

Trauma- and Gender-Informed Approaches to Seclusion and Restraint Reduction

Trauma, Gender and Substance Use Webinar Series

The Trauma/ Gender/ Substance Use (TGS) Project

- Financial assistance provided by Health Canada
- 2 year knowledge exchange project
 - Partner with CCSA and people working in the substance use field from across Canada to collaboratively develop:
 - Evidence based guidance
 - Training
 - Public health messages
 - Knowledge products (fact sheets, resource lists etc.)
- Gender informed and transformative principles integrated with TIP principles

TGS Project Goal

- To guide the further integration of trauma informed, gender informed and gender transformative practices into substance use prevention, health promotion, treatment, harm reduction and policy in Canada

Agenda

1. Introduction to Seclusion and Restraint Reduction
2. CAMH
 - Restraint Minimization/Prevention Journey: A Trauma-informed Approach
3. Questions (5m)
4. IWH Health Centre
 - Creation and implementation of recent policy on restraint prevention
5. Questions (5m)
6. Alberta Health Services
 - Restraint as a Last Resort project, part of the Trauma Informed Care Initiative
7. Discussion and final questions (5m)



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Trauma, Gender, Seclusion and Restraints

What do we mean by trauma informed practice (TIP)?

- Trauma-informed practice refers to integrating an understanding of past and current experiences of violence and trauma into all aspects of service delivery.
- The goal of trauma-informed services and systems is to:
 - Avoid re-traumatizing individuals; and
 - Support safety, choice, and control in order to promote health and healing.

Trauma Awareness

Trauma awareness is the foundation for trauma informed practice. Being 'trauma aware' means that individuals understand the high prevalence of trauma in society, the wide range of responses, effects and adaptations that people make to cope with trauma, and how this may influence service delivery (e.g., difficulty building relationships, missing appointments).

Safety and Trustworthiness

Physical, emotional, spiritual, and cultural safety are important to trauma-informed practice. Safety is a necessary first step for building strong and trustworthy relationships and service engagement and healing. Developing safety within trauma-informed services requires an awareness of secondary traumatic stress, vicarious trauma, and self-care for all staff in an organization.

Choice, Collaboration And Connection

Trauma informed services encourage opportunities for working collaboratively with children, youth and families. They emphasize creating opportunities for choice and connection within the parameters of services provided. This experience of choice, collaboration, and connection often involves inviting involvement in evaluating the services, and forming service user advisory councils that provide advice on service design as well as service users' rights and grievances.

Strengths Based and Skill Building

Promoting resiliency and coping skills can help individuals manage triggers related to past experiences of trauma and support healing and self-advocacy. A strengths-based approach to service delivery recognizes the abilities and resilience of trauma survivors, fosters empowerment, and supports an organizational culture of 'emotional learning' and 'social learning.'

Seclusion and Restraint Reduction

- An important part of TIP is creating an environment that:
 - Aims to prevent re-traumatizing practices
 - Promotes practices that are experienced as safe for both clients and staff
- Use of restraints and seclusion can lead to:
 - Psychological harm
 - Physical injuries and death
 - And can be re-traumatizing for people who have experienced trauma

Gender Difference

Men	Women
More <i>frequently</i> secluded and restrained	More <i>repeatedly</i> secluded and restrained
More likely to be secluded for <i>threatening</i> violence	More commonly secluded as a result of <i>actual</i> violence, agitation or disorientation
More <i>physical</i> seclusion and restraint	Greater use of <i>forced medication</i>



Download from:
www.bccewh.bc.ca

TRAUMA-INFORMED APPROACHES TO SECLUSION AND RESTRAINT REDUCTION

Strategies for Change

Trauma-informed practice is an approach to care that recognizes the high rates of trauma and violence in the lives of individuals accessing health care and social services. Experiences of restraint and seclusion are major events in the lives of individuals accessing services as well as the service providers who work with them. The use of restraints and seclusion can result in psychological harm, physical injuries and death and can be re-traumatizing for individuals who have already experienced trauma. Trauma-informed practice works to create an environment that prevents re-traumatizing practices and promotes practices that are experienced as safe for both individuals accessing care and all staff within an organization.

Many organizations, institutions, and systems of care have successfully undertaken initiatives to reduce or eliminate the use of restraints and seclusion. Strategies for change vary across programs, populations served, and the context of care, but have often included:

CAMH Restraint Minimization/Prevention Journey: A Trauma-informed Approach

Frances Abela-Dimech & Ann Pottinger

November 16, 2017





CAMH Restraint Minimization/Prevention Journey

- Commitment to creating a safe and therapeutic environment for all patients, staff and visitors
- Supports an environment in which staff takes a trauma informed approach to care
- Commitment to enhance recovery values and principles that support patient rights
- The restraint minimization journey at CAMH began in 2006 following two sentinel events in one year



CAMH Restraint Minimization/Prevention Journey

- A taskforce was developed
 - Formal 3 year initiative from 2008-2011
- The journey advanced the organization's trauma informed approach to restraint use, raising the awareness of the re-traumatization contributed by the use of restraints for patients as well as the traumatic experience for the staff involved in the event.



Six Core Reduction Strategies

Framework Adopted from National Executive Training Institute© July 2003):

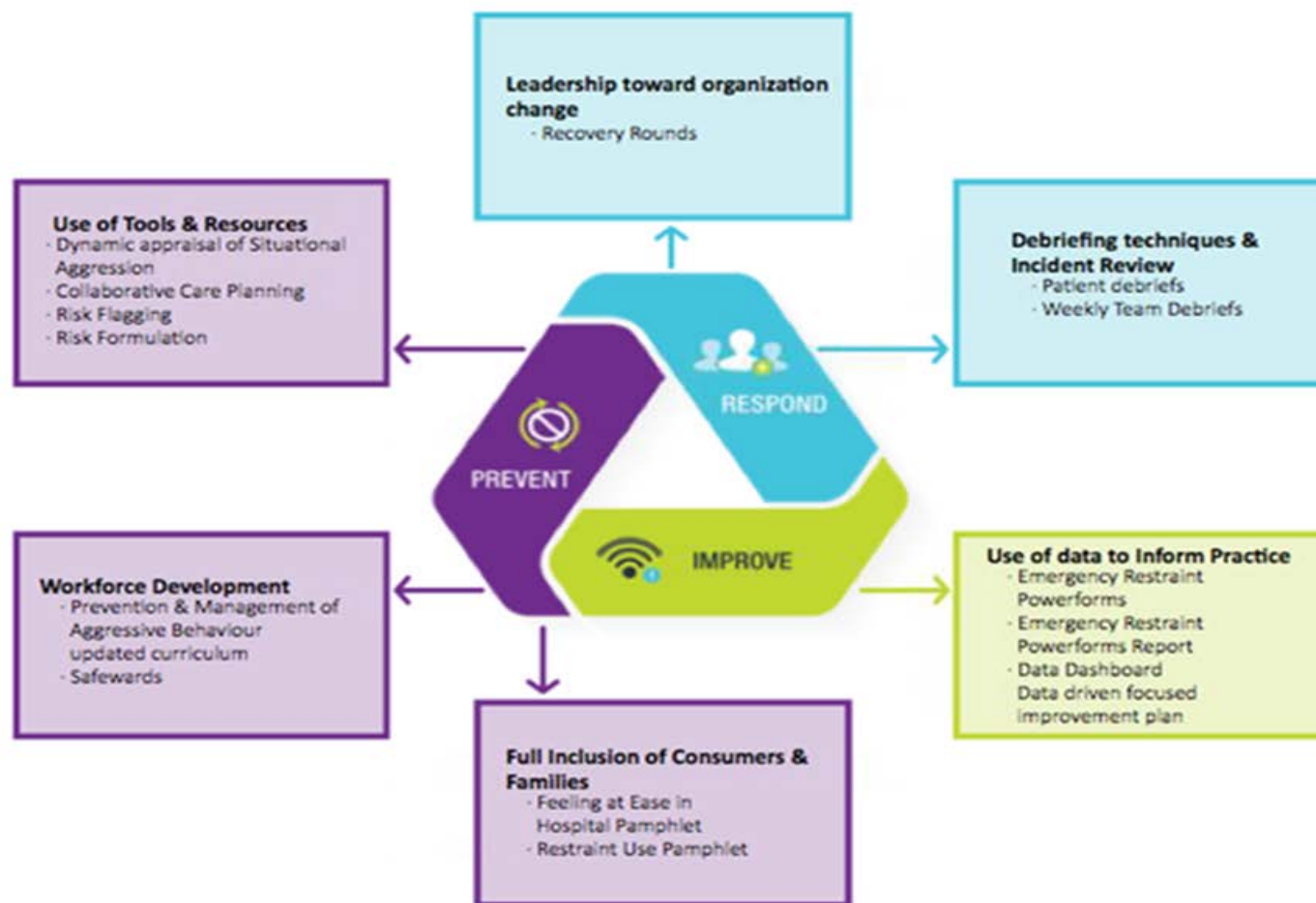
- Leadership toward organization change
- Use of data to inform practice
- Full inclusion of consumers and families
- Debriefing techniques & incident review
- Workforce development
- Use of tools and resources



Present Day CAMH

- Continue with Six Core Reduction Strategies to both prevent and manage acts of aggression and violence in the safest way possible
- Current focus- **Safe and Well CAMH** and the framework
 - Prevent, Respond, Improve
- Key factors impacting on our efforts:
 - Increasing acuity
 - Patient bed flow
 - Shorter lengths of stay
 - Imperfect environments

Present Day CAMH





camh

TRANSFORMING LIVES
TRANSFORMER DES VIES

FROM: Least Restraint Policy (2005)

TO: Restrain Prevention Policy (2017)

“Our Experience”



Melanie Kelly, RN, MN

Clinical Leader of Development
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Mental Health & Addictions Program Educator



Clinical Policy/Objective Manual LEAST RESTRAINT POLICY

(A Guide for the Development of Unit Specific Policy/Guidelines)

PREAMBLE:

Patients and families have the right to receive care in a safe environment and staff have the right to work in a safe environment. Patients and families have a right to dignity, liberty and autonomy, and **those rights may only be limited in exceptional circumstances.**

A. POLICY:

1. Restraint will be used only as a **last resort, respecting the human rights** of the patient, and **must never be used for discipline, convenience or as a solution for deficiencies in staffing.**
2. When restraint is necessary for safety and clinical reasons, **clinical and/or protection services staff will immobilize patients using the least restrictive method of restraint.**
3. Cultural diversity and religious perspectives must be respected.



B. PURPOSE:

1. To provide guidance in the development of unit specific policy/guidelines and decision making processes leading to the implementation of least restraint, on a patient-by-patient basis, across the IWK Health Centre. (This policy is a broad umbrella policy, meant to cover basics, and is not intended to cover every possibility.)
2. To ensure that appropriate interventions (the least restrictive method of restraint) are taken and documented.
3. To ensure that appropriate monitoring of the patient occurs while restraint is in place.
4. To promote the collection of specific data on whether or not the use of restraint was therapeutic and effective, in order to identify patterns of use. (Such data can then be used to refine approaches that demonstrate best practice outcomes for particular populations at risk. Each program is responsible for data collection and indicator development to meet the current and future needs of the population it serves.)



Code White



Crisis Prevention Institute

Nonviolent Crisis Intervention Course Description:

The cornerstone of CPI since 1980, this program is considered the global standard for crisis prevention and intervention training. With a core philosophy of providing for the *Care, Welfare, Safety, and SecuritySM* of everyone involved in a crisis situation, the program's proven strategies give human service providers and educators the skills to safely respond to various levels of risk behavior while balancing the responsibilities of care.

<https://www.crisisprevention.com/>



Nonviolent Crisis Intervention (NCI) at the IWK:

- 1) ALL employees in the Mental Health & Addictions Program are required (policy) to receive and maintain certification. Includes direct care providers (clinicians) and non-direct care providers (Registration clerks and ward clerk/aids). Includes *Emergency Mental Health and Addictions Services*.
- 2) Protection Services Officers are required (policy) to receive and maintain certification. Protection Services Officers are IWK Health Center Employees vs Private Security Staff.
- 3) Emergency Department employees are required to receive and maintain certification.
- 4) Other care areas that receive NCI training:
 - 1) EIBI (Early Intensive Behavior Intervention – for 2 to 5 year olds with ASD)
 - 2) Midwifery Team
 - 3) School Autism Team

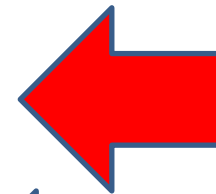


Table 1
The Acute Response to Threat

<i>[Adaptive Response]</i>	REST (Adult Male)	VIGILANCE	FREEZE	FLIGHT	FIGHT
<i>Hyperarousal Continuum</i>	REST (Male Child)	VIGILANCE (Crying)	RESISTANCE Freeze	DEFIANCE 'Posturing'	AGGRESSION
<i>Dissociative Coat worn</i>	REST (Female Child)	AVOIDANCE (Crying)	COMPLIANCE Freeze	DISSOCIATION 'Numbing'	FAINTING 'Mini-psychosis'
<i>PRIMARY Secondary Brain Areas</i>	NEOCORTEX Subcortex	SUBCORTEX Limbic	LIMBIC Midbrain	MIDBRAIN Brainstem	BRAINSTEM Autonomic
<i>Cognition</i>	ABSTRACT	CONCRETE	'EMOTIONAL'	REACTIVE	REFLEXIVE,
<i>Mental State</i>	CALM	AROUSAL	ALARM	FEAR	TERROR

When threatened, a human will engage specific adaptive mental and physical responses. Increasing threat alters mental state, style of thinking (cognition), and physiology (e.g., increase heart rate, muscle tone, rate of respiration). As the individual moves along the threat continuum from calm to arousal to alarm, fear, and terror—different areas of the brain control and orchestrate mental and physical functioning. The more threatened the individual, the more "primitive" (or regressed) becomes the style of thinking and behaving. When a traumatized child is in a state of alarm (because they are thinking about the trauma, for example) they will be less capable of concentrating, they will be more anxious and they will pay more attention to "nonverbal" cues such as tone of voice, body posture, and facial expressions. This has important implications for understanding the way the child is processing, learning, and reacting in a given situation. A traumatized child is often, at baseline, in a state of low-level fear—responding by using either a hyperarousal or a dissociative adaptation; the child's emotional, behavioral, and cognitive functioning will reflect this (often regressed) state.

Code White



Observable Behavior
(Verbal & Physical)



Meaning Behind the Behavior



Diagnosis



Neurological Process







HOLOCAUST



THE TRUTH ABOUT ACEs

WHAT ARE THEY?

ACEs *are*
ADVERSE
CHILDHOOD
EXPERIENCES

HOW PREVALENT ARE ACEs?

The ACE study* revealed the following estimates:

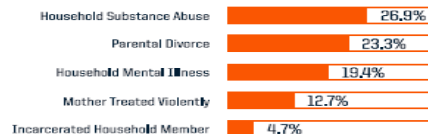
ABUSE



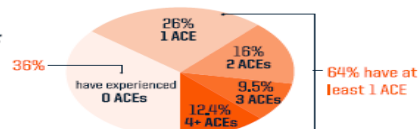
NEGLECT



HOUSEHOLD DYSFUNCTION



Of 17,000 ACE study participants:



The three types of ACEs include

ABUSE



Physical



Emotional



Sexual

NEGLECT



Physical



Emotional

HOUSEHOLD DYSFUNCTION



Mental Illness



Incarcerated Relative



Mother treated violently



Substance Abuse



Divorce

WHAT IMPACT DO ACEs HAVE?

As the number of ACEs increases, so does the risk for negative health outcomes



Possible Risk Outcomes:

BEHAVIOR



Lack of physical activity



Smoking



Alcoholism



Drug use



Missed work

PHYSICAL & MENTAL HEALTH



Severe obesity



Diabetes



Depression



Suicide attempts



STDs



Heart disease



Cancer



Stroke



COPD



Broken bones

Resiliency



- People who have experienced trauma are very resilient with being able to adapt to stress and adversity.
- Research has shown it's not the objective severity of an event that makes it traumatic, but rather the person's perception of the severity of the event: ***"Events are not traumatic until we experience them as traumatic"***.

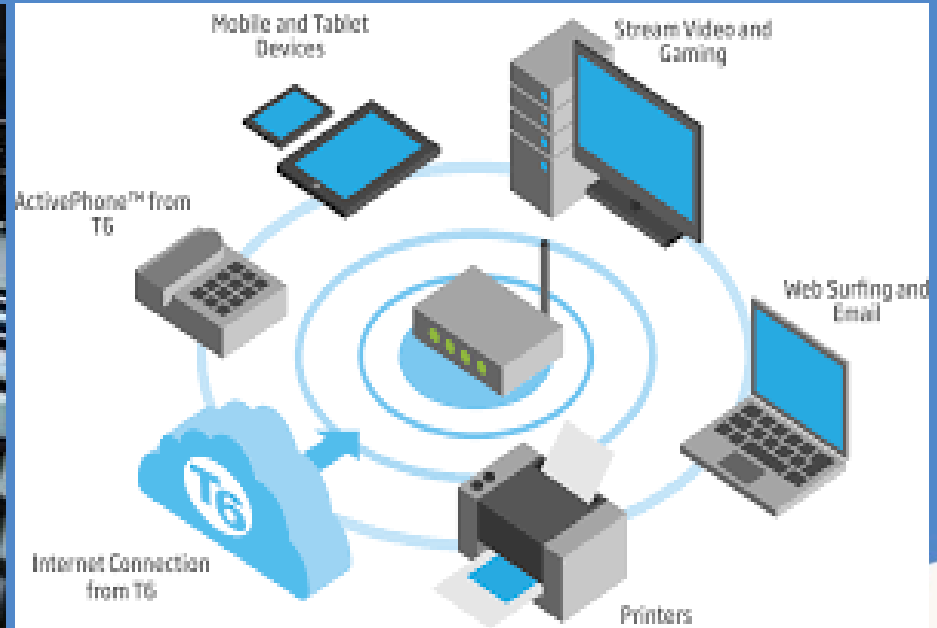
(Retrieved from: resilienceresearch.org)

Principles of Trauma-Informed Care for Client/Patients/Caregivers

- Safety: Ensuring physical and emotional safety
- Trustworthiness: Maximizing trustworthiness, making tasks clear, and maintaining appropriate boundaries
- Choice: Prioritizing client choice and control
- Collaboration: Maximizing collaboration and sharing of power with client
- Empowerment: Prioritizing client empowerment and skill-building



Vicarious Trauma (Secondary Trauma)



Vicarious Trauma

Workers experience a profound shift in their world view, when working with clients that present with trauma.

Adapted from Mathieu, 2008

Compassion Fatigue



- A profound emotional and physical erosion that takes place gradually when helpers are unable to refuel and regenerate.

Adapted from Mathieu, 2008

Burnout



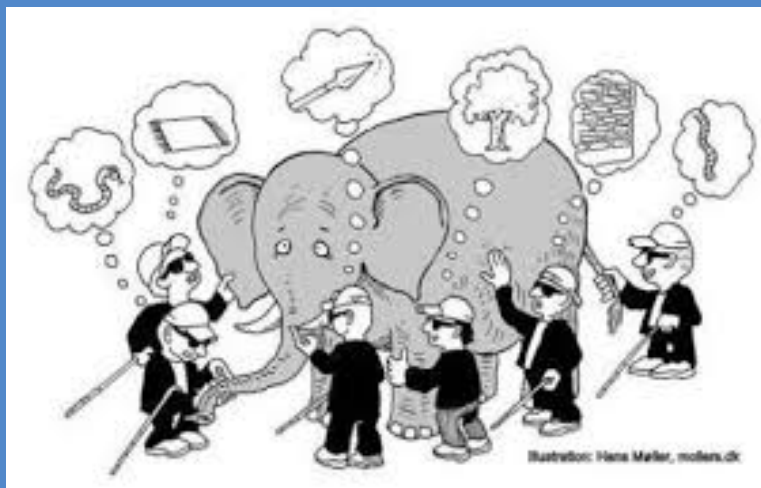
Burnout

- The physical and emotional exhaustion one experiences from low job satisfaction, one feels powerless and overwhelmed.

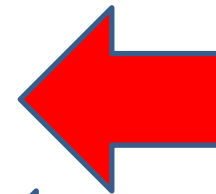
Adapted from Mathieu, 2008

Toxic Work Cultures

Adapted from Kahn & Langlieb, 2003 and Russo, 2007



Code White



Observable Behavior
(Verbal & Physical)



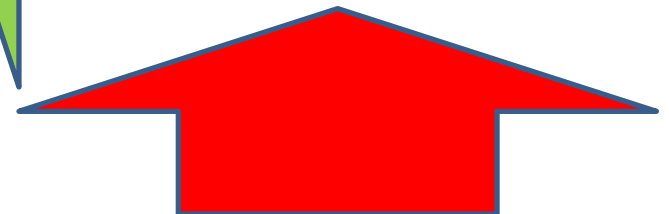
Meaning Behind the Behavior



Diagnosis



Neurological Process



Impact of Trauma

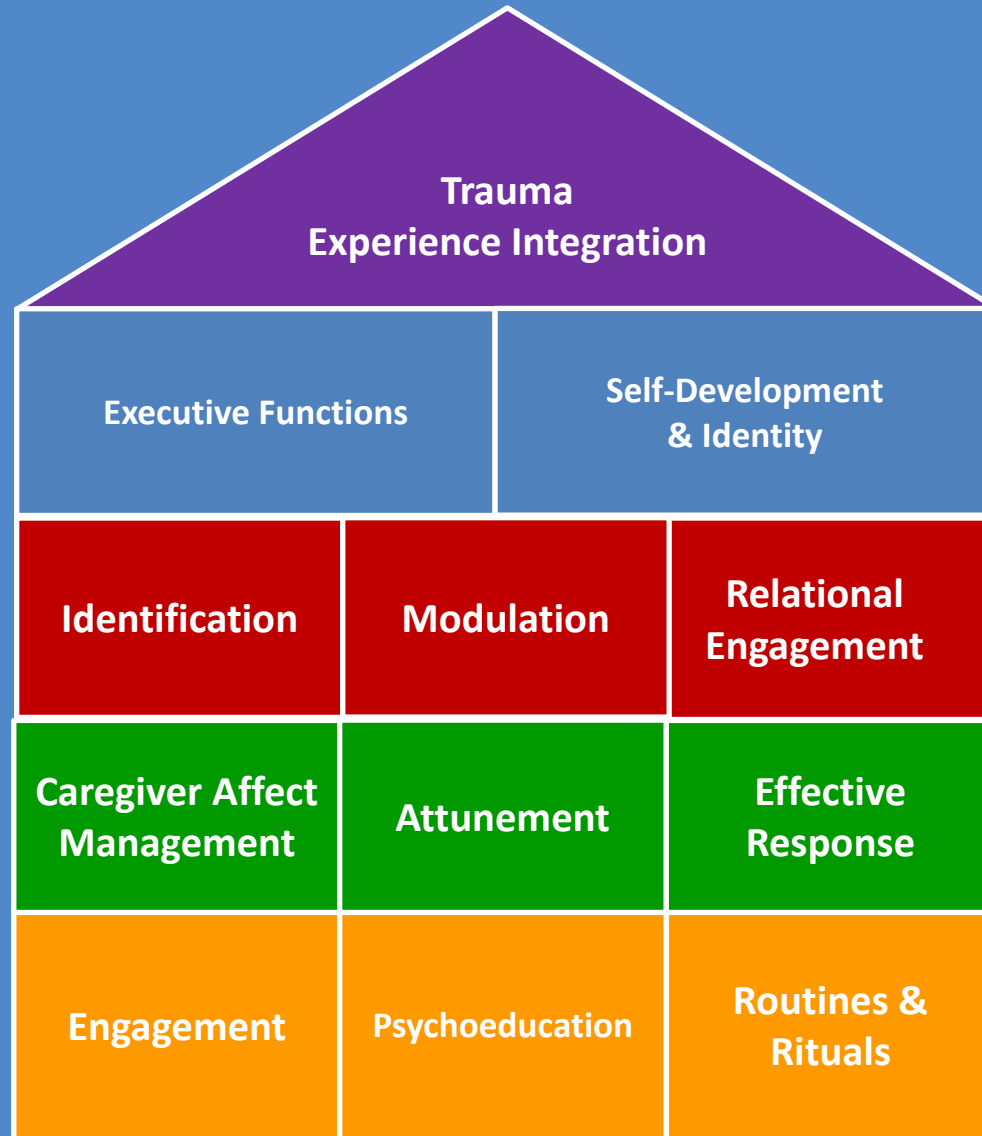


ARC Framework

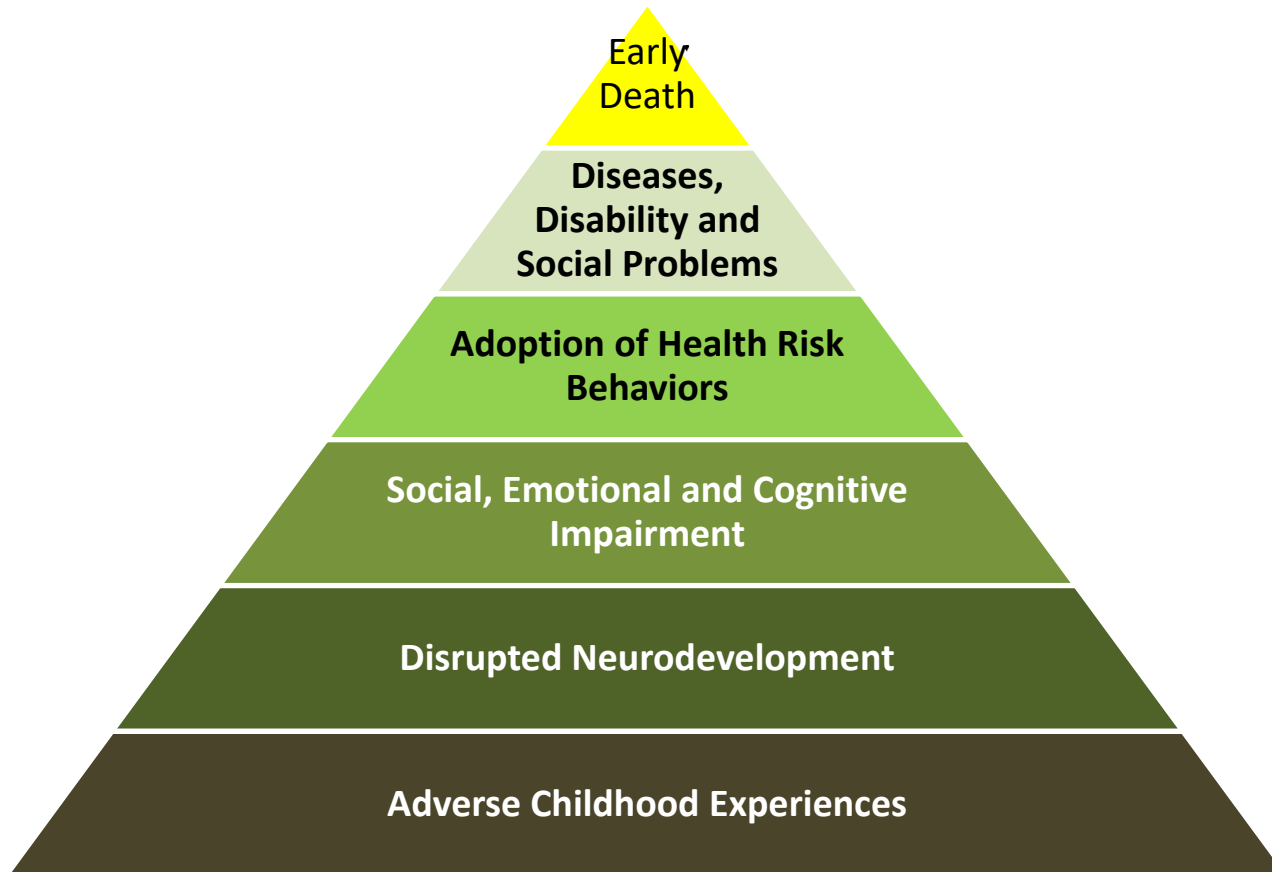
Competency

Regulation

Attachment



Adverse Childhood Experiences Study



Death

Conception

Code White

From	To
Escalating	Dysregulated
Maladaptive / Inappropriate	Protective / Survival Skills
Modeling Positive Behavior	Co-Regulating
Limit Setting (Take Control)	Give Control / Choice
Seclusion Room	Secure Room
Seclusion	Quiet Environment (door open)
Property Damage	Low Level Physical Behaviors
Safety Items	Comfort Items





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- 3) **Emergency Department** and *Emergency Mental Health and Addictions Services*. employees are required to receive and maintain certification.
- 4) Other care areas that receive NCI training:
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 - 2) Midwifery Team
 - 3) School Autism Team



Unforeseen Challenges

- 1) Trauma Informed = No Behavior Expectation / Restraint / Seclusion
- 2) Reduction in Code White events = Newer hires have not seen a Code White.



MENTAL HEALTH AND ADDICTIONS
Clinical Policy/Procedure

TITLE: Restraint Prevention

(vs Least Restraint)

NUMBER: 1102

Sponsor: MHA Director

Page: 1 of 18

Approved by:
MHA Leadership Team
Emergency Department QUOPS Committee

Approval Date: October 12, 2017

Effective Date: October 27, 2017

Applies To: Mental Health & Addictions Program (MHAP),
Emergency Department(ED)
Protection Services



YOUR
EXPERIENCES
MATTER

PREAMBLE

The IWK supports the philosophy that clients/patients have the right to dignified, respectful, and ethical treatment delivered in the least restrictive manner to promote positive clinical outcomes.

Environmental, physical, and chemical restraints are not treatment modalities but are last resort, emergency interventions utilized when less restrictive therapeutic de-escalation measures have failed to promote safety for clients/patients, staff, families, and others. The use of restraint, particularly when employed on an ongoing basis, can be a major barrier to the person's recovery since the loss of control, social isolation, shame, and stigma can exacerbate feelings of despair, hopelessness and can induce further physical and psychosocial traumas. Additionally, repeated use of environmental restraint can result in hopelessness, an increase in suicidal ideation, and paradoxically, an increase in aggression (Masters, 2002).



YOUR
EXPERIENCES
MATTER

PREAMBLE (Cont'd)

However, if staff decision for restraint is grounded in models of care such as Trauma Informed Care, ARC (Attachment, Self Regulation & Competency), Connect© and Collaborative Problem Solving (CPS), restraint can be reserved only for purposes of safety and security for the client/patients and staff. Establishing a relationship and rapport with the client/patient, throughout the intervention especially during post-intervention, is the opportunity to create a the rapport which is important for the client's/patient's emotional safety.

Responsibility for achievement of restraint prevention practice is shared with members of the interdisciplinary healthcare team, clients/patients, families, legal guardians, communities, agencies and governing bodies. Staff authorized to restrain clients/patients are trained to use the principles of Nonviolent Crisis Intervention (NCI) to prevent and manage risk of harm from clients/patients to themselves, staff, families and others.



GUIDING PRINCIPLES AND VALUES

- The IWK recognizes that restraint is traumatizing to any individual and is sensitive to the impact of exposure to traumatic events on patients/clients and their families. This includes recognition of signs and symptoms of trauma in clients/patients and families along with responses that integrate knowledge about trauma into policies, procedures and practices.
- We adhere to a philosophy of restraint prevention that encourages prevention of restraints and the use of alternate measures consistent with respect for and preservation of the client's/patient's dignity, right's, and values.
- Restrictions on an individual's freedom and liberty must never be used for purposes of convenience or punishment.
- Clinical staff and Protection Services Officers work collaboratively to promote a safe environment for all.



YOUR
EXPERIENCES
MATTER

GUIDING PRINCIPLES AND VALUES (Cont'd)

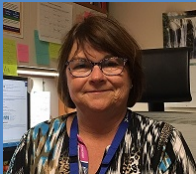
- The protection of independence and self-determination of the client/patient is a priority in decision making.
- Each client/patient and his/her situation are to be considered on an individual basis with an assessment and evaluation to guide understanding and direct the management of care.
- The decision to use restraints is made as a result of collaboration with members of the interdisciplinary care team, the individual when possible, and the client's/patient's parent/guardian/SDM whenever possible.
- We believe that non-restraint interventions should be used to reduce aggression and violence; we recognize restraint use may be the only intervention to manage a behavioral emergency and maintain safety (Canadian Patient Safety Institute, 2013).



FROM: Least Restraint Policy (2005)

TO: Restrain Prevention Policy (2017)

“Our Experience”



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Prasanna Kariyawansa

Mental Health & Addictions Program Educator



Restraint as a Last Resort Policy Suite Overview



Pat Edney

Manager, Policy Development
Clinical Business Initiatives
Provincial Addiction & Mental Health

Creating a Quality Health Care Environment

- Welcomes and engages patients and their families;
- Focuses on new learnings; and
- Encourages accountability and transparency.



Scope

- 1 Provincial policy
- 8 provincial procedures:
 - Acute Care Emergency/Urgent Care
 - Acute Care Inpatient–Adult
 - Acute Care Inpatient–Pediatrics
 - Critical Care
 - Acquired Brain Injury and Rehabilitation
 - Seniors and Continuing Care
 - Protective Services
 - **Addiction & Mental Health Inpatient**



Applies to



- All AHS staff, health care providers, physicians, students, volunteers and other person acting on behalf of AHS.
- Compliance by **February 1, 2018.**

Policy Objectives



- Use restraints as a last resort– only to be used as a type of control to prevent harm at times of behavioral emergencies or as part of treatment plan;
- Provides consistency in the decision-making process/clinical practices regarding using restraints, including seclusion; and
- Guides restraint as a last resort best practice at the program and unit level when developing processes.

Policy Objectives con't

- ▶ Outlines key organizational principles
 - Shall be used only when other strategies have been deemed ineffective or inappropriate in the circumstances
 - Staff training and preparedness is required
- ▶ Defines 4 types of restraints
 - Mechanical
 - Physical
 - Psychopharmacological
 - Environmental

AMH Procedure: Key Highlights

- Therapeutic relationship is central to prevention of behavioral emergencies.
- Not requiring a physicians/Nurse Practitioner's order to initiate or discontinue a restraint – enabling health care providers to work to their full scope.
- Conducting debriefings with interdisciplinary team/patient and/or alternate decision maker.



Delivering Trauma Informed Care

- Admission assessments should include patient's history of trauma, anxiety, behavioral emergencies and restraint use in the patient's past.
- Allows staff to have a better understanding of a patient's potential triggers/emotional responses to help patients develop personal strategies to prevent behavioral emergencies/de-escalate behavioral emergencies.

Any time we use a restraint on our unit, we feel it is a failure of our ability to successfully engage with our patient.

Supporting New Learnings



- Debriefings:
 - With interdisciplinary teams/patient and/or the alternate decision maker when a restraint had to be used to de-escalate a behavioral emergency.
 - Used as an opportunity for new learnings and improvement at patient-specific as well as unit-level.

Supporting our Teams

- Staff and physicians are using most of the concepts outlined in the *Restraint as a Last Resort* policy suite and achieving great success.



Putting Our Patients First



Questions?



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