to consumer relationships

Leadership
- Inspire others to see their own potential
- Foster relationship building among all
- Challenge process, not people
- Teach "there could be a better way" attitude
- Remove barriers to possibility thinking
- Be a learning organization

Page 1 of 2

PRESENTATION

Exercise/Discussion—Module 3

"My Organizational Culture Currently Is…" (continued)

DISCUSSION QUESTIONS:

- Which of the three areas—ecology, relationships, and leadership—is most likely to support the reduction of seclusion and restraint at your facility?
- Which of the three areas might struggle with these changes and why?
- What works well and what is a problem related to seclusion and restraint?

MATERIALS REQUIRED:

"My Organizational Culture Currently Is…" handout
Chalk board or flip chart

APPROXIMATE TIME REQUIRED: 30 minutes

PRESENTATION

Exercise/Discussion—Module 3

"People With a Mental Health Diagnosis Are..."

OBJECTIVE: To recognize the biases and stereotypes that impact work with consumers.

PROCESS: Divide the group into pairs. In each pair, assign one person to be A and one person to be B. Person A will simply listen to B and after each response say "thank you." Person B will say "People with a mental health diagnosis are _____" and fill in the blank. This sentence is repeated over and over. If B cannot think of anything to say, B can say the word "blank" and start over with the sentence. After a few minutes, have A and B switch roles. Facilitate a discussion.

DISCUSSION QUESTIONS:

- What were the common themes?
- How do you think these biases and stereotypes impact working with consumers?
- What was difficult about this exercise and why?

MATERIALS REQUIRED: None

APPROXIMATE TIME REQUIRED: 15 minutes

PRESENTATION

In Our Own Voices

- To end this session, we want to share with you responses from consumers regarding seclusion and restraint.
- The National Association of Consumer/Survivor Mental Health Administrators developed a survey to better understand the experience of seclusion and restraint.
- The survey was a paper and pencil mail questionnaire that asked four questions.

Survey Questions

1. Have you ever been in seclusion or restraints?
2. What would have been helpful in preventing the use of seclusion or restraints for you?
3. Some people suggest that "talking to them" helps. What would you have wanted to hear?
4. What other options may be have been beneficial?

- Seventy-two percent of people diagnosed with a mental illness who responded stated they had experienced seclusion or restraint.

Distribute handout on "What would have been helpful in preventing the use of seclusion or restraints for you?" and discuss.

- The second question asked on the NAC/SMHA survey was "What would have been helpful for you to hear?"
- The following exercise will illustrate the consumer responses of what they would have liked to have heard during a stressful time.

PRESENTATION

Exercise/Discussion—Module 3

What Would Have Been Helpful to Hear

OBJECTIVE: Identify words and phrases that consumers would like to hear during stressful times.

PROCESS: Before this module, prepare a 3x5 note card for each of the following quotes from consumers:

- Let's sit down and talk about the problem.
- It's your choice to discuss, I only have to restrain if you start hurting someone.
- You are going to be OK.
- We are here to help you.
- Can we call someone for you?
- That someone was not going to hurt me
- Something gentle and kind
- I'm here to listen, I'm here for you.
- It will get better.
- This will pass.
- I won't leave you.
- What I wanted to hear was that I can get better
- I would have wanted to hear I would soon feel calmer.
- How can we help?
- Your parents are coming.
- You are all right, but your behavior is inappropriate.
- I'm a person too and allowed to make mistakes
- All feelings are normal.
- I'm here to listen, I'm here with you.
- That I was OK, that I was safe
- Description of where I was and what was going on
- Do you want to talk about what you are feeling?
- Humor
- Could I get you something?
- Are you comfortable?
- I can see that you are hurting. Can we talk?

PRESENTATION

Exercise/Discussion—Module 3

What Would Have Been Helpful to Hear (continued)

- I'm not sure it's the exact words that are most important, but rather the tone of voice, body language, and the physical environment of the verbalization. The words need to be firm but kind, spoken by someone with whom the patient has had prior positive experiences. The words should include references to experiences and people that the staff has determined ahead of time will help the patient become grounded.

Have participants sit in a circle. Pass out cards to participants. Have participants read their cards to the group. Discuss what feelings this exercise raised.

DISCUSSION QUESTIONS:

- Which of these words/phrases do you currently use with consumers?
- What other words/phrases have you said that have been helpful?
- What are some things you have heard staff say that are not helpful?

MATERIALS REQUIRED:

3x5 note cards with quotes written on them
Optional—PowerPoint slide with the quotes given above
"What would have been helpful for you to hear?" handout

APPROXIMATE TIME REQUIRED: 15 minutes

PRESENTATION

As a group, review the handout "What other options may have been beneficial?"

What Other Options May Have Been Beneficial?

- Taking a walk
- Physical exercise
- Read my Wellness Recovery Action Plan (WRAP)
- To be able to cry; chemical restraints often prevent this
- Have someone sit with me for a while
- Sometimes just to be heard helps
- Take shower or bath
- Draw
- Being able to yell
- A homey setting – soft chairs, drapes, pictures

What Other Options May Have Been Beneficial?

- With permission, a hand on a hand, an arm around a shoulder – it is important to make contact EARLY on with someone about to "lose touch"
- Being allowed to have something of my own to comfort me
- Take time to review the file and ask questions
- Getting everyone's attention off of the misbehavior and onto what caused it to happen in the first place
- Talking to the doctor more about the medications
- A big overstuffed, vibrating, heated chair with a blanket, headphones, and gentle soft music

PRESENTATION

- One survey respondent wrote the following story:

"…my son was to be committed to the State hospital. When the sheriff came to take him, Mark said, "I'm not going." Instead of the sheriff putting restraints on Mark, he said, "Can I come in?" He sat down and talked to Mark for an hour. Mark finally said, "If I have to go, I'll go." He walked out to the car and rode in the front seat with the sheriff 250 miles to the closest State hospital. Talking, time, and patience does work."

HANDOUT

Flowers Are Red

The little boy went to the first day of school
He got some crayons and started to draw
He put colors all over the paper
For colors was what he saw
And the teacher said…what are you doing young man?
I'm paintin' flowers he said
She said…it's not the time for art young man
And anyway flowers are green and red
There's a time for everything young man
And a way it should be done
You've got to show concern for everyone else
For you're not the only one
And she said…flowers are red young man
Green leaves are green
There's no need to see flowers any other way
Than the way they always have been seen
But the little boy said…there are so many colors in the rainbow
So many colors in the mornin' sun
So many colors in a flower and I see every one
Well the teacher said… you're sassy
And you'll paint flowers the way they are
So repeat after me…
And she said…Flowers are red young man
Green leaves are green there's no need to see flowers any other way
Than the way they always have been seen
But the little boy said…
There are so many colors in the rainbow
So many colors in the morning sun
So many colors in a flower
And I see every one

Page 1 of 2

HANDOUT

Flowers Are Red (continued)

The teacher put him in a corner
She said…it's for your own good
And you won't come out
Til you get it right
And all responding like you should
Well finally he got lonely
Frightened thoughts filled his head
And he went up to the teacher
And this is what he said…and he said
Flowers are red, green leaves are green
There's no need to see flowers any other way
Than the way they always have been seen
Time went by like it always does and they moved to another town
And the little boy went to another school
And this is what he found
The teacher there was smilin'
She said…painting should be fun
And there are so many colors in a flower
So let's use every one
But that little boy painted flowers
In neat rows of green and red
And when the teachers asked him why
This is what he said…and he said
Flowers are red, green leaves are green
There's no need to see flowers any other way
Than the way they always have been seen

—Anonymous

Page 2 of 2

HANDOUT

My Organizational Culture Currently Is…

	Strengths	Gaps
Ecology Physical surroundings Formal policies and rules Resources Unit culture Attitudes Cultural norms		
Relationships Direct care staff peer relationships Direct care staff to administration relationships Direct care staff to consumer relationships Administrative staff to consumer relationships		
Leadership Inspire others to see their own potential Foster relationship building among all Challenge the process, not people Teach "there could be a better way" attitude Remove barriers to possibility thinking Be a learning organization		

HANDOUT

From NASMHPD's 1999 Report on Reducing the Use of Seclusion and Restraint

Factors Related to Reducing the Use of Seclusion and Restraint

- Employing a public health model that stresses prevention and early intervention.
- Sensitizing staff to the power differential that exists between themselves and the people they serve in order to prevent the misuse of power. Experiential training and training that involves service recipients can be particularly useful in this regard.
- Implementing individualized treatment plans that are mutually determined by service recipients and staff, and that effectively emphasize the individual recipient's assessment of what works and what doesn't.
- Using clearly defined clinical interventions, including clinical algorithms.
- Making sure that multiple treatment options are available at all times.
- Involving families and others (with permission of the service recipient) who have helpful information about what has worked and what hasn't in the past.
- Teaching skills of self-monitoring and self-control as part of the rehabilitation/recovery process.
- Ensuring that both staff and service recipients have access to mechanisms for resolving disputes without resorting to force.
- Creating a physical environment that minimizes the overstimulating conditions that may lead to conflict or agitation, particularly (but not exclusively) for elderly individuals.
- Developing a clinical paradigm that addresses past trauma as part of the clinical picture.
- Considering the use of seclusion or restraint to reflect a failure to intervene earlier, and aiming for the goal of using these interventions as close to "zero use" as possible.
- Ensuring adequate ongoing staff training specific to the situation and consumers being served.

Similarly, many factors were identified that contribute to an environment in which safety concerns are likely to emerge, and in which seclusion and restraint are likely to be misused. These factors include

- Lack of adequate attention to safety issues and risk factors at intake. Most episodes of seclusion and restraint occur within the first few days after admission, and the majority of incidents occur with a very small number of individuals.
- Lack of an organizational culture of respect.
- Not believing what service recipients say; labeling people as "manipulative."
- Lack of adequate attention to language accessibility and cultural uniqueness (e.g., race, gender, sexual orientation, and trauma history).
- Inadequate staffing, in quantity, training or both. Inexperienced staffs are assaulted more frequently; short staffing and the use of temporary staff also increase the likelihood of violence.

HANDOUT

NASMHPD's 1999 Report (continued)

- The assumption that "compliance" in and of itself is important for recovery. A culture that permits misuse or display of power, even in "small" ways (e.g., using keys to intimidate).
- The assumption that "structure" and/or rules for behavior are in and of themselves therapeutic, or that they are the only mechanisms for maintaining a therapeutic milieu.
- Responding to violence with violence.
- Inadequate monitoring and debriefing; a culture of secrecy.
- A culture in which direct care staff feel disrespected and "pass on" that disrespect to service recipients.

HANDOUT

What would have been helpful in preventing the use of seclusion or restraints for you?

- Listening
- Finding good qualities and mentioning them
- Teaching stress management exercises
- Good ongoing relationship with treatment staff that involved trust and cooperation
- If families were regularly included in treatment teams—and really considered to be valuable sources of insight into their ill family members, then situations leading to restraints might be defused
- If they had given me a stick of gum to chew or something to drink
- If they had given me some paper and a pencil, I would have written out my thoughts
- Naming and hearing what you're doing that's inappropriate and why
- Stopping inside jokes that confuse people
- Being allowed to listen to music
- Snuggle in blankets
- If the nurses had talked to me and offered alternatives first, like applying a warm washcloth to my forehead, like holding my hands or offering reassurance, such as "you are in a safe place now." "We are here to help you feel safe, to get away from the bad thoughts, voices, or visions."
- I'm afraid of closed-in places and this is in my files. No one took time to look or even read it.
- All it would have taken was for someone to talk to me and HEAR what I had to say
- To put it in simplistic terms: knowing the patient and educating the staff. All staff members need to know the patient's personal history, diagnosis, treatment experiences, and approaches which have been helpful in the past to avoid seclusion and restraints, i.e., avoid a one-size-fits-all response. This will necessitate a system which can more quickly involve family members and past treatment providers.

HANDOUT

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HANDOUT

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HANDOUT

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