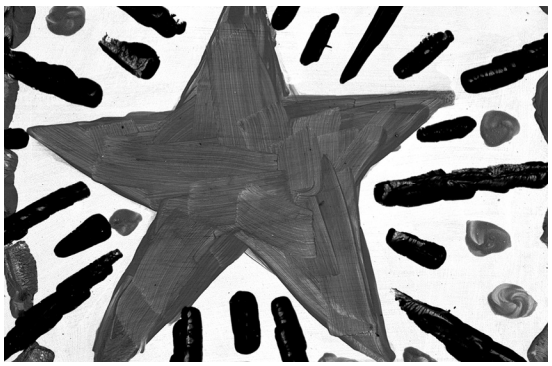


Leadership

Kevin Ann Huckshorn, RN, MSN, CAP, ICADC

Janice LeBel, Ph.D.

"Some are born great, some achieve greatness, and some have greatness thrust upon 'em."

Shakespeare, from *Twelfth Night*

Leadership

This chapter has been extracted and synthesized from the National Association of State Mental Health Program Directors' (NASMHPD) National Technical Assistance Center (NTAC)'s curriculum on eliminating treatment violence and coercion, also known as The Six Strategies©. This curriculum is part of the NTAC National Executive Training Institutes (NETI) and has been taught to more than 3,000 people from 48 states and territories in the United States as well as states within Australia and New Zealand. The Department of Mental Health thanks Kevin Ann Huckshorn, RN, MSN, CAP, ICADC; former Executive Director of NTAC, current administrator at Bridgewater State Hospital for the generous use of this material.

The National Executive Training Institute (NETI) has been advancing the national initiative to reduce S/R. In 2002, experts from around the country met to identify core strategies to make culture and practice change. The experts, most of whom had already successfully reduced or eliminated seclusion and restraint in their respective states or facilities, agreed that leadership was the single most important core strategy in this culture change process.

How can leaders create culture change to reduce S/R?

Simply put, leaders have the power, the role, and the authority to make the changes that are necessary for S/R reduction/elimination success, such as:

- Making and keeping S/R reduction a high priority
- Creating a plan for S/R reduction/elimination
- Reducing or eliminating organizational barriers
- Providing the necessary resources
- Holding people accountable for their actions
- Identifying and valuing champions who are committed to this work

What are the key leadership principles to creating culture change?

1. Commitment

Programs that want to create violence-free, strength-based, collaborative treatment environments must have leaders who are dedicated to these values and willing to make changes to existing policies, procedures, and practices to make that happen. This process can be difficult and time-consuming. It requires commitment, resources, and patience.

Changing culture and practice generates a lot of anxiety. People may feel nervous, unsure, or skeptical. This is a natural part of the process. But leaders must hold the staff member's anxiety and be willing to model the same behavior that is expected of staff members—utilizing a style of management that empowers and supports all staff.

2. Mission, vision, and values

Many program leaders in Massachusetts, other parts of the United States, and in other countries have revised their:

- mission statements
- vision statements, and
- core values/principles

as the first step in their strategic planning process. Generally speaking, these revisions include incorporating language that reflects the desire to establish affirming, trauma-sensitive, non-violent, strength-based treatment cultures that promote collaboration rather than control. This step is generally followed by the development of an organizational position statement about the goal of the reducing and striving to eliminate S/R practices.

Program mission statements reflect the core purpose of the program and should be inspiring and easy to communicate. Program vision statements are broad statements that describe the program's aspirations for the future. Bill Anthony, cited in the NETI Leadership module (2006), states:

> **"A shared organizational vision is like a magnet, it attracts people with its special characteristics."**

Mission and vision statements can be communicated to staff members in many ways, such as the use of metaphors, anecdotes, personalized accounts of S/R, and experiences with trauma-informed care. Mission and vision statements are important because they define who the organization is, help energize staff members, and mobilize them to work toward a common goal. They also provide a sense of purpose to staff members, children, families, and the community.

3. Clarifying organizational values

Once a program vision has been established, program leaders must set clear goals for reducing and striving to eliminate S/R based on the program vision. They must also create a program culture that identifies and lives by the key values of violence-free, coercion-free care. Many programs in the Massachusetts initiative have moved from being rule-based, institutional, impersonal, and, at times, coercive, to providing person-centered care based on respect and meeting the unique needs of each individual.

This is the point in the change process when programs conduct a comprehensive reality check and start to reexamine:

- Program policies
- Program procedures
- Treatment activities
- Rules
- Schedules
- Historic practices
- Traditions, beliefs, and unspoken rules that persist

Basically, everything must be reconsidered, reevaluated, and measured against the new program values of creating a strength-based, non-violent, respectful and caring culture that facilitates S/R reduction/elimination.

This is when you ask yourselves, “Is what we say, actually what we do?”

Practice what you preach—examples:

Value:	Individualized Person Centered Care
Practice:	Everyone goes to bed at 9:00 PM and lights out
Change:	There is a range of bedtimes to accommodate differences in bio- rhythms, nighttime difficulties, and preferences.

Value:	S/R only used for imminent danger
Practice:	Any kind of property destruction, threats, physical acting out results in S/R use
Change:	Children who engage in one time only hitting, break furniture, kick a staff person, throw something, or otherwise act out and then calm down are not put in seclusion or restraint but addressed in treatment team.

Value:	Program is trauma-informed
Practice:	Trauma not formally assessed or in treatment/crisis plans. Environment gives mixed message: rules posted, no welcome sign, institutional décor/color, metal detectors, searches, locked/alarmed doors, S/R rooms
Change:	Soften environment & reflect trauma awareness in treatment and program operations.

Using respectful language that recognizes the person

"Person-first" language is the preferred language for person-centered care and explicitly refrains from using labels and terms that are distancing, dehumanizing, institutional, and not recovery-oriented, such as: units, wards, line staff, in the trenches, non-compliant, manipulative, attention-seeking, an actress, etc. Person-first language is respectful and reflects the philosophy of how we speak about something is indicative of how we feel about and value it.

Person-first language encourages individualized, respectful descriptions that do not label. For example, it is better to say someone "has schizophrenia" rather than calling them "schizophrenic." People are not their diagnoses. Person-first language reminds us that the people we serve are, just like us, sons, daughters, friends, neighbors, employers, employees, students, teachers, and so much more than their illness or the challenges they face.

Examples:

- At **Central Louisiana State Hospital in Alexandria, Louisiana:** Adolescents who are hospitalized at Central Louisiana State Hospital are referred to by their given name and called "students" by all the staff. Their policies and procedures refer to "students." The hospital leadership believes this is an important way for everyone to remember that the adolescents are there to learn, and the job of staff is to teach, support, and coach.
- At **South Florida State Hospital in Pembroke Pines, Florida**: Adults who are hospitalized at South Florida State Hospital are referred to as: *"persons served."* This may seem different—but all the staff use this language to describe every person who is hospitalized at that facility. This is what consumers said they preferred to be called. It also reminds staff of their role, to help and serve the people in their care.

4. Using human technology! Empowering, supporting, and supervising staff

It is important for program leaders to empower the staff members who provide care to children in their programs. This entails sharing the program mission and vision, and providing the skills, information, authority, and resources necessary to carry out their responsibilities.

This can be done through on-going training, education, support, and supervision as well as involving staff members in program decision making. The goals are for staff members:

- to become empowered to negotiate with and empower the children so that they can provide choices that are "win-win," and
- to value the avoidance of trauma and re-traumatization more highly than compliance with program rules.

Weekly supervision and on-going training opportunities provide staff with the tools and information that they need to care for and treat the children in the program. It also ensures that new standards are well-integrated into the program culture and sustained over time.

To create a positive caring culture, training for staff must include trauma-informed care, understanding the impact of trauma on children, assessing traumatized children, learning and practicing verbal de-escalation techniques, utilizing individualized crisis prevention (Safety Tools), and eliminating power and control struggles with children.

Changing a program culture also means changing the staff culture. This can be accomplished if staff:

- understand the reason that change is needed
- are willing to try to do things differently
- are given new tools to use and understand how and when to use them
- receive ongoing supervision and feedback about their performance
- feel empowered and supported

Other ways to help staff feel like an important and active part of this change process is to have staff members:

- attend good training programs
- visit other successful programs
- spend time conceptualizing, implementing, and overseeing the program's strategic plan and change initiatives
- bring their skills and talent to the program! Lead poetry classes, teach yoga, coach a sport, and organize music groups, boy/girl scout troops, chess clubs, etc.

5. Using data to inform practice

Leaders should use data to inform their efforts to reduce S/R in their programs. They should gather historical data (six months to a year) to use as a baseline and then set realistic goals for reduction of S/R.

There are a number of variables that are important to gather and track to analyze events as part of a reduction/elimination plan, including:

- Unit/Day/Shift/Time of Day
- Age/Gender/Race
- Date of admission/diagnosis
- Attending physician
- Pattern of staff involved in events
- Number of grievances
- Precipitating events
- Safety issues justifying S/R

Data must be used to monitor the program's progress, share with staff, inform new practices, and to identify training needs. Data must be posted, visible, used, and common knowledge among the staff. Measuring S/R is a clear way that programs can explicitly see what they are doing and what works and what does not.

Many programs around the country actively use their data:

The Merrimack Center IRTP in Tewksbury, Massachusetts has been using an advanced data program that creates real-time charting of acuity and allows staff to see what is really happening in the program and with each adolescent, in the moment, and over time.

In Pennsylvania, the adult state hospital system issues monthly S/R reports electronically which are posted online and available to any interested parties. They share detailed aggregate data to ensure transparency, one of the goals of the New Freedom Commission Report, and to vigilantly measure what they are doing and where they are going.

At Fulton State Hospital in Missouri, every unit has a S/R Bulletin Board maintained by consumers and staff. Staff members post the data and offer unit-to-unit consultation to their peers. Consumers post their experiences in S/R and write thank you notes to staff who helped them avoid S/R. Written recommendations are offered from the "Peace Club" about how to "keep the peace." Data helps keep everyone focused around this common goal of increasing safety and decreasing S/R.

Some states, such as California, embrace transparency by posting S/R data from their inpatient systems on their state's web site at: http://www.dsh.ca.gov/Publications/Reports_and_Data/Seclusion_and_Restraint/default.aspx

6. Leaders develop a S/R plan

To effectively implement an organizational and cultural change process, the initiative has to be planned, written down, and be part of an overarching strategic action planning process.

In Massachusetts, the importance of developing a strategic plan to prevent S/R was part of the Child/Adolescent S/R Prevention Initiative since its inception. Now, this planning requirement is included in the DMH regulations governing S/R (104 CMR 27.12: Prevention of Restraint and Seclusion and Requirements When Used), which were promulgated and revised on February 15, 2018.

The new regulations require facilities governed by the regulations to develop and implement a plan to reduce, and wherever possible, eliminate the use of S/R. The DMH regulations offer an important degree of specificity and detail to help every facility frame their S/R prevention effort.

The NTAC NETI curriculum offers an overarching framework that leaves customization to the state/facility or treatment setting. They recommend that the plan should:

- Adopt a prevention approach;
- Utilize Performance Improvement Principles (CQI) with action steps, responsible parties, goals, timeframes and the names of individuals responsible for action steps within the plan;
- Involve a stratified, multi-disciplinary team with all levels of staffing represented;
- Be shared, and the team should meet on a regular basis to review data, measure progress and update the plan and action steps;

- Identify a realistic, measurable goal and core strategies to be implemented;
- Include the people we serve in the planning and implementation of the initiative. We have much to learn about what works, what doesn't, and how consumers and families think we can improve the care we provide. While consumer involvement can be challenging with short lengths of stay, it is still possible to solicit input in creative ways.

Example: The Inpatient Pediatric Psychiatry Unit at North Shore Medical Center Union Hospital in Lynn, Massachusetts creatively solicits input and feedback from families and visitors with an attractive form positioned right at the entry way. We need the voice of consumers—they are our customers.

Example: At Tewksbury State Hospital in Tewksbury, Massachusetts, three of the consumers who posed the greatest treatment challenges for staff were asked to make up an expert advisory panel for their S/R strategic planning effort. Some of Tewksbury's most important and useful recommendations came from consumers who could share exactly what helped, what didn't, and what strategies would be more effective.

Massachusetts interagency restraint and seclusion prevention initiative

The initiative was officially launched in May 2009, and brings together the Department of Children and Families (DCF), the

Department of Mental Health (DMH), the Department of Youth Services (DYS), the Department of Early Education and Care (DEEC), the Department of Elementary and Secondary Education (DESE), and the Department of Developmental Services (DDS). These state agencies are partnering with youth, providers, parents, schools and other community advocates to focus on preventing and reducing the use of restraints linked to behavior restrictions and to ensure that youth serving settings are utilizing trauma-informed practices that respectfully engage families and youth.

The Initiative builds on the nationally-recognized efforts of DMH, which significantly reduced use statewide. The *Massachusetts Interagency Restraint and Seclusion Prevention Initiative Charter* is included as an additional resource at the end of this chapter.

Summary

Program leaders are responsible for creating and maintaining a caring treatment culture that reduces and strives to eliminate S/R, violence and coercion.

This requires rethinking and likely redrafting portions of mission and vision statements and agency values with all staff members. It requires a thorough review of all program policies and procedures to assess for congruence between what programs say they do and actual practices and to be sure these important documents reflect the new values and the

direction of the program. This process also includes developing and regularly reviewing job descriptions and staff competencies, supervising annual performance reviews, overseeing program and agency operational goals, and measuring program outcomes.

Program leaders must anticipate the natural tendency for staff members to return to past treatment practices, particularly when stressed. Past practices are more familiar and comfortable. It is important for leaders to create systems that can quickly recognize and respond to any departures from the revised program values and goals.

Supervision is an important way to teach and reinforce new skills and to recognize and reward staff members' successes and hard work. Formal evaluation systems should be developed to assess whether staff members have learned the skills necessary to meet the new expectations and are using them regularly with all of the children.

Most importantly, leadership carries the responsibility for sustaining the effort and keeping it going! *It takes a long time and hard work to change thinking and practice… this is marathon work!*

Additional resources

- Massachusetts Interagency Restraint and Seclusion Prevention Initiative Charter, revised January 2017.
- Promoting Alternatives to the Use of Seclusion and Restraint- Making the Business Case. Issue Brief #4, March 2010.

Commonwealth of Massachusetts

CHARLES D. BAKER
Governor

Massachusetts Interagency Restraint and Seclusion Prevention Initiative

Executive Office of Health & Human Services:
Department of Children and Families (DCF)
600 Washington Street
Boston, MA 02111

Department of Mental Health (DMH)
25 Staniford Street
Boston, MA 02114
Department of Youth Services (DYS)
600 Washington Street
Boston, MA 02111

Department of Developmental Services (DDS)
500 Harrison Avenue
Boston, MA 02118

Executive Office of Education:
Department of Elementary and Secondary Education (ESE)
75 Pleasant Street
Malden, MA 02148

Department of Early Education and Care (EEC)
51 Sleeper Street
Boston, MA 02210

Initiative Charter

The Commonwealth is committed to serving youth and families in the most respectful manner possible. Massachusetts strives to ensure that treatment and educational settings employ behavior support methods that reflect current knowledge about child development, including the impact of early traumatic experiences. To that end, the Departments of Children and Families (DCF), Mental Health (DMH), Early Education and Care (EEC), Elementary and Secondary Education (ESE), Developmental Services (DDS) and Youth Services (DYS) are working together, in partnership with providers, advocates, educators, schools, families and youth, to focus on preventing the use of coercive behavior management that can be re-traumatizing., including restraint and seclusion.

Vision

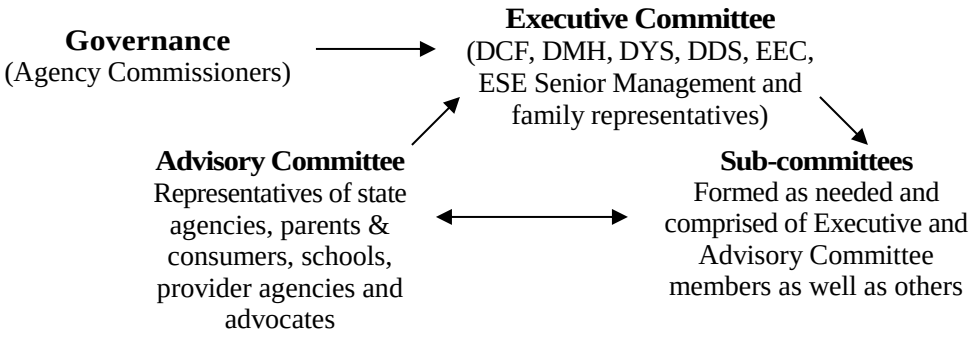
All youth serving educational and treatment settings will use trauma informed, positive behavioral support practices that respectfully engage families and youth.

Guiding Principles

The ***MA Interagency Restraint and Seclusion Prevention Initiative*** Partners commit to the following principles:

1. All parties will increase the use of positive behavioral supports and treatment services that reflect current knowledge about child development and the impact of early traumatic experiences.
2. Every effort will be made to prevent the need for the use of restraint and/or seclusion.
3. Restraint or seclusion should not be used except in situations where the child's behavior poses imminent danger of physical harm to self or others.
4. Children have a right to be treated with dignity and to be free from abuse and all policies and practices regarding behavioral interventions will reflect this right
5. Policies regarding the use of restraint and seclusion will require that all incidents resulting in the use of restraint and seclusion be documented and that overall data be collected in a manner that allows for review and oversight by parents, youth, teachers, administrators, and other school, district and program, staff.
6. Parents/guardians have a right to be informed of any and all policies or practices on restraint and seclusion at their child's school or program, as well as to be notified consistent with applicable legal or other provisions and as soon as possible following any instance in which restraint or seclusion is used with their child.
7. Teachers, administrators, and other school, district and program staff working with children and youth will receive regular training on the use of alternatives to physical restraint and seclusion, such as positive behavioral interventions and supports.
8. Treatment and educational settings will strive to maintain environments that are respectful of workforce safety.

R/S Prevention Initiative Organizational Structure/ Roles and Responsibilities



Governance

- Establishes vision and overall direction for the Initiative.
- Approves all major policy recommendations.
- Provides institutional and political support.
- Provides necessary resources to carry out the Initiative.

Advisory Committee

- Endorses Initiative principles and goals; uses individual/organizational networks/affiliations to promote the Initiative.
- Reviews and provides input to the Executive Committee on goals, objectives, activities and metrics for the Initiative.
- Reviews and provides commentary on Subcommittee reports and recommendations.

Executive Committee

- Develops and sets strategic priorities to accomplish the goals of the Initiative.
- Keeps the Governance Board updated on the status of the Initiative.
- Identifies resources to support the work of the Initiative.
- Ensures that the Initiative remains within the scope of its charter and sustains progress towards goals.
- Develops communication strategies to support the goals of the Initiative.
- Promotes cross system approaches to reducing the use of restraint and seclusion.
- Leads internal agency change efforts aligned with Initiative goals and priorities.

FY2017 Strategic Focus: Workforce Development

Priority Activities:

- Continue to engage current and new stakeholders to the Interagency Restraint/Seclusion (RS) Prevention Initiative through active, ongoing Advisory Committee recruitment and better/best practice exposure by sharing resources, presentations of innovative efforts, and systemic data and trends to continue to inform quality improvement.

- Enhance the knowledge, skills, and methods of RS prevention/reduction through shared learning opportunities and the development of an interagency/cross provider training calendar of restraint/seclusion prevention related training available to stakeholders.

- Promote this initiative and the importance of the work of RS prevention/reduction with an annual event.

Six Core Strategies© to Reduce the Use of Restraint and Seclusion

A key element of the Initiative is encouraging state agency partners, schools and residential service providers to develop and implement organizational culture/practice change efforts to reduce and prevent the use of restraint and seclusion that are aligned with and include the following *Six Core Strategies©*:

1. Leadership Toward Organizational Change: To reduce and prevent the use of restraint and seclusion (R/S) by defining and articulating a mission, philosophy of care, guiding values, and assuring for the development of a R/S reduction plan and follow through of plan implementation. Executive leadership is clearly demonstrated throughout the R/S reduction and prevention project by ensuring accountability as well as providing support, guidance, direction, participation, and ongoing review.

2. Use Data to Inform Practices: To reduce and prevent the use of R/S by using data in an empirical, non-punitive, manner. This includes using data to analyze characteristics of incidents including time of day, staff involved, precipitating events, etc. It also means identifying "baseline" data for each facility or programs, setting improvement goals and comparatively monitoring over time at all levels of the system: individual units, programs, agency and/or statewide as a system.

3. Workforce Development: To create a treatment environment whose policy, procedures, and practices are grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans. Includes an understanding of the characteristics and principles of trauma informed care systems such as choice, respect, dignity, partnerships, self-management, and full inclusion. This strategy is designed to create an environment that is less likely to be coercive or conflictual. It is implemented primarily through staff pre-service and in-service training and education and HRD activities (e.g., job descriptions and performance evaluations). It is also critical to include families in training and other professional development activities.

4. Use Restraint and Seclusion Prevention Tools: To reduce and prevent the use of R/S through the use of a variety of tools and strategies which are individualized and integrated into each consumer's treatment/care plan. This includes identifying risk factors or "triggers," understanding their restraint and seclusion history, the use of de-escalation or safety surveys and contracts; and environmental changes to include comfort and sensory rooms and/or other clinical interventions that have been shown to assist in emotional self-management.

5. Actively Recruit and Include Families and Youth: This strategy involves the full and formal inclusion of consumers, children, families and external advocates in various roles and at all levels in the organization to assist in the reduction and prevention of R/S. This may include their involvement in event oversight, monitoring, debriefing, peer support services or any key agency/program committees dealing with R/S. Programs may also choose to implement consumer satisfaction surveys with results used to inform or revise policies and procedures. Staff must also be trained on the importance of and need to involve consumers in efforts to reduce and prevent R/S.

6. Make Debriefing Rigorous: To reduce and prevent the use of R/S through knowledge gained from a rigorous analysis of R/S events and the use of this knowledge to inform policy, procedures, and practices to avoid repeats in the future. A secondary goal of this intervention is to attempt to mitigate to the extent possible the adverse and potentially traumatizing effects of a R/S event for involved staff and consumers. Different levels of debriefing often occur: with the consumer, with participants or witnesses, and as part of an administrative review to understand the organizational factors that contributed to the event. For this reason, senior leadership participation is vital.

Excerpted from: Huckhorn, Kevin Ann, "Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool," October 2005. The development of the Six Core Strategies model was funded by the US Substance Abuse and Mental Health Services Administration (SAMHSA) and created by National Association of State Mental Health Program Directors (NASMHPD), Office of Technical Assistance.

Promoting Alternatives to the Use of Seclusion and Restraint

Issue Brief #4 Making the Business Case

MARCH 2010

About the Series:

Promoting Alternatives to the Use of Seclusion and Restraint

The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed, in collaboration with partners at the Federal, State, and local levels, consumers, and national advocacy organizations, a series of issue briefs on the use of seclusion and restraint. The purpose of this series is to provide information on the use of seclusion and restraint throughout the country, efforts to reduce their use, and their impact at the individual/family, program, and system levels. For an overview of the background and history of the initiative to reduce the use of seclusion and restraints, please refer to the first issue brief in the series, entitled Promoting Alternatives to the Use of Seclusion and Restraint—Issue Brief #1: A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services*, which is available at* **http://www.samhsa.gov/matrix2/seclusion_matrix.aspx.**

Introduction

Seclusion[1] and restraint[2] are coercive, high-risk containment procedures that contribute to the problem of violence against consumers and staff members in behavioral health care settings. In fact, an estimated 50 to 150 individuals die each year as a result of seclusion and restraint practices in facilities, and countless others are injured or traumatized (Weiss et al., 1998). These practices are detrimental to the recovery of persons with mental illnesses and adversely affect the quality of care and the safety of all involved (di Martino, 2003; Huckshorn & LeBel, 2009). Equally important, yet often less recognized, is the multilevel economic burden that is inherent in their use (Flood, Bowers, & Parkin, 2008; LeBel & Goldstein, 2005).

Based on clinical best practice, inpatient and residential mental health facilities in the United States and other countries have implemented initiatives to reduce seclusion and restraint use (National Association of State Mental Health Program Directors [NASMHPD], 2009; Nunno, Day, & Bullard, 2008). Several programs that have reduced their use have reported fiscal benefits (LeBel & Goldstein, 2005; Murphy & Bennington-Davis, 2005; Sanders, 2009). These facilities have changed their organizational cultures and practices and report that benefits and savings exceed the costs associated with the use of seclusion and restraint (LeBel, 2009). Given the potential savings, health care organizations should reconsider reducing seclusion and restraint from a "best business practice" imperative.

This issue brief, the fourth in a series, provides a summary of a recently developed white paper,*The Business Case for Preventing and Reducing Restraint and Seclusion Use*, authored by Janice LeBel, Ed.D. for the Substance Abuse and Mental Health Services Administration (SAMHSA). The paper describes the systemic, organizational, and personal costs of the use of seclusion and restraint practices as well as cost savings related to reduction in their use.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

The Cost of Seclusion and Restraint Use

Although the fiscal cost of violence against staff members (workplace violence) has been well-studied, only recently has there been an exploration of the costs of violence against consumers associated with seclusion and restraint (Cromwell et al., 2005; Flood et al., 2008; Huckshorn, 2006; LeBel & Goldstein, 2005). This section of the issue brief will examine costs associated with seclusion and restraint at the systemic, organizational, and personal levels.

Systemic Costs

The systemic costs of seclusion and restraint are the larger economic bases of health care costs, which include workplace violence and organizational disruption such as decreased productivity and recruitment and retention challenges. Systemic costs also include preventable adverse events or medical errors that may follow seclusion and restraint use. Across health care, medical errors are a very serious problem potentially claiming up to 98,000 lives and costing $29 billion annually in health care (Institute of Medicine [IOM], 2000). Psychiatry now recognizes seclusion and restraint as medical errors "…of commission, perhaps errors of omission, causing either near misses or preventable adverse events in routine clinical practice" (Grasso et al., 2007).

The Federal Government, several States, and some private insurers are adopting new parameters for compensating care resulting in medical errors or hospital-acquired conditions. Specifically, certain "Never Events" will no longer be compensated (Centers for Medicare and Medicaid Services (CMS), 2008; National Quality Forum, 2006; and UniCare, 2008). "Never events" are defined by CMS as preventable adverse events with serious consequences for the patient that should never happen in health care (CMS, 2008). These "Never Events" include two occurrences related to seclusion and restraint use: (1) death or serious disability associated with restraints, and (2) death or significant injury resulting from a physical assault. The impact of this decision is significant, as public funding represents roughly 40 percent of the revenue for mental health treatment facilities (U.S. Government Accountability Office, 1999b).

Organizational Costs

Seclusion and restraint significantly increase a number of organizational and health care costs. The most significant day-to-day cost is the amount of staff time spent managing these procedures (Flood et al., 2008; LeBel & Goldstein, 2005). The full cost to an organization is unknown, but a time/motion/task analysis conducted within one State facility estimated the cost of one restraint episode to be between $302 and $354, depending upon the number of containment methods used (i.e., physical, mechanical, and/or medication) (LeBel & Goldstein, 2005). A 1-hour restraint involved 25 different activities and claimed nearly 12 hours of staff time to manage and process the event from the beginning until the end of all required tasks (LeBel & Goldstein, 2005). Collectively, restraint use claimed more than 23 percent of staff time and $1.4 million in staff-related costs, which represented nearly 40 percent of the operating budget for the inpatient service studied (LeBel & Goldstein, 2005). Flood et al. (2008) report 50 percent of nursing resources are used to manage seclusion and restraint-related incidents. The work of Cromwell and his colleagues (2005) confirmed that seclusion and restraint increase the cost of care due to additional staff time required to implement and monitor these procedures. They found that the monitoring time required during these procedures represented the greatest resource intensity, accounted for the most nursing-staff time, and significantly increased the daily cost of care (Cromwell et al., 2005).

Several other seclusion- and restraint-related costs, such as physical injuries to staff members and persons served, have been reported by inpatient and residential providers (Huckshorn, 2006; NASMHPD, 2009). Injuries to staff members, in turn, contribute to workforce instability (e.g., turnover, industrial accidents, absenteeism/sick time, replacement costs, hiring costs, training/retraining), which can be extremely costly to an organization (LeBel & Goldstein, 2005; Unruh, Joseph, & Strickland, 2007).

In addition to these economic burdens, organizations must address liability and legal costs. Liability matters may be the most significant fiscal consequence of seclusion and restraint. Many organizations have reported substantial liability costs associated with these practices (LeBel & Goldstein, 2005; Murphy & Bennington-Davis, 2005; Sanders, 2009) and several organizational leaders indicated that exorbitant liability policy premiums are a fiscally compelling reason to change practice (LeBel, 2009).

When injury or death occurs from seclusion and restraint use, litigation costs and judgments awarded by the courts also have the potential to be the most costly result (Haimowitz, et al., 2006; Stefan, 2002). Stefan noted, "Tort claims can involve a number of different causes of action: excessive force, medical malpractice, failure to protect, assault and battery, and failure to maintain a safe environment" (Stefan, 2002). Legal actions can lead to judgments including fines ranging from several thousand dollars to multimillion dollar settlements as well as incarceration and/or probation for staff members.

A Family's Experience of the Ultimate Restraint Cost

Tanner Wilson

Tanner Wilson was 9 years old when he was admitted to a residential program in Iowa. Within 24 hours of his admission, Tanner's leg was broken in a physical restraint. His leg required surgery, a body cast, and rehabilitation. He returned to the program using a walker. His leg was broken a second time in a separate incident at the program. Fifteen months after he was admitted, Tanner died while being restrained in a "routine prone physical hold."

Tanner was the son of Karen and Robert Wilson. His mother recounted:

Tanner was our only child. We sacrificed everything for him. He needed help, and that's what we wanted to get for him. We never thought this would happen. Nothing can bring Tanner back. We trusted this program to care for him. Our lives are changed forever. We would ask every healthcare leader to look at that child or that person being restrained, as though they were your own child. Tanner paid the ultimate price of restraint, but we hope his death and his story will help people to think twice, think about what they are doing, and to not take people to the floor… there has to be a better way. We are grateful for the beautiful memories we have of Tanner—because that's what we have to go on these days.

Costs to Consumers

The personal costs to consumers who are restrained or secluded have been recognized but have received less attention in the literature. Consumers can be physically injured, and deaths have resulted from these procedures (NASMHPD, 2009; Weiss et al, 1998). They may also be traumatized or retraumatized by the experience, which can result in longer lengths of stay (Calkins & Corso, 2007; LeBel & Goldstein, 2005). Two studies of youth in Massachusetts inpatient and residential programs, respectively, found that seclusion and restraint use not only led to extended stays but also increased recidivism/readmission to the hospital or residential care (LeBel & Goldstein, 2005; Thomann, 2009).

As a result of being restrained or secluded, consumers may experience subjective costs to interpersonal relationships, damage to the therapeutic alliance, and mistrust of the health care system and providers (NASMHPD, 2009). Additional personal costs to consumers are the "opportunity costs" incurred when treatment is not provided to those being restrained or secluded and when other consumers are not receiving care while staff attention is diverted to manage a seclusion or restraint procedure. Krueger (2009) noted that failure to take consumer time into account causes national health care expenditures to be significantly undercounted and leads to an overestimate of productivity and an understatement of actual health care costs.

A Provider Makes a Compelling Practice and Business Case

One example of cost savings and benefits of restraint and seclusion reduction is the Grafton School, Inc. Grafton is a large, nonprofit organization in Virginia serving children and adults with autism and mental retardation, most with comorbid psychiatric diagnoses. Following a longstanding institutional history of utilizing a restraint-centric approach to managing escalating assaultive behaviors, Grafton initiated an agency-wide restraint reduction effort in the Fall of 2004 when the new CEO issued a mandate: "Eliminate restraints without compromising employee and client safety" (Mental Health Corporations of America [MHCA], 2008; Sanders, 2009). Each regional facility was then charged with creating an evidence-based strategic plan to eliminate restraints (MHCA, 2008; Sanders, 2009).

Grafton focused on key reduction strategies, including (1) leadership oversight and review of every event; (2) supporting clients in crisis; and (3) providing staff with new training, tools, and management support. Since 2004, Grafton has reduced restraint use by 99.8 percent and was nationally recognized for this achievement (MHCA, 2008). In addition, Grafton identified many fiscal benefits and savings subsequent to reducing restraint use (Sanders, 2009). Positive outcomes included (1) reduced client related staff injuries by 41.2 percent; (2) reduced staff turnover (10 percent) with estimated annual savings surpassing $500,000; (3) reduced employee lost time and lost time expenses (94 percent); (4) reduced number of worker's compensation claims (50 percent) **[See Figure 1]**; (5) reduced total cost of worker's compensation claims; (6) reduced liability premiums (21 percent) and cumulative savings in excess of $1,239,167 **[See Figure 2]**; (6) reduced worker compensation experience modification factor (more than 50 percent) with a cumulative modification change of 62 percent; and (7) more than $483,470 in cumulative worker's compensation costs savings. Grafton also realized other benefits such as increased staff satisfaction and staff perception of greater safety on the job (MHCA, 2008).

Figure 1

Grafton's Reduced Workers' Compensation Costs

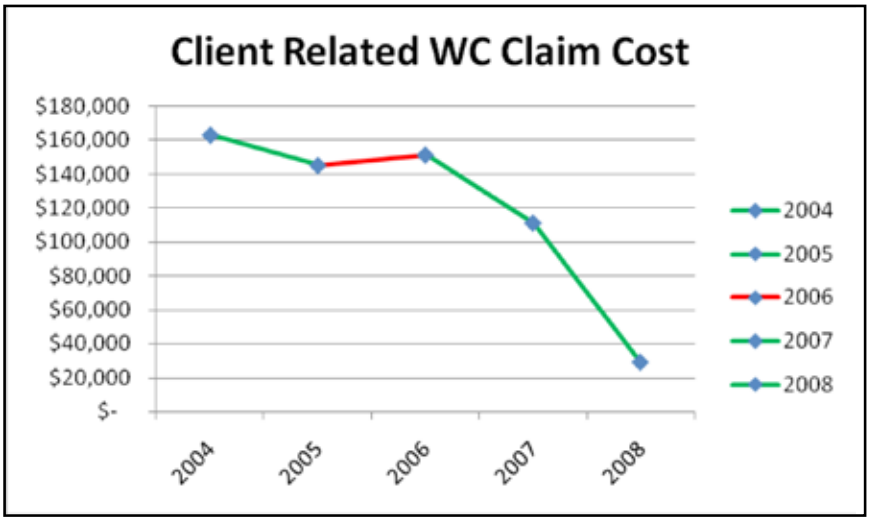
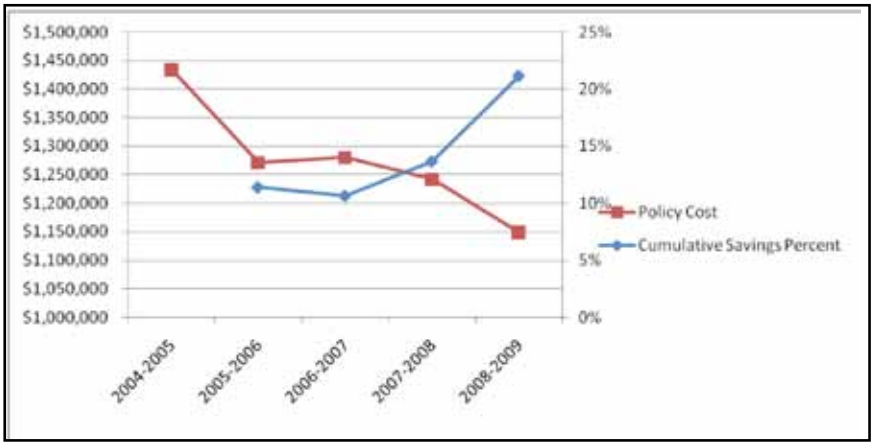


Figure 2

Grafton's Reduced Liability Premiums and Cumulative Savings



There are several important features to Grafton's experience. First, Grafton's documentation of an array of reduction benefits is an important feature of the initiative as they are not often reported in restraint and seclusion prevention efforts. Second, two months after Grafton began its effort, a tragic restraint associated sentinel event occurred redoubling the leadership team's commitment to the importance of reducing and preventing the use of restraint and seclusion. Third, Grafton studied the range of reduction outcomes, which are not often considered in restraint and seclusion prevention initiatives.

Costs Associated With Reducing Seclusion and Restraint

Since the beginning of the national initiative to prevent and reduce seclusion and restraint, many organizations have reduced the use of these practices with little to no additional fiscal resources (Huckshorn, 2006). Weiss and colleagues (1998) reported: "… with strong leadership, the physical restraint of patients can be minimized—indeed, nearly eliminated—safely and without exorbitant cost." Likewise, the GAO found, "…training in alternatives to restraint and seclusion and maintaining adequate staff levels are costly, but they can save money in the long run by creating a safer treatment and work environment... " (GAO, 1999a, p.21).

Successful organizations typically reallocate dollars to support the effort (NASMHPD, 2009). In general, the costs identified by programs that have reduced the use of seclusion and restraint include: (1) purchasing and/or implementing training curricula to promote practice change (e.g., models of care, crisis prevention, dispute resolution); (2) increasing staff supervision; and (3) encouraging staff training (e.g., compensating staff to attend or cover for those being trained, trainer costs, training costs such as venue, food, technology, materials) (GAO, 1999a; NASMHPD, 2009).

Curricula such as NASMHPD's *Six Core Strategies*© (NASMHPD, 2009) and the Roadmap to Seclusion and Restraint Free Mental Health Services (SAMHSA, 2005) are available at no cost, provide comprehensive information and training materials, and are showing positive results (NASMHPD, 2009; see also Issue Brief #2 in this series, *Major Findings From SAMHSA's Alternatives to Restraint and Seclusion (ARS) State Incentive Grant (SIG) Program*). There are other models and technical support packages available for purchase that also show positive results (Banks & Vargas, 2009).

Other costs associated with seclusion and restraint reduction efforts may include making environmental changes (such as creating sensory or comfort rooms) and purchasing sensory items to implement sensory-based interventions. Occasionally, environmental repair and property destruction costs may be incurred; however, some research suggests property destruction decreases during the restraint/seclusion reduction process. (Banks & Vargas, 2009; LeBel & Goldstein, 2005)

A number of States and facilities have developed or expanded consumer roles for youth, adults, and families (NASMHPD, 2009). Hiring or engaging consumers by reexamining vacant positions and converting them into new advocacy roles for persons served and/or family members may help prevent conflict, reduce the use of seclusion and restraint, and change the organizational culture.

Savings Resulting From Seclusion and Restraint Reduction

Systemic and Organizational Cost Benefits

Systemic interventions include the adoption of programs such as NASMHPD's *Six Core Strategies*© curriculum, which has shown significant reduction in seclusion and restraint and resultant savings to systems and organizations. Selected examples include Johns Hopkins Hospital, which reduced use of seclusion and restraint by 75 percent with no increase in staff or consumer injuries (Lewis, Taylor, & Parks, 2009); and Florida State Hospital at Chattahoochee, FL, which reduced use by 54 percent and realized nearly $2.9 million in cost savings from reduced workers' compensation, staff and consumer injuries, and length-of-stay costs (Florida TaxWatch, 2008).

Restraint and seclusion are costly in all kinds of ways – they are just plain costly. Whatever new costs we had were minimal. Most of the new training we put in place to reduce restraint and seclusion really were just good clinical practice and what we should be doing anyway.

—Andy Pond, LICSW, President and CEO, Justice Resource Institute

A multistate, multiservice residential and outpatient treatment provider

The Massachusetts statewide child/adolescent seclusion and restraint prevention initiative is another example of a systemic reduction effort with demonstrated savings (LeBel & Goldstein, 2005; NASMHPD, 2009). Overall, the system reduced seclusion and restraint use by 89 percent from Fiscal Year 2001 through 2008 and avoided more than 34,037 restraints—realizing an average of $1.33 million savings per year and more than $10.72 million in cumulative savings since the start of the initiative (LeBel, 2009). **[See Figure 3]**.

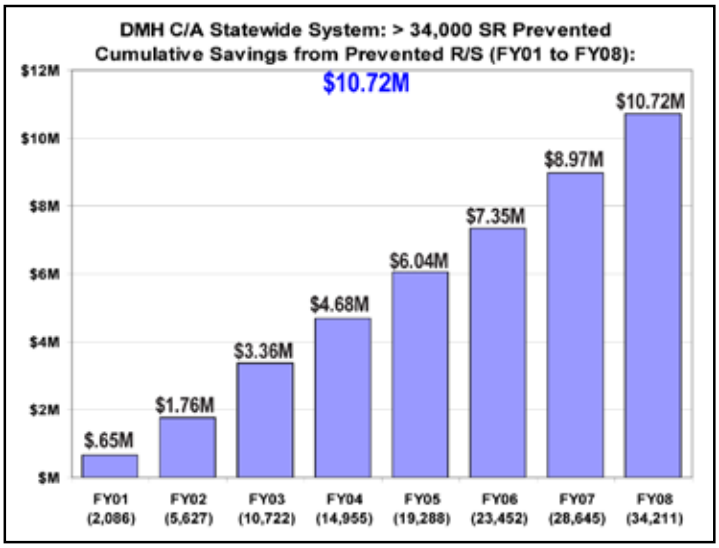
Organizations that have successfully reduced the use of seclusion and restraint report increased staff satisfaction and decreased staff turnover (Paxton, 2009). LeBel & Goldstein's (2005) study of restraint reduction on an inpatient service also reported an 80 percent reduction in staff turnover. Besemer and colleagues' (2008) work on restraint reduction identified a 42 percent reduction in direct care staff turnover and a 24 percent decrease in turnover costs following systemic changes and enhancements.

Other organizational savings include reduced staff absenteeism (Besemer et al., 2008; Unruh et al., 2007) and reduced staff injuries (Pollard, Yanasak, Rogers, & Tapp, 2007). The University of Massachusetts' adolescent inpatient service reduced their use of mechanical restraint by 98 percent and realized an 86 percent reduction in staff members' sick time use (LeBel, 2009).

Figure 3

Massachusetts Department of Mental Health Child/Adolescent Statewide Program

Restraints/Seclusions (R/S) Prevented and Savings by Fiscal Year (FY)



Moreover, many organizations have experienced significantly reduced workers' compensation and other workforce-related costs following seclusion and restraint reduction (Florida TaxWatch, 2008). LeBel and Goldstein's study (2005) of inpatient restraint reduction found a 91 percent reduction in use, which resulted in a 98 percent reduction in workers' compensation and medical costs and a 77 percent decrease in costs to fill shifts vacated due to restraint injuries. Other cost reductions attributed to decreased seclusion and restraint use include reduced workforce replacement costs (Paxton, 2009; Sanders, 2009) and less medication use (Barton et al., 2009; Murphy & Bennington-Davis, 2005).

Consumer Benefits

When seclusion and restraint are reduced and prevented, consumers receive more effective care. The research is clear about the benefits to persons served: (1) fewer injuries; (2) shorter lengths of stay (LeBel & Goldstein, 2005; Murphy & Bennington-Davis, 2005; Thomann, 2009); (3) decreased recidivism/ rehospitalization (LeBel & Goldstein, 2005; Paxton, 2009); (4) less medication use (Barton et al., 2009; Murphy & Bennington-Davis, 2005; Thomann, 2009); and (5) increased positive outcomes/discharges and/or higher levels of functioning at time of discharge (LeBel & Goldstein, 2005; Murphy & Bennington-Davis, 2005; Paxton, 2009). In short, people recover more quickly and may experience greater success in the community when violence is removed from the treatment setting.

Recommendations

In order to continue to build the business case for seclusion and restraint reduction and prevention, a few recommendations have been offered by experts within the field:

National leaders and accrediting bodies should develop and implement standardized seclusion and restraint definitions and consistent measurement methods across and within the industry. Without common parameters, a complete and accurate analysis of seclusion and restraint use, costs, and benefits is not possible;

Experts, researchers, and organization leaders should continue to study and publish on the fiscal impact and outcomes of seclusion and restraint use and prevention and reduction efforts; and

Organizational leaders should also assess current practices that contribute to conflict, violence, and seclusion and restraint and consider approaches implemented by others to help prevent and reduce their use.

Conclusion

The goal of this issue brief was to describe the systemic, organizational, and personal costs of the use of seclusion and restraint practices as well as the cost savings and benefits related to the reduction in their use. These practices are expensive, violent, and harmful procedures that prolong recovery and raise the cost of care. Reducing and preventing their use can yield significant savings, enhance quality of treatment, and increase satisfaction for those providing and receiving services. The full scope of the fiscal impact of seclusion and restraint is still being assessed.

Compelling data about the adverse effects of seclusion and restraint, higher standards of practice demonstrated by many providers, and effective no-cost resources are available to help facilitate reduction and prevention of seclusion and restraint practices. Providers who have not begun to engage in these efforts will be challenged to justify continuing practice as usual. Stated more explicitly by the IOM (2000):

> *The status quo is not acceptable and cannot be tolerated any longer. Despite the cost pressures, liability constraints, resistance to change and other seemingly insurmountable barriers, it is simply not acceptable for patients to be harmed by the same health care system that is supposed to offer healing and comfort . . . .*

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Endnotes

[1]Seclusion is the involuntary confinement of a person alone in a room or area from which the person is physically prevented from leaving. 42 C.F.R. §482.13(e)(1)(ii); See also 42 C.F.R. §483.352.

[2] Restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a person to move his or her arms, legs, body, or head freely. 42 C.F.R. §482.13(e)(1)(i)(A). See also 42 C.F.R. §483.352.

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SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

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