



MODULE 6

Sustaining Change Through Consumer and Staff Involvement

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“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. It didn’t matter that it might offer me something helpful; I didn’t want any of it if that horrible experience was going to be a part of the package.”

—Will Pflueger, Consumer

“I encourage you to make meaningful changes regarding physical restraint standards in psychiatric facilities by seeking the help of Psychiatric Technicians as change agents and champions of the cause.”

—George Blake, Ph.D., American Association of Psychiatric Technicians

Learning Objectives

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

- Recognize leadership roles for administration, staff, and consumers in the elimination of seclusion and restraint.
- Describe the role of the Office of Consumer Affairs/Consumer Advocate and the role they play in eliminating the use of seclusion and restraint.
- Outline key elements of debriefing, advance crisis management, and data collection.
- Outline the pros and cons of having an external monitoring system related to seclusion and restraint.
- Identify key characteristics of the role of the champion.

MODULE 6: SUSTAINING CHANGE THROUGH CONSUMER AND STAFF INVOLVEMENT

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BACKGROUND FOR THE FACILITATORS: SUSTAINING CHANGE THROUGH CONSUMER AND STAFF INVOLVEMENT

Overview

Change is hard work. Once change has begun, it is necessary to sustain positive changes through consumer and staff involvement if the goal of eliminating seclusion and restraint is to be reached. Various strategies for sustaining change are addressed in this module.

Leadership

Every group within the mental health system has a leadership role. Each should take responsibility for making sustainable changes in the system.

Administrative/Management Leadership

The administration/management has the most power to make structural changes within the system. Administrative/management staff sets the stage in creating a culture that minimizes the use of seclusion and restraint while promoting a safe environment for clients and staff. First, administrators/management must carefully examine their own beliefs and assumptions about seclusion and restraint in order to wholeheartedly buy into a respectful treatment system without the use of seclusion and restraints.

The administration/management controls the policies and the overall climate of the system. Mission statements, formal policies, and everyday practices need to be examined. The administration/management provides the leadership, vision, and planning for moving to a restraint-free environment. On a practical level, when top administration/management is involved with every post-seclusion/restraint debriefing in a supportive and problem-solving manner, (not a fault-finding manner), the use of seclusion and restraint decreases. It is administration/management's job to provide for ample staffing, staff training, and continuing in-service trainings. In order to maintain a level of consciousness about seclusion and restraint, administration has the responsibility to ensure the issue of seclusion and restraint is on the agenda in every facility, from the housekeeping department to the board of directors. Leadership at this level is critical in developing the atmosphere of respect and concern for consumers that is necessary to minimize the use of seclusion and restraint.

Consumer Leadership

Consumers bring a unique perspective; their experiential knowledge is vital to any discussion about cultural change. All persons deserve to participate in decisions that affect their lives; no one can speak for consumers. Multiple perspectives from all stakeholders are keys to good decisionmaking.

The term “meaningful involvement” is frequently heard. What does this mean? According to Darby Penney (1999), meaningful involvement is:

- Beyond tokenism: Involved in sufficient numbers to have real influence.
- Beyond review and comment: Involved in framing the issues and setting the agenda.
- Beyond advice: Participating in governance and policymaking.
- Beyond sign-off: Directing one’s own recovery.

Office of Consumer Affairs/Consumer Advocates

In January 2005, 45 States had Office of Consumer Affairs (OCA) positions within State mental health agencies. An OCA is a vehicle to ensure that a variety of consumer/survivor voices are heard within meaningful system change initiatives, at local, regional, and state-wide meetings, forums, legislative hearings, and workgroups that focus on policy and regulations. OCAs support ongoing training to all stakeholders and agencies providing services to people using mental health services on the principles of recovery, self-determination, advance crisis planning, etc.

OCA positions strategically placed within State hospitals and on executive teams demonstrate commitment to the principles of equality and inclusion of consumers and advocates in changing the culture that tolerates seclusion and restraint. For further information on establishing an OCA position within State hospital settings, go to the National Association of Consumer/Survivor Mental Health Administrators Web page at www.nasmhpd.org.

The goal of a consumer advocate is to represent consumers/families/guardians from their perspective, and to promote the highest standard of care for people receiving treatment for mental illnesses. The job of a consumer advocate is to ensure that consumer rights are protected. This may include receiving and assessing complaints regarding a consumer’s rights, dignity, care, and treatment. On a local or regional level, a consumer advocate provides education, advice, or consultation on issues, standards, and policies to promote the highest standard of care and treatment for persons diagnosed with a mental illness. This means meeting with families, guardians, consumers, and staff to provide training and consultation on consumer rights. The consumer advocate may review and monitor facility policies and procedures that impact consumer rights. The consumer advocate also reviews and responds to all incident reports and makes recommendations as needed.

The Protection and Advocacy (P&A) System and Client Assistance Program (CAP) comprise the nationwide network of congressionally mandated legally based disability rights agencies. P&A employees encourage a nonadversarial approach and strive for a partnership perspective in their work. P&A Offices were established to address the public outcry in response to the abuse, neglect, and lack of programming in institutions for persons with disabilities. P&A agencies have the authority to provide legal representation and other advocacy services, under all Federal and State laws, to all people with disabilities (based on a system of priori-

ties for services). These agencies also devote considerable resources to ensuring full access to inclusive educational programs, financial entitlements, health care, accessible housing, and productive employment opportunities. A listing of P&A Offices by State is included in the handouts for this module. For more information on Protection and Advocacy, please visit www.napas.org.

Direct Care Staff Leadership

Leadership qualities are important to individuals who are responsible for the safety of consumers as well as their own safety. Direct care staff can play many roles. Examples include being an advocate, a whistle blower, or assisting with the tracking of data. The exercise in this section empowers staff to acknowledge and develop their own skill set.

Debriefing

Debriefing should always be done after an incident of seclusion or restraint. Debriefing can be used for different purposes, such as risk management, quality improvement, or staff support. For example, if the purpose of a debriefing is risk management, then it will be important to conduct a root cause analysis, including a behavioral and physical assessment, observation procedures, care planning process, staffing, training, competency, supervision, communication, etc. However, if the purpose of the debriefing is to assist quality improvement, it would be important to look at what part of the system failed and how the incident could be prevented in the future. And finally, if the purpose of the debriefing is staff support, it would be important to focus on the physical, psychological, and emotional needs of the staff involved in the traumatic incident. The purpose of the debriefing will help determine who should be present, e.g., staff, consumer/survivor, family members, or advocates.

One staff member, trained in the debriefing process, sets the stage for the debriefing. This person explains the situation and the purpose of the meeting and establishes ground rules. Examples of ground rules include confidentiality, no one is forced to talk, and only respectful communication is allowed to promote emotional safety.

One debriefing model (adapted from Rupert Goetz, M.D., Medical Director, Hawaii State Hospital, 2002) has four distinct sections: facts, feelings, education, and planning. The facts section reviews what is known to be true. Rumors, hearsay, and speculation are labeled as such. In the next phase, feelings are explored. It is important to separate the facts from the feelings. During the feelings section, each person has an opportunity to express his or her own feelings about the situation. Often, a wide variety of feelings are expressed and it is important to validate all of them. During the education section, it is often helpful to review normal adaptive responses to stress as well as maladaptive responses. It is often helpful for staff and consumers to be reminded of common reactions to stress and trauma. Finally, in the planning section, the facilitator discusses any follow-up and recommends steps for members of the debriefing team to take.

Advance Crisis Planning

Individual treatment plans have goals and interventions jointly defined by the consumer, family, and treatment team to eliminate the need for seclusion and restraints. When an incident of seclusion or restraint occurs, it is important to document all forms of de-escalation that were attempted to prevent seclusion and restraint and their effects. Input from the consumer about what worked and what didn't should also be included. Finally, treatment plans need to be easily accessible and readily available to staff.

The University of Illinois at Chicago National Research and Training Center on Psychiatric Disability (phone: 312-422-8180) has developed a toolkit and training manual, *Increasing Self-Determination Through Advance Crisis Management in Inpatient and Community Settings: How to Design, Implement, and Evaluate Your Own Program*. As a facilitator, you may find it useful to use this toolkit. The fundamental values underlying the Advance Crisis Management initiative is the belief that people's crises would be addressed more humanely if they were allowed to specify in advance actions to be taken during times when they are too distressed to make decisions.

Another resource is the Wellness Recovery Action Plan (WRAP) developed by educator/consumer Mary Ellen Copeland. One section in the WRAP specifically addresses the need for advance crisis planning.

Data Collection

The Bazelon Law Center for Mental Health Web site at www.bazelon.org suggests the following regarding reporting of seclusion and restraint use: Facilities are required to report any serious occurrence, such as death, serious injury, or a suicide attempt to the State Medicaid agency and the State protection and advocacy agency, unless prohibited by State law. This reporting must occur by the close of business of the next business day after the occurrence and include the name of the resident; a description of the occurrence; and the name, street address, and telephone number of the facility. Staff must document in the resident's record that this report was made and keep a copy of the report in the resident's record. *Reporting of the death of any resident must also be made to the Centers for Medicare and Medicaid Services (CMS) regional office.*

In addition, every incident of seclusion and restraint should be documented and reported in a systematic way so trends can be analyzed and improvements made. Pennsylvania found that making data publicly accessible was one of the key components to decreasing the use of seclusion and restraint in their State hospitals (Pennsylvania Department of Public Welfare, 2001). Making data public fostered a healthy competition between hospitals to decrease the incidences of seclusion and restraint. A performance improvement and monitoring program designed to continuously review, assess, and analyze the facility's use of seclusion and restraints should also be in place.

External Monitoring

External monitoring groups may consist of consumer advocates, family members, and concerned citizens. The overall goal of citizen monitoring groups is to improve and enhance the quality of life for consumers while they are receiving mental health treatment. In addition, external monitoring groups promote effective communication between consumers, staff, and families. According to NAMI, “Some State hospital systems and some facilities such as Delaware, Massachusetts, New Hampshire, New Jersey, and Pennsylvania, have reduced the use of seclusion and restraints by using third party citizen, consumer, and family monitoring groups” (see www.nami.org).

Monitors are allowed to visit, unannounced at any time—24 hours a day, 7 days a week. Monitors document items such as time of day, number of consumers on the census, number of consumers currently on the unit (and where they are if not on the unit), activities, amount of interaction between staff and consumers, physical surroundings, overall appearance and cleanliness of the facility, how consumers are dressed, supplies available to consumers, quality and choice of food, etc. Monitors file a written report within an agreed upon time period—typically 2 to 5 days after their visit. The facility coordinator responds to the report in a timely manner. In order to make sure the monitoring system is functioning smoothly, it is important for key staff (e.g., CEO, Director of Nursing, and Facility Coordinator) and monitors to meet on an ongoing basis. Often this is done quarterly.

External monitors can raise the consciousness of key State and local policymakers, educate the public about the needs and problems of consumers, and encourage the development of effective community-based alternatives. A successful example of this type of program is the Child Watch Visitation Program, an initiative of the Children’s Defense Fund. A document on this program, *Checking Up on Juvenile Justice Facilities: A Best Practices Guide*, released by the National Mental Health Association (www.nmha.org/children/justjuv/checkingUpOnJFfacilities.cfm), could be used as a guide for developing external monitoring programs (Siegfried, 1999).

Initially, hospital staff may be resistant to having outsiders evaluate the physical surroundings and milieu. Over time, however, external monitors and staff often see the advantages of working together and they join forces to improve the overall experience for consumers. Typically, a staff person is designated as the facility coordinator for the external monitoring group. The facility coordinator also helps train both monitors and staff. Monitors go through an extensive training that covers topics such as confidentiality, what to look for on a site visit, how to accurately document, how to write a report, how to follow up on issues, and how to report emergency issues. Included in the training is a clear understanding that monitors are not there to evaluate clinical issues—they are there to evaluate milieu issues. Staff are also trained in these issues so there is no misunderstanding about the purpose and parameters of external monitoring.

Role of the Champion

Given the magnitude and complexities of the mental health system and its bureaucracy, many roles are open for systems change agents. Some are in administration. Some are in the legislature and consumer and family organizations. However, each one of us here has a personal and professional role to play—the role of champion. It is our personal commitment to making a difference wherever we are and in whatever capacity we find ourselves. For example, if someone were using language that is stigmatizing or telling a joke at the expense of another, what would a champion do? If one were asked to serve on a committee to look at policies within the unit or facility, what would a champion do? How does a champion implement or suggest to his or her supervisor that a philosophy of recovery be implemented on the unit?

The role of the champion is a difficult and sometimes lonely role. If someone chooses to accept this role, the rewards are many. Change is up to the individual. Nobody can make someone else change. All we can do is offer suggestions and increase awareness. The privilege and responsibility is up to the individual. Shared vision is rooted in personal vision. Mandates attempt to establish visions from the top. But real vision comes from within. It is about solving the day-to-day problems by keeping that personal vision in mind. It is our hope that people who participate in this training will, with a personal commitment, join in establishing a treatment culture dedicated to eliminating seclusion and restraint within psychiatric treatment settings for all people of all ages.

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 5: Strategies to Prevent Seclusion and Restraint. Ask each participant to share one of the Take Action Challenges from Module 5 and report on their progress. Then go over the learning objectives for this module.

Learning Objectives

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

- Recognize leadership roles for administration, staff, and consumers as they relate to the elimination of seclusion and restraint
- Describe the role of the Office of Consumer Affairs/Consumer Advocate in eliminating the use of seclusion and restraint
- Identify key elements of debriefing, advance crisis management, and data collection and analysis
- Outline the pros and cons of having an external monitoring system related to seclusion and restraint
- Identify key characteristics of the role of the champion

"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. It didn't matter that it might offer me something helpful; I didn't want any of it if that horrible experience was going to be a part of the package."
Will Pflueger, Consumer

Overview

- In an ideal world, there would be no use of seclusion or restraint.
- However, we understand we do not always live in an ideal world and recognize that sometimes seclusion and restraints are used.
- This module will explore ways of sustaining change through consumer and staff involvement in eliminating the use of seclusion and restraint via leadership, Office of Consumer Affairs, debriefing, updating treatment plans, data collection, and external monitoring.
- Staff and consumers have important leadership roles in eliminating the use of seclusion and restraint.
- In the unfortunate event that seclusion and restraint do occur, several key things need to happen.
- All consumers, family members, or identified significant others need to be informed immediately about any use of seclusion and/or restraint.
- Consumer advocates need to be included in debriefing sessions and their knowledge utilized for preventing future seclusion and restraint.
- The Office of Consumer Affairs can ensure that a variety of consumer/survivor voices are heard within meaningful system change initiatives and can provide ongoing training for all stakeholders.
- Following any use of seclusion and/or restraint, consumers should participate in debriefing sessions with their primary caregivers using clear words that consumers can understand. This helps with symptom recognition and earlier de-escalation, and promotes problem-solving and conflict resolution skills.

- Staff also needs to debrief on their own involvement in the seclusion and restraint.
- Advance crisis management needs to take place, including updating treatment plans.
- It is critical to collect data and make it readily available. Data is particularly helpful in looking at trends over time and understanding potential underlying reasons for the use of seclusion and restraint.
- External monitoring can improve communication between staff, consumers, and families and can help to improve the overall quality of life for consumers.

Leadership

- Every group within the mental health system has a leadership role. This includes administrators/managers, direct care staff, consumers, and families.
- Each group should take responsibility for making sustainable changes in the system.

Administrative/Management Leadership

- Administrative staff sets the stage in creating a culture that minimizes the use of seclusion or restraint while promoting a safe environment for clients and staff.
- Administrators must carefully examine their own beliefs and assumptions about seclusion and restraint in order to wholeheartedly buy into a respectful treatment system without the use of seclusion and restraints.
- Administrators and leaders from all levels of the organization need to make highly visible statements and actions in support of change.

Administrators can sustain change by providing:

- Policies and procedures that move toward a seclusion and restraint free environment
- Adequate staffing
- Staff training and continuous in-service training
- Placing seclusion and restraint training on all meeting agendas from the housekeeping department to the board of directors
- Personal involvement in debriefing after every incident of seclusion or restraint in a supportive and problem-solving manner

Consumer Leadership

- Consumers bring a unique perspective; their experiential knowledge is vital to any discussion about sustaining cultural change.
- According to Darby Penney, past president of NAC/SMHA, “Consumers need meaningful involvement” (Penney, 1999).

Meaningful Consumer Involvement means:

- Beyond tokenism
- Beyond review and comment
- Beyond advice
- Beyond sign-off

- Beyond tokenism: Involved in sufficient numbers to have real influence.
- Beyond review and comment: Involved in framing the issues and setting the agenda.
- Beyond advice: Participating in governance and policymaking.
- Beyond sign-off: Directing one’s own recovery through self-management (e.g., advance directives, WRAP).
- Educating consumers and nonconsumers through articles, lectures, and workshops as exemplified in the exercise using the *Networks* newsletter article.
- As of January 2005, 45 States have Offices of Consumer Affairs (OCAs).



An Office of Consumer Affairs (OCA) is a vehicle to ensure that a variety of consumer/survivor voices are heard within meaningful system change initiatives.



- An OCA is an element of empowerment for people who have been diagnosed with mental illness or psychiatric disability.
- Although an Office of Consumer Affairs is representative of consumer concerns and issues, it must take into consideration other stakeholders' opinions as well if the office is to ensure that the consumer voice is heard and considered in policy, planning, and practice development.
- The OCA is a focal point for consumer/survivor/ex-patient concerns and information.
- The Director advocates for the consumer perspective *within* the mental health authority and works to increase consumer participation in a variety of areas to produce change in types of services and how they are provided.

Benefits of an Office of Consumer Affairs

- De-stigmatizing people diagnosed with mental illness or psychiatric disability
- Ongoing process of consumer participation
- Recognizing the civil and human rights of people diagnosed with mental illness/psychiatric disabilities

OCA Areas of Responsibility

- Policy and Regulation Development
- Program Planning
- Evaluation and Monitoring
- Training
- Finance and Contract Management
- Complaints and Grievances

- The OCA serves as a system change agent. As a change agent within government, the OCA is responsible for raising tough issues.
- Some of the issues are protection of consumer rights, the coerciveness of forced treatment, and any other topics that consumers raise as important issues to shape future policy, reshape services, or change priorities where other stakeholders may not be in agreement with consumers.
 - The goal of a consumer advocate is to represent consumers, families, and guardians from their perspective and to promote the highest standard of care for people receiving treatment for a mental illness.

Goals of Consumer Advocates

- Represent consumers/families/guardians from their perspective
- Promote highest standard of care for people receiving treatment for a mental illness

- The job of a consumer advocate is to ensure that consumer rights are protected.

Job of Consumer Advocate

Protect Consumer Rights!

- Protecting consumer rights might include receiving and assessing complaints regarding a consumer's rights, dignity, care, and treatment.
- On a local or regional level, a consumer advocate provides education, advice, or consultation on issues, standards, and policies.
- Consumer advocates meet with families, guardians, consumers, and staff to provide training and consultation on consumer rights.
- The consumer advocate may also review and monitor facility policies and procedures that impact consumer rights.
- In relation to seclusion and restraint, a consumer advocate reviews and responds to all reports and makes recommendations as needed.
- Other responsibilities of a consumer advocate may include those shown on this slide:

Consumer Advocate Roles

- Administering de-escalation form
- Making regular rounds on units
- Being part of policymaking and new initiatives (e.g., comfort rooms, special programs, recognition, festivities)
- Being present at team meetings
- Being the "eyes and ears" for the administrator

- Protection and Advocacy (P&A) Offices were established to address the public outcry in response to the abuse, neglect, and lack of programming in institutions for persons with disabilities.

P&A Nationwide Network

Protection and Advocacy is a nationwide network of congressionally mandated, legally based disability rights agencies

P&A Responsibilities:

- Provide legal representation
- Maintain a presence in facilities, if possible
- Monitor, investigate, and attempt to remedy adverse conditions



Distribute handout Protection and Advocacy Offices. Tell participants to visit www.napas.org for the latest information.

Exercise/Discussion—Module 6

National Technical Assistance Center *Networks*

OBJECTIVE: Participants will explore personal feelings related to seclusion and restraint inspired by the essay of a consumer leader. Participants will be familiar with resources available (e.g., National Technical Assistance Center (NTAC) *Networks* newsletter).

PROCESS: Ask each participant to read a copy of the National Technical Assistance Center Summer/Fall 2002 *Networks* newsletter article by Will Pflueger, "Consumer View: Restraint Is Not Therapeutic." Read the discussion questions out loud. Direct participants to spend 5 minutes writing in their journal about any feelings they may have experienced as they participated in seclusion and restraint. Ask participants if anyone is willing to share their feelings with the group.

DISCUSSION QUESTIONS:

- What kinds of feelings have you experienced as a result of using seclusion and restraint?
- What is the personal impact on you when you use seclusion and restraint?
- How accurate do you think this consumer is about the shame?

MATERIALS REQUIRED: National Technical Assistance Center Summer/Fall 2002 *Networks* newsletter article by Will Pflueger

APPROXIMATE TIME REQUIRED: 15 minutes

SOURCE: NTAC *Networks* newsletter

Exercise/Discussion—Module 6

Direct Care Staff Leadership

- OBJECTIVE:** Identify how direct care staff can use their leadership skills to eliminate seclusion and restraint.
- PROCESS:** Lead a brainstorming session, asking participants to list things they can do as leaders to change the culture within their workplace environment to move towards the elimination of seclusion and restraint. Write all ideas on the board. Highlight themes.
- DISCUSSION QUESTIONS:** How can you take what you have learned from this training back to the unit?
- MATERIALS REQUIRED:** Chalkboard/dry erase board, chalk/markers
- APPROXIMATE TIME REQUIRED:** 15 minutes

Debriefing

- "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." Consumer, NAC/SMHA Survey

- If seclusion and/or restraint does occur, it is important to discuss what happened and how to prevent it from happening again.
- The following information on debriefing has been adapted from Rupert Goetz, M.D., Medical Director, Hawaii State Hospital, an expert on seclusion and restraint (Goetz, 2002).
- Debriefing is always done after an incident of seclusion or restraint.
- Debriefing can be used for different purposes, such as risk management, quality improvement, or staff support.

Debriefing can be used for different purposes:

- Risk Management
- Quality Improvement
- Staff Support

- Depending on the purpose of the debriefing, it may look different from time to time.
- Some facilities recommend doing two separate debriefings. The first one is a face-to-face discussion between the consumer and all staff involved, and discusses the circumstances that led to the use of seclusion or restraint and strategies that could be used to prevent future use. Parents or legal guardians may participate when appropriate.
- A second debriefing is held among all staff members involved in the emergency safety situation and appropriate supervisory and administrative staff. These sessions include a discussion of the emergency safety situation that led to the use of seclusion or restraint, alternative techniques, any staff procedures that may be used to prevent the reoccurrence, and the outcomes.
- It is important that the debriefing not be a “blame game.” This type of attitude will make debriefing ineffective.

Staff Debriefing Sessions include the following:

- Discussion of the emergency safety situation that led to the use of seclusion or restraint
- Alternative techniques
- Staff procedures that may be used to prevent the reoccurrence
- Outcomes

- A staff member who is trained in the debriefing process sets the stage for the meeting. This person explains the situation and the purpose of the meeting and establishes ground rules.
- Examples of ground rules include confidentiality, no one is forced to talk, and only respectful communication is allowed to promote emotional safety.
- One model of debriefing, adapted from Rupert Goetz, M.D. (2002) has four distinct sections: facts, feelings, education, and planning.

Debriefing Model - Rupert Goetz, M.D.

- Facts
- Feelings
- Education
- Planning

- The facts section reviews what is known to be true. Rumors, hearsay, and speculation are labeled as such.
- During the feelings section, all feelings are explored. Each person has an opportunity to express his or her feelings. It is important for the leader to validate all feelings.
- During the education section, it is helpful to review normal adaptive responses to stress as well as maladaptive responses. It is often helpful for staff and consumers to be reminded of common reactions to stress and trauma.
- In the planning section, the facilitator discusses any follow-up that is going to happen and recommends steps for members of the debriefing team to take.
- One useful tool, original source unknown, has been a survey for consumers. It can be given to the consumer/survivor to fill out before a debriefing session.



Distribute handout Debriefing Survey for Consumers.

Exercise/Discussion—Module 6

Debriefing Role Play

OBJECTIVE: Understand the different roles for implementing an effective debriefing session.

PROCESS: Invite the participants to volunteer for the following roles: Consumer Advocate, Director of the Office of Consumer Affairs, Consumer, two Direct Care Staff who restrained the consumer, one Consumer Family Member, Director of Nursing, Administrative Supervisor, Medical Director, and the Physician who ordered seclusion and restraint. You may adjust these roles as necessary, given the size of the class. If possible, have several people role play the role of the consumer—they can switch on and off with each other. Set the stage by reading out loud the following scenario:

The consumer was admitted on an inpatient psychiatric locked unit early this morning. Initially, the consumer was cooperative with the admission procedure. When the admitting nurse began asking questions related to past trauma, the consumer became agitated and began to rock back and forth on the chair. The admitting nurse stopped asking questions about trauma and asked the consumer what would be helpful. The consumer said that all that would be helpful would be to "get out of here." When the response from the nurse was, "No, that's not possible at this time," the consumer began to raise her/his voice, stand up, and look for a way out. The admitting nurse called for security which further agitated the consumer, who began looking for ways to protect her/himself. As the security staff approached the consumer, he/she began kicking, screaming, making threats, and attempted to bite two direct care staff. The consumer was subdued and forcefully taken down and removed to the seclusion/restraint room. The consumer continued to "struggle" and was subsequently put in four-point restraints face up. The consumer regained control and was released after 25 minutes in restraints. A debriefing session was set up for later that afternoon.

Exercise/Discussion—Module 6

Debriefing Role Play (continued)

Each person assumes a role and attempts to act out an effective debriefing session based on the above scenario. First, the staff will debrief by themselves. Next, the consumer and staff will jointly debrief the session. The audience is to listen and observe both the verbal and non-verbal language of all participants. Once the role play is completed, each actor gets to briefly discuss what it was like for him or her to be in that role. Finally, ask the audience to provide feedback along with the actors on what went well and what could have been done differently.

DISCUSSION QUESTIONS:

- What did staff do well in this debriefing?
- What did the consumer do well in this debriefing?
- How did the consumer advocate help?
- How did the Office of Consumer Affairs help?
- What could have been done to make this debriefing more useful for both staff and the consumer?

MATERIALS REQUIRED:

None

APPROXIMATE TIME REQUIRED:

25 minutes

Advance Crisis Planning

- Advance crisis management is essential to preventing further use of seclusion and restraint.
- The fundamental value underlying the Advance Crisis Management initiative is the belief that a person's crisis would be addressed more humanely if he or she were allowed to specify in advance actions to be taken during times when he or she is too distressed to make decisions.
- One of the important aspects of debriefing and updating treatment plans is to identify any triggers or precursors that might lead to the use of seclusion and restraint.
- Individual treatment plans have goals and interventions jointly defined by the consumer, family, and treatment team to eliminate the need for seclusion or restraints.
- Information for the individual treatment plan can be obtained from the initial assessment from the consumer when he or she entered the hospital. (Modules 2 and 5 addressed this issue.)
- In Mary Ellen Copeland's WRAP, there is a section on crisis planning which is covered in Module 5. Refer back to it if needed.
- Documentation of all forms of de-escalation that were attempted to prevent seclusion and restraint and their effect should be included in the treatment plan.
- Input from the consumer about what worked and what didn't should also be in the treatment plan.
- We recommend using the video *Increasing Self-Determination: Advance Crisis Planning with Mental Health Consumers in Inpatient and Other Settings* developed by the University of Illinois at Chicago, National Research and Training Center on Psychiatric Disability. The video may be obtained in one of the following ways: (1) calling Jeff Parks at (312) 422-8180, ext. 10 or Tina Carter, ext. 11; (2) writing to the National Research and Training Center on Psychiatric Disability, Attn: Dissemination Coordinator, 104 South Michigan Avenue, Suite 900, Chicago, IL 60603, or (3) visiting the Web site at www.psych.uic.edu/mhsrp.



Show the first 13 minutes of the video *Increasing Self-Determination: Advance Crisis Planning with Mental Health Consumers in Inpatient and Other Settings*.

- "I'm afraid of closed in places and this is in my files.
 - No one took time to look at it or even read it."
- Consumer, NAC/SMHA Survey

- Information from the treatment plan needs to be accessible. Some hospitals have been very creative with this. One example is having an index card easily accessible to staff that lists de-escalation techniques that the staff and consumer have jointly agreed upon.

Data Collection

- Every incident of seclusion and restraint needs to be documented and reported in a systematic way so trends can be analyzed and improvements made.
- Facilities should maintain documentation for each use of seclusion and restraint (Public Law 106-310, Children's Health Act of 2000, Parts H and I, sections 591 through 595B of the Public Health Service Act (42 U.S.C. 290jj-290jj 2)).
- There is no mandatory, consistent, and publicly accessible system of reporting on seclusion/restraint uses, serious injuries, or deaths.
- When a minor is involved, the parent or legal guardian should be notified as soon as possible, but not later than 24 hours after the occurrence.
- Among States that have succeeded in lowering their use of seclusion and restraint, mandatory reporting has been a critical tool for improving outcomes.
- Such reporting should include consumer deaths and serious injuries, the number of seclusion/restraint incidents, the duration of the use of seclusion, medication errors, falls, staff injuries, and airway obstructions (California Senate Office of Research, 2002).
- A performance improvement and monitoring program designed to continuously review, assess, and analyze the facility's use of seclusion and restraints is vital.

External Monitoring

- Some State hospital systems and some facilities in Delaware, Massachusetts, New Hampshire, New Jersey, and Pennsylvania, have reduced the use of seclusion and restraints by using third party citizen, consumer, and family monitoring groups (www.nami.org).
- External monitoring groups can consist of family members, consumer advocates, and citizens.
- The goals of external monitoring are to (1) improve and enhance the quality of life for consumers and (2) promote effective communication between consumers, staff, and families.

Goals of External Monitoring

- Improve and enhance the quality of life for consumers
- Promote effective communication between consumers, staff, and families

- External monitors can be used to raise the consciousness of key State and local policy makers, educate the public about the needs and problems of consumers, and encourage the development of effective community-based alternatives. A successful example of this type of program is the Child Watch Visitation Program, an initiative of the Children's Defense Fund. E-mail: cdfinfo@childrensdefense.org. Phone: (202) 628-8787. Web: www.childrensdefense.org.

What Monitors Are Looking For

- Overall appearance and cleanliness of unit
- Census, number of staff, number of consumers on the unit
- Interaction between consumers and staff
- Activities currently available
- Number of consumers sleeping or in their rooms
- Quality and choices of food
- Number of incidents of seclusion and restraint
- Supplies/equipment available to consumers

- Typically the facility designates a Facility Coordinator to work with the monitoring group.
- The Facility Coordinator and the Monitoring Chairperson work together to provide training for monitors and staff.
- Training for monitors is extensive and includes the following:

Monitors are typically trained in the following areas:

- Confidentiality
- What to look for on a site visit
- How often to visit
- When to visit
- How to accurately document
- How to write a report
- How to follow up on issues reported
- How to report emergency issues
- How to evaluate milieu issues (not clinical issues)

- The Facility Coordinator and the Monitoring Chairperson train staff in these same issues.
- Training staff and having clear expectations of how the monitoring system works in advance help to avoid misunderstandings and mistrust.
- Several key issues ensure an effective monitoring program.
- Monitors are allowed to visit at any time—24 hours a day, 7 days a week.
- Typically, a staff person accompanies monitors on their rounds so both parties can see exactly what is being monitored. The monitor is allowed to go anywhere in the facility that has been previously agreed upon by all involved parties.
- Oftentimes, staff will ask monitors to report certain things that they have not been able to change through their own channels of communication.
- In general, monitors are looking at the overall milieu of the unit—not clinical issues.
- The monitors file a written report after their visit. A copy of this report goes to the Facility Coordinator, the CEO, and the Director of Nursing.
- The Facility Coordinator responds, in writing, to the report within a specified period of time, such as 2 weeks.
- A copy of the original report and the response then gets forwarded to the appropriate personnel at the State level, for example, the Office of Consumer Affairs and the Commissioner.
- To ensure the monitoring system is working properly, a meeting between key facility personnel and monitors is held periodically.

Role of the Champion

- The role of the champion is a difficult and sometimes lonely one. If someone chooses to accept this role, the rewards are many.
- Change is up to the individual.
- No one can make someone else change.
- Shared vision is rooted in personal vision. Real vision comes from within.
- There are many roles for systems change agents.
- Dr. Martin Luther King eloquently outlined the role of the champion in the following quote:

*"Cowardice asks the question - is it safe?
Expediency asks the question - is it politic?
Vanity asks the question - is it popular?
But conscience asks the question - is it right?
And there comes a time when one must take a
position that is neither safe, nor politic, nor
popular, but one must take it BECAUSE it is
right."
Dr. Martin Luther King, Jr.*

- Seclusion and restraint is no longer "right."
- Seclusion and restraint do not change behavior.
- Seclusion and restraint do not help people with serious mental illnesses better manage the thoughts and emotions that can trigger behaviors that can injure them or others.
- Seclusion and restraint can retraumatize people who have already had far too much trauma in their lives.
- Seclusion and restraint is traumatizing to staff.

JOURNAL/TAKE ACTION CHALLENGE



Give participants time to respond to one or two questions from the Journal section and at least one question from each of the Personal Take Action Challenges and the Workplace Take Action Challenges for Modules 5 and 6. They will use these Take Action Challenges extensively on the last day of the training.

JOURNAL TOPICS AND TAKE ACTION CHALLENGES FOR MODULES 5 & 6

Journal Topics

Pick one or two questions and respond in writing. Your responses are confidential.

- Which consumer-driven supports would you like to learn more about and why?
- Why do you think consumers feel it is important to have a place that is not run by mental health professionals?
- What ideas do you have about ways to prevent emergency situations that might lead to seclusion and restraint?
- What are your communication strengths and weaknesses? What could you do to improve on your weaknesses?
- What language do you hear at work that might be hurtful to consumers?
- Write about your own ideal “comfort room.” What kinds of things make you feel more comfortable (e.g., music, soft lighting, taking a bubble bath, going for a walk, sitting outside, meditating, essential oils, being held, watching your favorite movie, reading a book)?
- Which of the ideas from your own personal “comfort room” could be incorporated into your workplace?
- What do you personally need to do to take care of yourself after an incident of seclusion or restraint? How can you make sure this happens? What do you find helpful about the debriefing process? What do you dislike about the debriefing process? What do you see as the administration's role in the debriefing process? How do you think data collection about seclusion and restraints should be gathered and who should have access to this information?

Personal Take Action Challenges

Pick one topic and develop a plan. You will use this plan on the last day of training.

- Create a wellness plan for your own mental health based on the WRAP outline. Include the following: What are you like when you feel your best? How much of your time is spent feeling your best? What changes in your life would you have to consider accomplishing to maintain your wellness plan every day? Name at least three things you need to do on a daily basis to keep yourself healthy. List at least five things that help you when you are feeling stressed.
- Find a place in your personal life that could improve from using the information from Communication Strategies, Comfort Rooms, or Alternative Dispute Resolution/Mediation. Make a list of two things you can personally commit to in your daily life to move forward in one of these areas.

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Journal Topics/Take Action Challenges (continued)

- Do you have access to the information you need in the treatment plan? If not, how could this information be made more readily available to you? How does a seclusion/restraint incident affect the treatment milieu? What could be done to help the other residents on the unit cope with a seclusion/restraint incident?

Workplace Take Action Challenges

Pick one topic and develop a plan. You will use this plan on the last day of training.

- Look up consumer-driven supports on the Internet and make a list of Web sites that would be helpful for staff and consumers to know about.
- Find one area in your work setting where you could implement the strategies from Communication Strategies, Comfort Rooms, or Alternative Dispute Resolution/Mediation. Make a list of two things that you can personally commit to every day at work to move your workplace forward in one of these areas. Make a detailed plan of how you will implement these changes.
- Do you have access to the information you need in the treatment plan? If not, how could this information be made more readily available to you?
- How does a seclusion/restraint incident affect the treatment milieu? What could be done to help the other residents and staff on the unit cope with an incident of seclusion/restraint?
- How are family members and/or friends involved in treatment planning and debriefings of seclusion and restraints? How would you like to see them involved?
- What do you think is the best way to balance the rights of people diagnosed with a mental illness with the rights of the staff? What would need to change if these are out of balance? How could you make that change happen?

PROTECTION AND ADVOCACY OFFICES

For more information please visit www.napas.org.

State Protection and Advocacy Agencies for Persons with Developmental Disabilities and Mental Illness, and the Client Assistance Program

ALABAMA

CAP

Jerry Norsworthy, CAP Director
Division of Rehabilitation Services
and Children's Rehabilitation Services
2125 East South Boulevard
Montgomery, AL 36116
Phone: 1-800-228-3231 Voice/TDD
(in-State only)
1-800-441-7607 (out-of-State)
Fax: 334-288-1104
E-mail: jnorsworthy@sacap.org
Web site: www.sacap.org

PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Ellen Gillespie, Interim Director
Alabama Disabilities Advocacy Program
The University of Alabama
Box 870395
Tuscaloosa, AL 35487-0395
Phone: 205-348-4928; 1-800-826-1675
(in-State only)
TDD: 205-348-9484
Fax: 205-348-3909
E-mail: adap@adap.ua.edu
egillespie@adap.ua.edu
Web site: www.adap.net

ALASKA

CAP

Pam Stratton, CAP Director
ASIST, Inc.
2900 Boniface Parkway, #100
Anchorage, AK 99504-3195
Phone: 907-333-2211; 1-800-478-0047
Fax: 907-333-1186
E-mail: akcap@alaska.com

PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Dave Fleurant, Executive Director
Disability Law Center of Alaska
3330 Arctic Boulevard, Suite 103
Anchorage, AK 99503
Phone: 907-565-1002 voice/TDD;
1-800-478-1234 (in-State only)
Fax: 907-565-1000
E-mail: dfleurant@dlcak.org
Web site: www.dlcak.org

AMERICAN SAMOA

CAP/PADD/PAIMI/PAIR/PABSS/ TBI/PAVA

Marie Ma'oa, Executive Director
Client Assistance Program and
Protection & Advocacy
P. O. Box 3937
Pago Pago, American Samoa 96799
Phone: 011-684-633-2441
Fax: 011-684-633-7286
E-mail: marie@samoatelco.com

Protection and Advocacy Offices (continued)

ARIZONA

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Leslie Cohen, Executive Director
Arizona Center for Disability Law
100 North Stone Avenue, Suite 305
Tucson, AZ 85701
Phone: 520-327-9547 voice/TTY;
1-800-922-1447 voice/TTY (nationwide)
Fax: 520-884-0992
E-mail: lcohen@acdl.com
Web site: www.acdl.com

ARKANSAS

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Nan Ellen East, Executive Director
Disability Rights Center
1100 North University Ave., Suite 201
Little Rock, AR 72207
Phone: 501-296-1775 voice/TTD;
1-800-482-1174 voice/TTD (nationwide)
Fax: 501-296-1779
E-mail: panda@arkdisabilityrights.org
nanelleneast@arkdisabilityrights.org
Web site: www.arkdisabilityrights.org

CALIFORNIA

CAP

Sheila Conlon-Mentkowski, Chief
Client Assistance Program
Department of Rehabilitation
2000 Evergreen Street
Sacramento, CA 95815
Phone: 916-263-7372; 1-800-952-5544
TTY: 916-263-7465; 1-866-712-1085
Fax: 916-263-7464
E-mail: smentkow@dor.ca.gov
Web site: www.rehab.cahwnet.gov

PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Catherine Blakemore, Executive Director
Protection & Advocacy, Inc.
100 Howe Avenue, Suite 185N
Sacramento, CA 95825
Phone: 916-488-9955 Admin. Office;
916-488-9950 Legal Office
1-800-776-5746 (nationwide)
Fax: 916-488-2635 or 9962
E-mail: legalmail@pai-ca.org
catherine.blakemore@pai-ca.org
Web site: www.pai-ca.org

COLORADO

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Mary Anne Harvey, Executive Director
The Legal Center
455 Sherman Street, Suite 130
Denver, CO 80203
Phone: 303-722-0300 voice/TDD;
1-800-288-1376 (nationwide)
Fax: 303-722-0720
E-mail: tlcmal@thelegalcenter.org
maharvey@thelegalcenter.org
Web site www.thelegalcenter.org

CONNECTICUT

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Jim McGaughey, Executive Director
Office of P&A for Persons with Disabilities
60B Weston Street
Hartford, CT 06120-1551
Phone: 860-297-4300; 1-800-842-7303 (in-
State only)
TDD: 860-566-2102
Fax: 860-566-8714
E-mail: james.mcgaughey@po.state.ct.us
Web site: www.state.ct.us/opapd/

Protection and Advocacy Offices (continued)

DELAWARE

CAP

Melissa H. Shahan, CAP Director
Client Assistance Program
United Cerebral Palsy, Inc.
254 East Camden-Wyoming Avenue
Camden, DE 19934
Phone: 302-698-9336; 1-800-640-9336
Fax: 302-698-9338
E-mail: capucp@magpage.com

**PADD/PAIMI/PAIR/PABSS/
TBI/TBI/PAVA**

James McGiffin, Executive Director /
Brian Hartman, Administrator
Community Legal Aid Society, Inc.
Community Services Building, Suite 801
100 W. 10th Street
Wilmington, DE 19801
Phone: 302-575-0660 voice/TDD
Fax: 302-575-0840
E-mail: bhartman@declasi.org

DISTRICT OF COLUMBIA

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Jane Brown, Executive Director
University Legal Services
220 I Street, NE, Suite 130
Washington, DC 20002
Phone: 202-547-0198
Fax: 202-547-2083
E-mail: jbrown@uls-dc.com
Web site: www.dcpanda.org

FLORIDA

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Hubert A. Grissom, Interim Executive Director
Advocacy Center for Persons with Disabilities
The Times Building, Suite 513
1000 N. Ashley Drive
Tampa, FL 33602
Phone: 813-233-2920; 1-866-875-1794
TDD: 1-866-875-1837
Fax: 813-233-2917
E-mail: info@advocacycenter.org,
h.grissom@advocacycenter.org
Web site: www.advocacycenter.org

GEORGIA

CAP *

Charles L. Martin, CAP Director
Georgia Client Assistance Program
123 N. McDonough
Decatur, GA 30030
Phone: 404-373-3116
Fax: 404-373-4110
E-mail: GaCAPDirector@theOmbudsman.com
Web site: www.theOmbudsman.com

**PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Ruby Moore, Executive Director
Georgia Advocacy Office, Inc.
One Decatur Town Center
150 E. Ponce de Leon Avenue, Suite 430
Decatur, GA 30030
Phone: 404-885-1234 voice/TDD;
1-800-537-2329 (nationwide)
Fax: 404-378-0031
E-mail: info@thegao.org
rubymoore@thegao.org
Web site: www.thegao.org

Protection and Advocacy Offices (continued)

GUAM

CAP

Edmund Cruz, Executive Director
Parent-Agencies Network, CAP
J. Madarang Dental Building
2238 Route 16, Suite 1-B
P.O. Box 23474
GMF, Guam 96921
Phone: 1-671-637-4227
Fax: 1-671-637-4211
E-mail: capguam@ite.net

PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Daniel Somerfleck, Executive Director
Guam Legal Services
113 Bradley Place
Hagatna, Guam 96910
Phone: 1-671-477-9811
Fax: 1-671-477-1320
E-mail: glsc@netpci.com

HAWAII

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Gary Smith, Executive Director
Hawaii Disability Rights Center
900 Fort Street Mall, Suite 1040
Honolulu, HI 96813
Phone: 808-949-2922 voice/TDD
Fax: 808-949-2928
E-mail: info@hawaiidisabilityrights.org
gary@hawaiidisabilityrights.org
Web site: www.hawaiidisabilityrights.org

IDAHO

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Jim Baugh, Executive Director
Co-Ad, Inc.
4477 Emerald Street, Suite B-100
Boise, ID 83706-2066
Phone: 208-336-5353 voice/TDD;
1-866-262-3462 (nationwide)
Fax: 208-336-5396
E-mail: coadinc@cableone.net
jbaugh@cableone.net
Web site: users.moscow.com/co-ad

ILLINOIS

CAP *

Kathy Meadows, CAP Director
Illinois Client Assistance Program
100 N. First Street, 1st Floor
Springfield, IL 62702
Phone: 217-782-5374
Fax: 217-524-1790
E-mail: DSHRLOL@dsh.state.il

**PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Zena Naiditch, Executive Director
Equip for Equality, Inc.
20 N. Michigan Avenue, Suite 300
Chicago, IL 60602
Phone: 312-341-0022;
1-800-537-2632 (nationwide)
TTY: 1-800-610-2779
Fax: 312-341-0295
E-mail: contactus@equipforequality.org
Web site: www.equipforequality.org

Protection and Advocacy Offices (continued)

INDIANA

CAP/PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Tom Gallagher, Executive Director
Indiana Protection and Advocacy Services
4701 N. Keystone Avenue, Suite 222
Indianapolis, IN 46204
Phone: 317-722-5555 voice/TDD;
1-800-622-4845 (nationwide)
Fax: 317-722-5564
E-mail: tgallagher@ipas.state.in.us
Web site: www.IN.gov/ipas

IOWA

CAP

Harlietta Helland, CAP Director
Client Assistance Program
Division on Persons with Disabilities
Lucas State Office Building
Des Moines, IA 50310
Phone: 515-281-3957; 1-800-652-4298
Fax: 515-242-6119
E-mail: harlietta.helland@iowa.gov

PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Sylvia Piper, Executive Director
Iowa P&A Services, Inc.
950 Office Park Road, Suite #221
West Des Moines, IA 50265
Phone: 515-278-2502;
1-800-779-2502 (nationwide)
TTY: 515-278-0571; 1-866-483-3342
Fax: 515-278-0539
E-mail: info@ipna.org
spiper@ipna.org
Web site: www.ipna.org

KANSAS

CAP

Sharon Kearse, CAP Director
Client Assistance Program
3640 SW Topeka Boulevard, Suite 150
Topeka, KS 66611
Phone: 785-266-8193;
1-800-432-2326
Fax: 785-266-8574
E-mail: slzk@srskansas.org
Web site: www.ink.org/public/srs/CAP

PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Rocky Nichols, Executive Director
Kansas Advocacy & Protective Services
3745 SW Wanamaker Road
Topeka, KS 66610
Phone: 785-273-9661
Fax: 785-273-9414
E-mail: rocky@ksadv.org

KENTUCKY

CAP

Gerry Gordon-Brown, CAP Director
Client Assistance Program
209 St. Clair, 5th Floor
Frankfort, KY 40601
Phone: 502-564-8035; 1-800-633-6283
Fax: 502-564-2951
E-mail: VickiL.Staggs@ky.gov
Web site: kycap.ky.gov

PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Maureen Fitzgerald, Executive Director
Kentucky Protection and Advocacy
100 Fair Oaks Lane, 3rd Floor
Frankfort, KY 40601
Phone: 502-564-2967; 1-800-372-2988 TDD
(nationwide)
Fax: 502-564-0848
E-mail: Maureen.Fitzgerald@ky.gov
Web site: www.kypa.net

Protection and Advocacy Offices (continued)

LOUISIANA

**CAP/PADD/PAIMI/PAIR/PABSS/TBI/
PAVA**

Lois Simpson, Executive Director
Advocacy Center
225 Baronne Street, Suite 2112
New Orleans, LA 70112-2112
Phone: 504-522-2337 Voice/TDD;
1-800-960-7705 (nationwide)
Fax: 504-522-5507
E-mail: lsimpson@advocacyla.org
Web site: www.advocacyla.org

MAINE

CAP*

Steve Beam, Program Director
CARES, Inc.
47 Water Street, Suite 104
Hallowell, ME 04347
Phone: 207-622-7055; 1-800-773-7055
Fax: 207-621-1869
E-mail: capsite@aol.com
Web site: www.caresinc.org

PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Kim Moody, Executive Director
Disability Rights Center
24 Stone Street
P.O. Box 2007
Augusta, ME 04338
Phone: 207-626-2774;
1-800-452-1948 TDD (in-State only)
Fax: 207-621-1419
E-mail: advocate@drcme.org
kamoody@drcme.org
Web site: www.drcme.org

MARYLAND

CAP

Beth Lash, CAP Director
Client Assistance Program
Maryland State Department of Education
Division of Rehabilitation Services/MD
Rehabilitation Center
2301 Argonne Drive
Baltimore, MD 21218-1696
Phone: 410-554-9359; 1-800-638-6243
Fax: 410-554-9362
E-mail: cap@dors.state.md.us

PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Gary Weston, Executive Director
Maryland Disability Law Center
The Walbert Building, Suite 400
1800 N. Charles Street
Baltimore, MD 21201
Phone: 410-727-6352;
1-800-233-7201 (in-State only)
TDD: 410-727-6387
Fax: 410-727-6389; 410-234-2711
E-mail: garyw@mdlcbalto.org
Web site: www.mdlcbalto.org

MASSACHUSETTS

CAP *

Barbara Lybarger, CAP Director
Massachusetts Office on Disability
Client Assistance Program
One Ashburton Place, Room 1305
Boston, MA 02108
Phone: 617-727-7440
Fax: 617-727-0965
E-mail: Barbara.Lybarger@modi.state.ma.us
Web site: www.state.ma.us/mod/MSCAPBRO.html

Protection and Advocacy Offices (continued)

**PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Christine Griffin, Executive Director
Disability Law Center, Inc.
11 Beacon Street, Suite 925
Boston, MA 02108
Phone: 617-723-8455; 1-800-872-9992
TTY: 617-227-9464; 1-800-381-0577
Fax: 617-723-9125
E-mail: cgriffin@dlc-ma.org
Web site: www.dlc-ma.org/

MICHIGAN

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Elmer Cerano, Executive Director
Michigan P&A Services
4095 Legacy Parkway, Suite 500
Lansing, MI 48911-4263
Phone: 517-487-1755 voice/TDD
1-800-288-5923 (in-State only)
CAP only: 1-800-292-5896
Fax: 517-487-0827
E-mail: ecerano@mpas.org
Web site: www.mpas.org

MINNESOTA

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Brenda Jursik, Administrator
Minnesota Disability Law Center
430 First Avenue North, Suite 300
Minneapolis, MN 55401-1780
Phone: 612-332-1441;
1-800-292-4150 (in-State only)
Fax: 612-334-5755
E-mail: bjursik@midmnlegal.org
Web site: www.mndlc.org

MISSISSIPPI

CAP

Presley Posey, CAP Director
Client Assistance Program
Easter Seal Society
3226 N. State Street
Jackson, MS 39216
Phone: 601-982-7051
Fax: 601-982-1951
E-mail: pposey8803@aol.com

PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Rebecca Floyd, Executive Director
Mississippi P&A System for DD, Inc.
5305 Executive Place, Suite A
Jackson, MS 39206
Phone: 601-981-8207 Voice/TDD;
1-800-772-4057
Fax: 601-981-8313
E-mail: info@mspaspas.com
Web site: www.mspaspas.com-ms

MISSOURI

**CAP/PADD/PAIMI/PAIR/PABSS/TBI/
PAVA**

Shawn de Loyola, Executive Director
Missouri P&A Services
925 S. Country Club Drive, Unit B-1
Jefferson City, MO 65109
Phone: 573-893-3333;
1-800-392-8667 (nationwide)
MO Relay TDD: 1-800-735-2966
Fax: 573-893-4231
E-mail: mopasjc@earthlink.net
Web site: www.moadvocacy.org

Protection and Advocacy Offices (continued)

MONTANA

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Bernadette Franks-Ongoy, Executive Director
Montana Advocacy Program
400 North Park, 2nd Floor
P.O. Box 1681
Helena, MT 59624
Phone: 406-449-2344 voice/TDD;
1-800-245-4743 (nationwide)
Fax: 406-449-2418
E-mail: bernie@mtadv.org
Web site: www.mtadv.org

NATIVE AMERICAN

PADD/PAIMI/PAIR/PABSS/TBI

Therese Yanan, Executive Director
Native American Protection &
Advocacy Project
3535 East 30th Street, Suite 201
Farmington, NM 87402
Phone: 505-566-5880;
1-800-862-7271 (intakes & clients only)
Fax: 505-566-5889
E-mail: tyanan@dnalegalservices.org

NEBRASKA

CAP

Victoria Rasmussen, CAP Director
Client Assistance Program
P.O. Box 94987
Lincoln, NE 68509
Phone: 402-471-3656; 1-800-742-7594
Fax: 402-471-0117
E-mail: victoria@cap.state.ne.us

**PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Timothy Shaw, Executive Director
Nebraska Advocacy Services, Inc.
134 South 13th Street, Suite 600
Lincoln, NE 68508
Phone: 402-474-3183 voice/TDD;
1-800-422-6691
Fax: 402-474-3274
E-mail: nas@nas-pa.org

NEVADA

CAP *

Margaret Moroun, CAP Director
Client Assistance Program
1820 E. Sahara Avenue, Suite 109
Las Vegas, NV 89104
Phone: 702-486-6688
Fax: 702-486-6691
E-mail: mjmoroun@nvdetr.org
Web site: members.delphi.com/nvcap/index.html

PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Jack Mayes, Executive Director
Nevada Advocacy & Law Center, Inc.
6039 Eldora Avenue, Suite C-3
Las Vegas, NV 89146
Phone: 702-257-8150; 1-888-349-3843
(nationwide)
TTY: 702-257-8160
Fax: 702-257-8170
E-mail: ndalc@earthlink.net for Las Vegas
Office
JMAYES9524@aol.com
reno@ndalc.org for Reno office
Web site: www.ndalc.org

Protection and Advocacy Offices (continued)

NEW HAMPSHIRE

CAP*

Bill Hagy, Ombudsman
Client Assistance Program
Governor's Commission on Disability
57 Regional Drive
Concord, NH 03301-9686
Phone: 603-271-2773
Fax: 603-271-2837
E-mail: bhagy@gov.state.nh.us
Web site: www.state.nh.us/disability/caphomepage.html

PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Richard Cohen, Executive Director
Disabilities Rights Center
18 Low Avenue
Concord, NH 03302-4971
Phone: 603-228-0432
TDD: 1-800-834-1721
Fax: 603-225-2077
E-mail: advocacy@drcnh.org
Richard C@drcnh.org
Web site: www.drcnh.org

NEW JERSEY

CAP/PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Sarah Wiggins-Mitchell, Executive Director
New Jersey P&A, Inc.
210 S. Broad Street, 3rd Floor
Trenton, NJ 08608
Phone: 609-292-9742;
1-800-922-7233 (in-State only)
TTY: 609-633-7106
Fax: 609-777-0187
E-mail: advocate@njpanda.org
smitchell@njpanda.org
Web site: www.njpanda.org

NEW MEXICO

CAP/PADD/PAIMI/PAIR/PABSS/TBI/PAVA

James Jackson, Executive Director
Protection & Advocacy, Inc
1720 Louisiana Boulevard, NE, Suite 204
Albuquerque, NM 87110
Phone: 505-256-3100 voice/TDD;
1-800-432-4682 (in-State only)
Fax: 505-256-3184
E-mail: info@nmpanda.org
Web site: www.nmpanda.org

NEW YORK

CAP/PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Gary O'Brien, Executive Director
New York State Commission on Quality of Care
for the Mentally Disabled
401 State Street
Schenectady, NY 12305-2397
Phone: 518-388-2892; 1-800-624-4143 TDD
(nationwide)
Fax: 518-388-2890
E-mail: marcelc@cqc.state.ny.us
garyo@cqc.state.ny.us
Web site: www.cqc.state.ny.us

NORTH CAROLINA

CAP

Kathy Brack, CAP Director
North Carolina Department of Health and
Human Services
Client Assistance Program
2806 Mail Service Center
Raleigh, NC 27699-2806
Phone: 919-855-3600; 1-800-215-7227
Fax: 919-715-2456
E-mail: Kathy.Brack@ncmail.net

Protection and Advocacy Offices (continued)

**PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Allison Bowen, Acting Executive Director
Governor's Advocacy Council for
Persons with Disabilities
1314 Mail Service Center
Raleigh, NC 27699-1314
Phone: 919-733-9250 Voice/TDD;
1-800-821-6922 (in-State only)
Fax: 919-733-9173
E-mail: allison.bowen@ncmail.net
Web site: www.Gacpd.com

NORTH DAKOTA

CAP

Dennis Lyon, CAP Director
North Dakota Client Assistance Program
600 South 2nd Street, Suite 1B
Bismarck, ND 58504-4038
Phone: 701-328-8947; 1-800-207-6122 CAP
only
Fax: 701-328-8969
E-mail: CAP@state.nd.us
Web site: www.state.nd.us/cap/

PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Teresa Larsen, Executive Director
North Dakota Protection & Advocacy Project
400 E. Broadway, Suite 409
Bismarck, ND 58501
Phone: 701-328-2950; 1-800-472-2670
1-800-642-6694 (24-hour line)
(in-State only)
TDD: 1-800-366-6888
Fax: 701-328-3934
E-mail: tlarsen@state.nd.us
Web site: www.ndpanda.org

N. MARIANAS ISLANDS

CAP/PADD/PAIMI/PAIR/PABSS/TBI

Lydia Fujihira Barcinas, Executive Director
Northern Marianas
Protection and Advocacy System, Inc.
P.O. Box 503529
Saipan, MP 96950-3529
Phone: 1-670-235-7274/3
Fax: 1-670-235-7275
E-mail: nmpasi@vzpacifica.net
Web site: www.NMPASI.com

OHIO

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Carolyn Knight, Executive Director
Ohio Legal Rights Service
8 E. Long Street, 5th Floor
Columbus, OH 43215
Phone: 614-466-7264; 1-800-282-9181 (in-
State only)
TTY: 614-728-2553; 1-800-858-3542
Fax: 614-644-1888
E-mail: CKnight@olrs.state.oh.us
Web site: [olrs.ohio.gov/ASP/HomePage.
asproper](http://olrs.ohio.gov/ASP/HomePage.asproper)

OKLAHOMA

CAP

James Sirmans, CAP Director
Client Assistance Program
Oklahoma Office of Handicapped Concerns
2401 NW 23rd, Suite 90
Oklahoma City, OK 73107
Phone: 405-521-3756; 1-800-522-8224
Fax: 405-522-6695
E-mail: James.Sirmans@ohc.state.ok.us
Web site: www.ohc.state.ok.us

Protection and Advocacy Offices (continued)

**PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Kayla Bower, Executive Director
Oklahoma Disability Law Center, Inc.
2915 Classen Boulevard, Suite 300
Oklahoma City, OK 73106
Phone: 405-525-7755;
1-800-880-7755 (in-State only)
Fax: 405-525-7759
E-mail: odlcokc@flash.net
kbower1@flash.net
Web site: www.oklahomadisabilitylaw.org

OREGON

**CAP/PADD/PAIMI/PAIR/PABSS/TBI/
PAVA**

Robert Joondeph, Executive Director
Oregon Advocacy Center
620 SW Fifth Avenue, 5th Floor
Portland, OR 97204-1428
Phone: 503-243-2081;
1-800-452-1694 (nationwide)
TDD: 1-800-556-5351
Fax: 503-243-1738
E-mail: welcome@oradvocacy.org
bob@oradvocacy.org
Web site: www.oradvocacy.org

PENNSYLVANIA

CAP

Stephen Pennington, CAP Director
Center for Disability Law and Policy
1617 JFK Boulevard, Suite 800
Philadelphia, PA 19103
Phone: 215-557-7112; 1-888-745-2357
Fax: 215-557-7602
E-mail: info@equalemployment.org

**PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Ilene Shane, Executive Director
Pennsylvania P&A, Inc.
1414 N. Cameron Street, Suite C
Harrisburg, PA 17103
Phone: 717-236-8110; 1-800-692-7443
(nationwide)
TTY: 717-346-0293; 1-877-375-7139
Fax: 717-236-0192
E-mail: ppa@ppainc.org
Web site: www.ppainc.org

PUERTO RICO

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Jose Raul Ocasio, Executive Director
Office of the Governor
Ombudsman for the Disabled
P.O. Box 41309
San Juan, PR 00940-1309
Phone: 787-721-4299; 787-725-2333;
1-800-981-4125 (in-State only)
TTY: 787-4014
Fax: 787-721-2455
E-mail: mmorales@oppi.gobierno.pr
jrocasio@oppi.gobierno.pr
Web site: www.oppi.gobierno.pr

RHODE ISLAND

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Ray Bandusky, Executive Director
Rhode Island Disability Law Center, Inc.
349 Eddy Street
Providence, RI 02903
Phone: 401-831-3150;
1-800-733-5332 (in-State only)
TDD: 401-831-5335
Fax: 401-274-5568
E-mail: rbandusky@ridlc.org

Protection and Advocacy Offices (continued)

SOUTH CAROLINA

CAP

Dr. Larry Barker, CAP Director
Office of the Governor
Division of Ombudsman and Citizen Services
1205 Pendleton Street
Columbia, SC 29211
Phone: 803-734-0285; 1-800-868-0040
Fax: 803-734-0546
E-mail: mbutler@govoepp.state.sc.us
lbarker@govoepp.state.sc.us
Web site: www.govoepp.state.sc.us/cap/

PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Gloria Prevost, Executive Director
Protection & Advocacy for People
with Disabilities, Inc.
3710 Landmark Drive, Suite 208
Columbia, SC 29204
Phone: 803-782-0639 voice/TDD;
1-866-275-7273 (in-State only)
Fax: 803-790-1946
E-mail: info@protectionandadvocacy-sc.org
prevost@protectionandadvocacy-sc.org
Web site: www.protectionandadvocacy-sc.org

SOUTH DAKOTA

**CAP/PADD/PAIMI/PAIR/PABSS/TBI/
PAVA**

Robert Kean, Executive Director
South Dakota Advocacy Services
221 S. Central Avenue
Pierre, SD 57501
Phone: 605-224-8294 voice/TDD;
1-800-658-4782 (in-State only)
Fax: 605-224-5125
E-mail: keanr@sdadvocacy.com
Web site: www.sdadvocacy.com

TENNESSEE

**CAP/PADD/PAIMI/PAIR/PABSS/TBI/
PAVA**

Shirley Shea, Executive Director
Tennessee P&A, Inc.
P.O. Box 121257
Nashville, TN 37212
Phone: 615-298-1080 voice;
615-298-2471 TTY;
1-800-287-9636 (nationwide)
Intake Unit: 901-458-6013;
901-343-4241 TTY;
1-800-342-1660 (nationwide)
TTY: 1-888-852-2852 (nationwide)
Fax: 615-298-2046
E-mail: gethelp@tpainc.org; shirleys@tpainc.org
Web site: www.tpainc.org

TEXAS

**CAP/PADD/PAIMI/PAIR/PABSS/TBI/
PAVA**

Mary S. Faithfull, Executive Director
Advocacy, Inc.
7800 Shoal Creek Boulevard, Suite 171-E
Austin, TX 78757
Phone: 512-454-4816 voice/TDD;
Intake 1-800-315-3876
1-800-252-9108 (nationwide)
Fax: 512-323-0902
E-mail: infoai@advocacyinc.org
mfaithfull@advocacyinc.org
Web site: www.advocacyinc.org

Protection and Advocacy Offices (continued)

UTAH

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Fraser Nelson, Executive Director
Disability Law Center
The Community Legal Center
205 North 400 West
Salt Lake City, UT 84103
Phone: 801-363-1347;
1-800-662-9080 (nationwide)
TTY: 801-924-3185
Fax: 801-363-1437
E-mail: fnelson@disabilitylawcenter.org
Web site: www.disabilitylawcenter.org

VERMONT

CAP

Nancy Breiden, CAP Director
Vermont Disability Law Project
57 N. Main Street, Suite 2
Rutland, VT 05701
Phone: 802-775-0021;
1-800-769-7459
Fax: 802-775-0022
E-mail: nbreiden@vtlegalaid.org

PADD/PAIMI/PAIR/PABSS/TBI/PAVA

Edward Paquin, Executive Director
Vermont Protection & Advocacy, Inc.
141 Main Street, Suite 7
Montpelier, VT 05602
Phone: 802-229-1355;
1-800-834-7890 (nationwide)
Fax: 802-229-1359
E-mail: info@vtpa.org
epaquin@vtpa.org
Web site: www.vtpa.org

VIRGIN ISLANDS

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Amelia Headley LaMont, Executive Director
Virgin Islands Advocacy, Inc.
63 Estate Cane Carlton
Frederiksted, VI 00840
Phone: 340-772-1200
TDD: 340-772-4641
Fax: 340-772-0609
E-mail: info@viadvocacy.org
alamont@justice.com
Web site: www.viadvocacy.org

VIRGINIA

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

V. Colleen Miller, Executive Director
Virginia Office for Protection & Advocacy
1910 Byrd Avenue, Suite 5
Richmond, VA 23230
Phone: 804-225-2042 Voice/TDD;
1-800-552-3962 (in southern VA only)
Fax: 804-662-7057
E-mail: colleen.miller@vopa.virginia.gov
Web site: www.vopa.state.va.us

WASHINGTON

CAP

Jerry Johnsen, CAP Director
Client Assistance Program
2531 Rainier Avenue South
Seattle, WA 98144
Phone: 206-721-5999; 1-800-544-2121
Fax: 206-721-4537
E-mail: capseattle@att.net

Protection and Advocacy Offices (continued)

**PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Mark Stroh, Executive Director
Washington P&A System
315 Fifth Avenue South, Suite 850
Seattle, WA 98104
Phone: 206-324-1521;
1-800-562-2702 (nationwide)
TTY: 206-957-0728; 1-800-905-0209
Fax: 206-957-0729
E-mail: wpas@wpas-rights.org
Mstroh@wpas-rights.org
Web site: www.wpas-rights.org

**PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Lynn Breedlove, Executive Director
Wisconsin Coalition for Advocacy
16 N. Carroll Street, Suite 400
Madison, WI 53703
Phone: 608-267-0214;
1-800-928-8778 TTY
Fax: 608-267-0368
E-mail (Madison): wcamnsn@w-c-a.org
lynnb@w-c-a.org
(Milwaukee): wcamke@w-c-a.org
Web site: www.w-c-a.org

WEST VIRGINIA

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Edward W. Rugeley, Jr., Interim
Executive Director
West Virginia Advocates, Inc.
Litton Building, 4th Floor
1207 Quarrier Street
Charleston, WV 25301
Phone: 304-346-0847 voice/TDD;
1-800-950-5250 (nationwide)
Fax: 304-346-0867
E-mail: wvainfo@wvadvocates.org
erugeley@wvadvocates.org
Web site: www.wvadvocates.org

WYOMING

**CAP/PADD/PAIMI/PAIR/PABSS/
TBI/PAVA**

Jeanne Thobro, Executive Director
Wyoming Protection & Advocacy
System, Inc.
320 West 25th Street, 2nd Floor
Cheyenne, WY 82001
Phone: 307-632-3496
1-800-624-7648 (in-State only)
Fax: 307-632-3496
E-mail: wypanda@vcn.com
Web site: wypanda.vcn.com

WISCONSIN

CAP

Linda Vegoe, CAP Director
Department of Agriculture
Trade and Consumer Protection
2811 Agriculture Drive
P.O. Box 8911
Madison, WI 53708-8911
Phone: 608-224-5070; 1-800-392-1290
Fax: 608-224-5069
E-mail: linda.vegoe@datcp.state.wi.us

NTAC Summer/Fall 2002 Networks Newsletter

Perspectives From the Field

Consumer View: Restraint Is Not Therapeutic

by William Pflueger*

It is difficult to write about my experiences with seclusion and restraint. Someone who has experienced it wouldn't want to read any further, and for someone who hasn't, how can it be explained? A comparison that comes to mind is describing the practice of whipping as a control and conditioning mechanism for slaves to an audience from the 1850s. Depending on the sympathies of the reader, possible reactions could be, "How ghastly! How wrong! This practice must be ended!" or, "Understandably upsetting to the squeamish, but a necessary, albeit unpleasant treatment to maintain control and safety for all involved."

Fortunately for me, it has been a number of years since I was locked up and tied down. It always seemed like overkill. Here I am in a locked facility and I get put in a locked room and then strapped and locked to a bed. I was expecting that next a canvas bag would be put over me and I would be dropped into a river.

I can't bring myself to describe the moment-by-moment struggles and shear gut-wrenching terror of being put into five-point restraint. Tears well up in my eyes and I feel a dark hole opening below me. I don't feel comfortable wearing watches any more and for a long time belts were out of the question. Just the smell of leather and jingle of the hardware were enough to trigger memories of those horrible times. The faces of the people who put me in restraints are stamped in my mind as indelibly as members of my family. The whole experience made me feel ashamed and that my soul had been dishonored. I sense that some of the shame rubbed off on the people who were ordered to do that to me. 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. It didn't matter that it might offer me something helpful; I didn't want any of it if that horrible experience was going to be a part of the package. So then where does one go with the feelings that are swirling around in the aftermath of that experience?

The trauma of the treatment is not something that can be discussed with the person who ordered it. How can a doctor acknowledge that the first tenet of the Hippocratic Oath has been violated at his or her own hand? The standard professional response is, "unfortunate but necessary. Let's not dwell on the past."

Page 1 of 2

Perspectives From the Field (continued)

The techniques normally don't leave any permanent physical scars, but if the practitioners could see the psychological damage done they would know that the treatment causes more harm than good. It is like amputating someone's leg to deal with a broken ankle. The mental condition that you leave with shouldn't be worse than the one you arrived with, but when a human being is treated like a non-human, that insult and injury is added on to the diagnosis that you already have. However it is not acknowledged by anyone but the person who experienced it.

If we could all just recognize and acknowledge that the ordeal of seclusion and restraint is harmful, it would be a wonderful beginning for creating a mental health system that is truly about recovery, wellness, and helping the whole person.

**Mr. Pflueger is the Treasurer of the Statewide Mental Health Consumer/Survivor Network of Minnesota.*

Debriefing Survey for Consumers

Before staff put me in seclusion or restraint.....

1. I was acting in a manner that could have been dangerous to myself or others.
2. Someone tried to calm me down or resolve my problem.
3. The reasons why I was restrained or secluded were explained to me.
4. Staff said my behavior was inappropriate, however, my behavior was not dangerous.
5. I was given medication.

While in seclusion or restraint...

1. I was allowed to take a drink of water and/or eat at mealtime.
2. I was released every two hours and given an opportunity to move about and exercise.
3. Hospital staff checked on me every 30 minutes to see if I was okay.
4. I was examined by a physician.
5. I was allowed to use the bathroom at least every hour.
6. Unnecessary force was used.
7. I was physically injured.
8. I was physically abused.
9. I was sexually abused.
10. I was psychologically abused, ridiculed, or threatened.

MODULE 6 - REFERENCES

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- Steele, E. (1999). *Seclusion and restraint practice standards: A review and analysis, 1999*. Alexandria, VA: National Mental Health Association, Consumer Supporter Technical Center.
- University of Illinois at Chicago National Research and Training Center on Psychiatric Disability. (2002) *Increasing self-determination through advance crisis management in inpatient and community settings: How to design, implement, and evaluate your own program*. Phone: 312-422-8180. Web site: www.psych.uic.edu/mhsrp.