



*California's Protection & Advocacy System
Toll-Free (800) 776-5746*

Peer Training Manual: How to Avoid Seclusion and Restraint

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INTRODUCTION

As peers who have had different experiences as residents in various locked psychiatric facilities, the staff of the Peer/Self-Advocacy (PSA) Program at Disability Rights California feel it is important to share some of our ideas and suggestions to help prevent or reduce the use of extreme measures, such as seclusion and restraint, that are often used by facility staff to control residents' behavior.

This training manual will provide information for readers and participants to more effectively prepare and plan ahead in order to avoid crisis intervention situations.

Highlights include:

- A review of the specific rights and responsibilities of both consumers and service providers under the California Welfare and Institution codes
- An overview, definitions and descriptions of seclusion and restraint
- Information to help you identify the unique “triggers” that may lead to a crisis situation
- Tips and strategies that will help you avoid the need for crisis intervention techniques
- Personal testimonies from consumers about their individual experiences with crisis situations
- How to make arrangements and agreements with treatment staff by developing your own Advance Directive

It is important to understand that there is not *one* particular technique, suggestion, and/or experience that can completely eliminate the need for crisis interventions. We must also remember that hospital and treatment staff has a legal and moral responsibility to make sure that all consumers are safe and free from harm, abuse, and neglect. As mental health consumers ourselves, we know that being physically restrained and/or placed in seclusion can be a frightening, traumatic and degrading experience. For others, the use of seclusion and/or restraint may be the preferred method for resolving a crisis situation, as long as it is voluntary; for instance, some may feel a sense of safety from these measures, and therefore request that they be used under certain circumstances. For this

reason, it is important that you and your treatment team work together to ensure your mutual safety by making plans for the use of the most effective crisis prevention and intervention methods that work best for you.

Please feel free to ask as many questions as you'd like – all questions are important questions and will only help you and staff, friends, and family more effectively manage crisis situations. Remember: Crisis prevention and intervention is a *team* effort – you are not alone.

CHAPTER 1

Seclusion and Restraints: Everything You Wanted to Know but Were Afraid to Ask

Introduction

This chapter will inform you about the basic issues regarding seclusion and restraints in facilities for adult mental health clients. If you are a consumer in the mental health system and have received treatment in an acute care psychiatric facility, state hospital or long-term locked nursing facility, you may have experienced being placed in seclusion and/or restraints against your will. If you are a staff member working in the above facilities, you probably have received training about placing an individual in seclusion and restraints. At times, the codes and laws related to these types of crisis intervention methods may be very technical, so this chapter will provide information in language that is easier to understand from a layperson's perspective.

In this chapter, the following information about the use of seclusion and restraints will be discussed:

- The Legal Definitions
- The Types of Facilities and Specific Situations that are Covered under State Laws
- The Different Types of Restraint Devices
- The Rights and Responsibilities of Staff and Residents
- The Admission Screening Process
- Observation and Debriefing Requirements, and
- The Written Policies that Facilities are Required to Develop and Implement

I. Definitions

I. Seclusion

What exactly is seclusion? Seclusion is the involuntary isolation of a patient in a locked room. (Title 9 of the California Code of Regulations § 865.4) It is also defined as, "... the involuntary confinement of a person alone in a room or an area from which the person is physically prevented from leaving." (California Health and Safety Code §1180.1)

An example of seclusion is when a staff member takes you against your will and puts you alone in a room that you cannot voluntarily leave. This includes situations when a staff member stands in the doorway and physically prevents you from leaving the room, or when the door is held closed but is unlocked.

On the other hand, it is not considered seclusion if, for example, you would like some time alone, and you ask a staff member if you may sit in a seclusion room for a while, **and** you are free to leave the room whenever you want, **and** the door is not locked. It also does not include times in the unit or program schedule when residents are required to stay in their room, as might happen between activities or during staff change of shift.

II. Behavioral Restraint

A behavioral restraint is an intervention that restricts a person's ability to freely move a part or all of their body and is used to stop a person from immediately hurting themselves or others. There are three general categories of behavioral restraint: (1) mechanical restraint; (2) physical restraint; and (3) chemical restraint. A mechanical restraint is when a device or material is attached to a person's body that restricts freedom of movement or restricts normal access to his/her body. Most commonly in mental health settings, leather cuffs attached to a strap are used to restrain a person to a bed. Bed linens, blankets, and belts may be used as mechanical restraints.

A physical restraint is when a manual hold is used to restrict freedom of movement. This may include holding someone against the wall or on the floor (often referred to as a "takedown") or holding someone's arms and shoulders while forcing them to move from one place to another (referred to

as a walking restraint or escort). Physical restraint does **not** include briefly holding a person in order to calm or comfort him or her, or to gently assist a person in performing tasks or guiding them from one area to another. (California Health and Safety Code, §1180.1)

III. Prone Restraint

Prone restraint is when a staff member places you on your stomach, face-down. In a physical restraint your hands may be held or restrained behind your back. (California Health and Safety Code §1180.4)

IV. Chemical Restraint

Chemical restraint refers to the situation when a staff member gives you medication against your will in an emergency to manage your behavior or restrict your freedom of movement. This refers to medication that is not part of your standard treatment and has not been prescribed specifically to treat your psychiatric condition (Leslie Morrison, Director, Investigations Unit, Disability Rights California, Power Point presentation). Chemical restraints are often given as an injection or shot but can be given by mouth, as a pill or liquid. This is not the same as a PRN medication that you take willingly and that is used periodically to treat intermittently occurring conditions, such as episodes of anxiety or sleeplessness.

The following scenario is an example of the use of chemical restraint:

Joe is living in a mental health rehabilitation center and is on conservatorship. He has been diagnosed with schizophrenia and has been doing well on Zyprexa, the medication that the doctor has prescribed to treat his psychiatric disability. Since Joe is over 6 feet, 2 inches tall and weighs about 250 pounds, staff is a little fearful of him because of his size.

One day, Joe becomes upset when he is not allowed to go on an outing with other residents. He starts yelling and swearing at everyone and, when staff asks him to stop, he continues to yell and swear. To manage the situation, a staff member calls Joe's doctor about Joe's behavior, and as a result, the doctor orders that 100 mgs of Thorazine be given to Joe every two hours up to a maximum of three times. This medication is not a part of

Joe's regularly prescribed treatment and is not a *prn* that Joe has requested for himself. The staff gives Joe this medication against his will to stop his loud and threatening behavior.

This situation is considered the use of chemical restraint because: (1) the Thorazine is not a part of Joe's regularly prescribed treatment for his underlying medical condition of schizophrenia (for that he is on Zyprexa); (2) the Thorazine is ordered in an emergency to restrict Joe's behavior, and; (3) the Thorazine is being given to Joe against his wishes or involuntarily. Therefore, in this instance, Thorazine is being used to chemically restrain Joe.

II. Types of Facilities Covered Under California Law

The following types of facilities are mandated to follow California laws regarding the use of seclusion and/or restraints: Psychiatric units of general acute care hospitals, acute psychiatric hospitals, psychiatric health facilities, crisis stabilization units, community treatment facilities, group homes, skilled nursing facilities, intermediate care facilities, community care facilities, and mental health rehabilitation centers. (California Health and Safety Code § 1180.3)

III. Situations That Involve Restraint

A) When Restraints May Be Used

Seclusion and/or restraints can **only** be used when a person's behavior presents an immediate danger of serious harm to self or others and other less restrictive means of intervention are determined to be ineffective to protect the person or others from harm. (California Health and Safety Code §1180.4)

They **cannot** be used to punish a person for doing something or not doing something, or to make staff's job easier. Staff is not allowed to threaten you with being placed in seclusion and/or restraints. (Title 9, California Code of Regulations § 865.4)

Let's look at two different situations:

Let's say things have been going pretty badly for you one day. You are feeling really frustrated and you start banging your head on a wall. A staff member tells you to stop banging your head, but you ignore him or her and continue your actions. No matter what the staff member says or does, you are unable or choose not to stop banging your head. As a result, the staff member gets the help of other employees and places you in seclusion and/or restraints. Is the staff member acting according to the law? The answer is **No**, because the staff could use other less restrictive means to prevent the risk of injury, such as putting a pillow or blanket between your head and the wall to prevent you from injuring yourself.

Let's say, instead of banging your head against the wall, you punched a hole in the wall with your fist and you are using pieces of the wall plaster to cut your forearm. Staff tells you to stop cutting yourself but you are unable to stop or choose to continue to gouge at the wound. As a result, staff restrains your arms, escorts you into a seclusion room and places you onto a bed in leather restraints. Is the staff member acting according to the law? The answer is **Yes**, because you are an immediate danger to yourself, so the staff member may place you in seclusion and/or restraints to protect you from further injury.

On another day, you and some friends in a facility are having a good time listening to the radio and singing along at the top of your voices. A staff member asks you to turn the volume on the radio down and to sing more quietly, but you choose to continue to play the radio loud and sing along. The staff person asks you several times to turn the music down. Finally, the staff member becomes very frustrated and says, "If you don't turn that music down right now, I am going to put you in restraints!" Is the staff member acting according to the law? The answer is **No**, because you are not presenting an immediate danger to yourself or others.

B) When Restraints May Not Be Used

Staff members may **not**:

1. Hold or restrain you in any way that makes it difficult for you to breathe. They may not use restraint techniques that place pressure on your back or put their weight against your torso.

2. They may not use a pillow, blanket, or other item covering your face as part of a physical or mechanical restraint or containment process.
3. Staff cannot use physical or mechanical restraint if you have a known medical or physical condition such that there is reason to believe that the restraint technique used would endanger your life or seriously compromise your medical condition.
4. Additionally, staff is forbidden from using **prone mechanical restraint**, which involves placing you face-down on your stomach, if you have any of the following risk factors (California Health and Safety Code §1180.4):
 - a) Obesity
 - b) Pregnancy
 - c) Agitated delirium or excited delirium syndromes
 - d) Cocaine, methamphetamine, or alcohol intoxication
 - e) Exposure to pepper spray
 - f) A pre-existing heart disease, including, but not limited to, an enlarged heart or other cardiovascular disorders or respiratory conditions, such as emphysema, bronchitis, or asthma

The above does **not** apply if: (1) Being placed in restraints in a prone position is your preference, **AND** (2) A physician has written an order that states you may be placed in a prone position.

Another exception is if a doctor states that other clinical risks take precedence **AND** (2) A physician has written an order that states you may be placed in a prone position. The written authorization may not be a standing order, and shall be evaluated on a case-by-case basis by the physician.

A facility **shall** avoid deliberately placing a person in prone physical restraint whenever possible. Staff should first use early intervention techniques, such as de-escalation.

If a person is physically restrained on their stomach in an emergency situation, a staff member **shall** observe the person for any signs of physical duress for as long as the person is in a prone restraint position.

Whenever possible, the staff member monitoring the person shall not be involved in restraining the person. (California Health and Safety Code §1180.4)

IV. Rights and Responsibilities of Staff and Residents

A) Least Restrictive and Freedom of Movement

A facility **shall** allow a person who is restrained the least restrictive alternative and the maximum freedom of movement, while ensuring the physical safety of the person and others, and **shall** use the least number of restraint points. (California Health and Safety Code §1180.4)

This might mean that a person can be safely contained by restraining only one arm and the opposite foot instead of being placed in four-point restraints. The use of four-point restraint is when a person's arms and legs are placed in restraint cuffs and the cuffs are secured to a bed.

B) Admission Process Requirements

Each facility is required by law to conduct an assessment when a person is admitted about factors related to the use of restraint or seclusion. (California Health and Safety Code § 1180.4) During the assessment, you have the right to have a family member, significant other or a friend with you. For the purpose of the assessment, a staff member will do the following:

1. Ask if you have an Advance Directive for Health Care, and if it states your wishes about seclusion and/or restraints or alternatives. *Be sure to give the facility a copy of your Advance Directive for Health Care.*
2. Ask about any medical conditions you have that might place you at risk if you are placed in seclusion and/or restraints.

3. Talk with you about early warning signs and triggers that might cause you to be placed in seclusion and/or restraints. If staff is aware of these signs, then they may be able to help you get control before the use of seclusion and/or restraints is necessary.
4. Ask you what techniques or strategies help you calm down and focus when you feel you might lose control.
5. Ask if you have any history of trauma, including sexual or physical abuse. Since a person's trauma history may include the experience of being placed in seclusion and/or restraints, the use of these extreme measures may cause the person to re-live the traumatic event and cause potential harm.

C) Observation in Situations of Seclusion and/or Restraints

A facility **shall** keep a person who is in seclusion and/or restraint under constant, face-to-face human observation at all times. Observation by means of video camera with audio capability may be utilized only in facilities that are already permitted to use video and audio monitoring under federal regulations specific to that facility. (California Health and Safety Code §1180.4)

D) Debriefing After the Use of Seclusion and/or Restraints

A facility is required by law to conduct a review for each incident of the use of seclusion and/or restraints. This review **shall** take place as quickly as possible, but no later than 24 hours after such an incident. Part of this review includes a debriefing with the person who was placed in seclusion and/or restraints. You may have a family member, domestic partner, significant other, or authorized representative with you during this debriefing. The purpose of the debriefing is to talk about how to avoid a similar incident in the future. Your participation in the debriefing is voluntary. The purpose of the debriefing shall be to:

1. Talk about what led up to the incident and suggest safer methods that will more effectively deal with any potential future incidents.

2. Help staff understand what led up to the incident and develop alternative methods for helping you avoid or cope with such incidents.
3. Assist staff in developing interventions to address the root cause of the incident and its consequences and to modify the treatment plan as needed.
4. Help assess whether the use of seclusion and/or restraints was necessary and whether it was implemented in a manner consistent with staff training, facility policies and legal regulations.
5. Provide both the person who was secluded and/or restrained and staff the opportunity to discuss the circumstances of the incident and strategies that can be used to prevent the future use of seclusion and/or restraints. It is an important opportunity to share what was going on before the incident happened.
6. Document in the person's medical record that the debriefing session took place and any changes to the person's treatment plan that resulted from the debriefing. (California Health and Safety Code §1180.5)

Here is an example:

You were in the lounge area, and another resident came up behind you and grabbed your hair. You got up and started hitting the resident. Staff came and tried to break up the fight. You started lashing out at staff. Staff felt you were an immediate danger to others, so they placed you in seclusion and restraints. What staff did not know was that, when the resident grabbed your hair, this terrified you. It caused a flashback to a time in your childhood when your father used to grab your hair just before he hit you. In your mind, you were defending yourself against someone who was going to hurt you.

The debriefing would give you an opportunity to share what you were experiencing. Having a flashback does not relieve you of the responsibility not to hurt other people, but at least you and staff will have an insight into what happened. Sharing this information should result in staff working with

you on how to stay present in the here and now and help you develop a list of things that you could do to calm yourself when you feel triggered.

Written Policies

State law requires any health facility to adopt written policies and procedures regarding the use of restraints and to make such information available to facility residents. (California Health & Safety Code § 1599.1)

You, as a resident of a facility, have the right to ask for and receive a copy of the facility's policies on the use of restraints.

If you feel that the facility where you reside has violated any of the codes and laws, you have the right to make a complaint with your county's Patient Rights Advocate, the local Ombudsman, Adult Protective Services and/or the Department of Mental Health.

CHAPTER 2

Myths and Realities about the Use of Seclusion and/or Restraint

By Mohr, Petti, Mohr, 2003 and NASMHPD, 2003

Efforts to reduce the use of restraint and seclusion invariably encounter a range of longstanding assumptions about these practices – assumptions that research has shown are erroneous. Examples of beliefs expressed by staff – and the “reality” associated with each of these myths – include the following:

Myth: Restraint and seclusion are used only to insure safety.

Reality: While the consensus in the field is that restraint and seclusion should be used only to ensure safety, they actually are used mostly for loud, disruptive, or non-compliant (but not violent) behavior.

Myth: Restraint and seclusion are used only when there is no other alternative.

Reality: In fact, although there is an emerging consensus in the field that these interventions should only be used if no other intervention is possible, restraint and seclusion often are staff’s first, automatic responses to difficult behavior.

Myth: Restraint and seclusion reduce patient and staff injuries.

Reality: Decreasing the use of restraint and seclusion does not result in increased patient and staff injuries, and may actually reduce them.

Myth: Restraint and seclusion help individuals feel secure, gain self-control, and learn to follow rules.

Reality: There is absolutely no evidence that these interventions have any therapeutic value.

CHAPTER 3

The Effectiveness (or Ineffectiveness) of Seclusion and Restraint

David Ferlegen, American Association of Intellectual and Developmental Disabilities and Leslie Morrison, Disability Rights California

1. There is no therapeutic value or basis in clinical knowledge for the use of seclusion and/or restraints.
2. The use of seclusion and/or restraints does not positively change behavior. It may in fact, increase negative behavior and decrease positive behavior.
3. The use of seclusion and/or restraints is traumatic and potentially physically harmful to both staff and consumers.
4. Death may occur even when seclusion and/or restraints are done 'safely' and correctly following all the correct guidelines.
5. Being secluded and/or restrained leaves lasting psychological scars.
6. The decision to use seclusion and/or restraints is almost always arbitrary, idiosyncratic and generally avoidable because:
 - There is a cultural bias
 - Staff has negative role perceptions and attitudes
 - Many times administrators have greater influence on the use of restraints and seclusion than clinical factors
 - Seclusion and/or restraint are often staff's first, automatic response to difficult behavior
7. Most use of seclusion and/or restraints is for the purpose of dealing with loud, disruptive, non-compliant (but not violent) behavior.

8. The use of seclusion and/or restraints generally stems from a power struggle.

CHAPTER 4

Incentives for Reducing the Use of Seclusion and Restraint

Leslie Morrison, Director, Investigations Unit, Disability Rights California

There are many good reasons to reduce the use of seclusion and/or restraints. Here are but a few:

1. The reduction in the use of seclusion and/or restraints is part of delivering services that use Best Practices. It is better for the consumer and better for the staff.
2. There would be fewer injuries, deaths, and a decreased incidence of seclusion or restraint-induced traumas. Some known injuries or fatal outcomes include:
 - Asphyxia
 - Aspiration
 - Cardiac events
 - Fractures
 - Dislocations
 - Psychological trauma and the repeated experience of trauma
3. If facilities reduced the use of seclusion and/or restraints, administrators would find there would be an improvement in staff's job satisfaction, which would lead to a decrease in staff turnover. This would translate into a cost-savings by reducing staff recruitment and training needs. Additional cost-savings would come from fewer workers' compensation claims from staff that result from the incurrence of injuries while placing an individual in seclusion and/or restraints.
4. There is an opportunity to save the facility money because the average cost of placing a person in restraints is about \$302.02 per

incident and \$354.51 for an episode of restraint with medication given to the individual.

5. By reducing the use of seclusion and/or restraints, a facility would decrease their chances of scrutiny and resulting administrative sanction by such agencies as the Joint Commission (JCAHO), the Centers for MediCare and Medicaid Services (CMS) and the Department of Justice (DOJ).
6. Lastly, facilities would reduce their exposure to civil litigation and criminal prosecution for charges that may include:
 - Assault and Battery
 - Negligence/ Medical Malpractice
 - Civil Rights Violations
 - Wrongful Death/Homicide

CHAPTER 5

Working Together with Staff to Prevent Crisis Situations

I. Crisis Prevention is a Team Effort

Nobody likes a crisis. It is stressful for all parties involved, and finding ways to avoid crisis situations will help strengthen relationships among people in our lives and make everyone's lives easier and more peaceful. It is important to establish that crisis prevention is a mutual goal that we all share - one that we can accomplish by working together to improve our living and working conditions.

Crisis prevention is a team effort that requires effective communication and cooperation among everyone involved. For this reason, it is important for staff and residents to discuss and develop a joint action plan that will provide easy-to-understand steps that can be taken to avoid and mitigate crisis situations. This will help prevent the unpleasant consequences that may come when a crisis cannot be resolved in a manner that respects the dignity and value of each person involved, such as the use of seclusion and/or restraints to control a person's behavior.

It is important to develop an individual crisis prevention plan, or a personal safety plan, as soon as you start working together. Putting together a crisis plan is more than just a plan – it is the start of a dialogue and a working relationship that involves a conversation between staff and each individual person to identify known triggers and recognize what helps and what does not when a problem emerges.

Some consumers may prefer to fill out their crisis plan by themselves, but it is crucial that staff and consumers discuss the plan and communicate with one another to make sure that everyone understands it and can follow it easily.

In this way, crisis prevention is a joint project in which staff work together with each individual to find ways to keep everyone calm and safe. By

involving both consumers and staff in the process of developing their crisis prevention plan, it will be a plan that is meaningful and effective for everyone.

II. Guidelines for Developing a Customized Crisis Plan

Because each individual is unique, with different life experiences and skills, a crisis plan must be customized to meet each person's specific needs. Since both consumers and staff have **unique triggers, early warning signs and coping strategies** that affect how we act and react when a problem arises, identifying these in advance will prevent crisis situations from taking place. Crisis plans should be developed at the time of admission, and revisited on a regular basis as a reminder and as an opportunity to review and revise the plan as needed.

It makes it easier for everyone involved if the crisis plan is simple and concise, but well-detailed and easy to understand. Each consumer should have a copy of his or her own crisis plan, and staff needs to make sure that they can access it as needed. Rather than putting it in a person's medical chart where it might not be seen regularly, it is suggested that the crisis plan be posted in a place where everyone can see it; for example, on the door of the person's room or on an index card. Some people may not want this information displayed for confidentiality reasons, so it is important to discuss other ways to keep this information private and handy.

This is especially important because there are many staff and shift changes, and new consumers regularly move in and out of facilities. Keeping the plan in a place that is readily accessible will ensure the document is there for everyone to refer to in the event of a problem. This is also helpful to prevent situations when staff members may unintentionally contradict one another or be inconsistent in the way they respond to a situation, which can be very upsetting and confusing to everyone involved.

III. Components of a Crisis Plan

A) Triggers

A trigger is something that sets off an action, process, or series of reactions that can produce uncomfortable emotions, such as fear, panic, or agitation,

and that can lead to a crisis. Triggers are specific to each individual – what may be a trigger for one person may not be a trigger for someone else. Triggers are often changes in the physical and/or social environment.

Examples of triggers may include:

- Bedtime checks
- Room checks
- Loud noises
- Silence
- Certain noises or a tone of voice
- A smell
- Large crowds
- Lack of privacy
- Feeling that no one is listening to what you have to say
- Being teased or picked on
- Being touched; being touched in a certain way or on a particularly body part
- Feeling lonely
- Not having control
- Being told what to do
- Someone's appearance that reminds you of someone else who you didn't like or who hurt you

Some of these triggers are easy to identify, such as yelling and room checks, and it's very clear what is causing a person's particular reaction. Others may not be as apparent, such as a feeling or emotion that a person is having that is uncomfortable or disturbing. For this reason, it is important to remember that sometimes the cues may not be very obvious, and communication is a key to helping one another identify them.

There are other kinds of triggers that may be associated with a person's history of trauma. For instance, a particular time of day, a smell, contact

with a family member or a holiday may remind someone of an unpleasant or scary experience from his or her past. This may cause disturbing feelings and activate that person's anxiety, which could then lead to actions and reactions that produce a crisis situation.

In these instances, it is important to ask the person questions and listen to what they have to say to better understand what a person is experiencing and what may be causing their actions. Sometimes, a person may be reacting to a memory of a situation rather than the actual situation that is taking place, so it is important to clarify this so that everyone knows how to respond to avoid a crisis.

B) Early Warning Signs

An early warning sign can be a physical symptom, reaction or an emotion that can often signal a potential crisis. Some warning signs are observable, such as:

- Pacing
- Agitation
- Wringing hands
- Crying
- Shaking
- Loud voice
- Bouncing legs
- Swearing

These are behaviors that can be easily identified by other people. Other warning signs may not be observable or readily apparent, such as:

A sensation of tightness in the chest

- Heart pounding
- Shallow breathing
- Muscle stiffness

- Headaches

Since these physical symptoms are not obvious and cannot be readily observed, it is important that the person who experiences them includes them in their individual crisis plan and talks about them with staff. Knowing a person's early warning signs can help identify and resolve a problem before it leads to a crisis.

It is important to understand that some people's warning signs may be another person's strategy for coping with a problem that creates distress. For example, it may be helpful for someone to pace back and forth to lessen their anxiety, providing them a way to use up their excess energy without being harmful to others. In this instance, it would benefit everyone to allow that person to use his or her coping strategies rather than attempt to stop or control them. For this reason, it is important to know the difference between each person's early warning signs and his or her unique coping strategies to effectively respond and prevent a crisis. It is also important for staff to identify their personal early warning signs to develop their own coping strategies for dealing with potentially stressful situations. The more that we learn and know about one another and communicate, the better we can prevent crisis situations from happening.

C) Strategies

We all have our own ways of dealing with problems. These coping strategies help us to manage and minimize the stress we feel in reaction to difficult and/or uncomfortable situations. Some of these calming strategies may include:

- Going for a walk
- Talking with someone who will listen
- Lying down
- Listening to music
- Sitting quietly
- Rocking in a rocking chair or on a swing
- Working out; shooting hoops; running on a treadmill

- Squeezing a stress ball
- Pacing or walking a set path
- Watching TV; playing video games
- Time alone
- Taking a shower
- Writing in a journal
- Coloring or drawing
- Calling friends or family
- Cooking, eating, cleaning

Many of these coping strategies are a **process** that takes time – they may not be over in 5 minutes. This is why it's important to be flexible, to pay attention and be able to adapt to any unexpected changes or events to address the needs of the individual rather than the needs of the facility. This takes time and patience, but will benefit everyone involved.

Another strategy for preventing crisis situations is to know the things that don't help when someone is upset. These are behaviors or situations that occur after a stressful situation takes place. Some examples include:

- Not being listened to
- Being told to stay in your room or to sit down
- A loud tone of voice
- Being ignored
- Not being taken seriously
- Being surrounded by a lot of people

Knowing this information can help others intervene early so that a crisis doesn't develop. Ultimately, the more strategies that we have and develop, the better prepared we are to prevent and intervene in the event of a potential crisis.

IV. Extreme Emergencies

While preventing a crisis is a mutual goal, there are times when our efforts are not successful, and more restrictive measures such as seclusion and restraints may be necessary to prevent imminent harm.

In this case, there are some actions that are preferable to others, because they can minimize any trauma that staff and/or residents may experience as a result of the crisis. For instance, it may be more beneficial and effective to have a “time out” rather than restrain or isolate a person who is in crisis.

For this reason, it is important to identify these measures before a crisis happens. This can be done by developing an “Advance Directive” at the first joint meeting, which is a document that specifies what the person prefers to happen in the event of an emergency.

For example, in the event that medication is necessary to minimize a crisis, it is important to specify the type of medication a person prefers and how they prefer to receive it, such as by mouth or by injection. An Advance Directive can also specify other factors that are important, such as whether a person prefers to be restrained by a man or a woman, or prefers to be restrained by holding hands rather than restraining her or his body. Some people may prefer to be mechanically restrained face down rather than face up.

It is also essential to identify other factors that may help in the event of a crisis. For instance, is it helpful to talk with the person when they are having a hard time, or is it best to give them some time alone? What else can staff do to prevent harm or trauma? Additional factors to consider include environmental, medical, physical, racial, cultural and/or religious circumstances that may affect a person during a crisis.

By filling out an Advance Directive at a time when you can have a calm and quiet discussion, you create a plan which will help prevent the harmful and negative effects of a crisis. This document can be a “work in progress” that can be modified as you learn what works and what doesn’t from your experiences together. In this way, crisis prevention and intervention is a mutual goal and a team effort.

V. Debriefing and Revising Your Crisis Plan

After you have been restrained or secluded, California law requires a facility to conduct a debriefing. See page 14 above. The purpose of the debriefing is to talk about what led up to the incident and suggest ways to handle things differently if these circumstances (or others like them) should arise again. It might be useful to review your crisis plan during the debriefing to see if your crisis plan was followed, and if not, why not. You may need to add to your list of triggers or early warning signs. The debriefing might reveal that your crisis plan didn't work as you had hoped and should be revised or modified. You may need to come up with more or different strategies to help you and staff manage and minimize the stress. It is a good time to remind staff about your plan and make sure everyone is familiar with it.

**Adapted from materials from "Seclusion/Restraint Prevention Tools," National Executive Training Institute (NETI). (2005). Training curriculum for reduction of seclusion and restraint. Draft curriculum manual. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD), National Technical Assistance Center for State Mental health Planning (NTAC).*

CHAPTER 6

Steps for Identifying and Preventing a Potential Crisis

A crucial part of learning more effective ways to deal with potential crisis situations is to review your reactions to past events. Learning to give an example of a crisis situation *simply* and *clearly* in a four-step sequence is important.

The best way to learn is to review a *past* crisis situation or think of *examples* of situations that you think *could* lead to a crisis and go through each step to help you determine what works best for you.

*Step 1: Report a single situation or event that occurred - an everyday event when you began to work yourself up. Focus on a brief description of what happened: specifically, what triggered your symptoms?

When describing the situation or event, be clear but brief. It's tempting to go into a lot of "background" and detail, but this is usually unnecessary and even distracting. Practice focusing on just a few sentences of basic information that will clarify the situation or event that generated your symptoms or discomfort. The descriptions in Step 1 should be both brief and precise.

*Step 2: Report the symptoms you experienced - both physical and mental (for instance, angry and fearful thoughts, confusion, palpitations, disturbing impulses, tightness in your chest, sweaty palms, etc.).

People often skip this step to get to Step 3. However, while this step, like the others, should be kept brief, it is important to recognize and describe both your physical and mental responses. This objectivity makes these responses seem less threatening and overwhelming. Avoid diagnosing ("I became paranoid") and judging yourself ("I'm a bad person because of this"). Just describe your physical and mental sensations ("I felt flushed and angry, my head hurt," etc.).

Step 3: Report your thoughts about the event – What is the story that you’ve created about it? Why do you think it happened? What do you think it means?

*We all create a “story” about what has happened – what we **think** caused the event and what we **think** it means. It is important to separate your “story” from fact, which is your description of the event in Step 1.*

Step 4: Think about the choices you have available to respond to the event, and note how you would have responded to such an event in the past. What strategies have proven most effective for you?

Completing this 4-step process will help you identify and evaluate the strategies that were most helpful in resolving the crisis so that you can better prepare and respond to crisis situations in the future.

**Adapted from materials from Recovery, Inc., International (www.recovery-inc.org), and “The Essential Components of the Power to Change”*

CHAPTER 7

Personal Testimonials about Experiences with Restraint and Seclusion

Self-advocacy group members at a local IMD Facility reported that, in crisis situations, facility staff members and/or clinicians will “always” err on the side of caution when they need to make a decision about whether or not to use restraints and/or seclusion when there is a situation that involves dangerous behavior.

In the past, peer-self advocacy group members have admitted that we have not always been successful in avoiding restraints and/or seclusion. There have been times when it seemed we were just at the wrong place at the wrong time, with the “one person in the universe” who doesn’t have a clue or a desire to learn how to speak, deal with, and/or handle an individual with acute symptoms of a psychiatric disability.

Although it may not appear to us at the time, there are situations when the use of restraints may be necessary in order to prevent harming ourselves and/or others. Ultimately, group members admitted that the secret is to manage our behaviors before they escalate to self-harm and/or harm to others.

With this in mind, self-advocacy group members thought it would be a good idea to share our stories with you in order to see, prevent, and/or plan ahead in order to avoid the same humiliating experiences.

Testimonial # 1 – “Shelia”

One group member, “Shelia,” reported last year that she was once arrested by the local police department under a 51/50 Psychiatric Observation hold at an acute-care facility because of her inability to walk on the street safely. Shelia stated that her auditory hallucinations were compelling her to walk in the middle of the street in the hopes of being hit by a passing car. She was very frightened and physically agitated when a police officer attempted to handcuff her and place her in the back of a police car.

Shelia was becoming more fearful by the second, and when the police officer placed her legs and hands in vinyl restraint ties, she became hysterical and began to fight the officer so that he wouldn't put her in the back of the police car. She informed the police officer that having her both her legs and arms restrained was frightening to her. Fortunately, one the police officers agreed to release both her legs and arms if she would calm down and go with them to the hospital. She was forced to admit to the police that she did indeed need to go to a hospital because she was a danger to herself and others.

While Shelia admits that she needed some help because she had lost her medications and was experiencing hallucinations, the main point of her story is that, even though she was really ill and angry with the police, she still had to calm down enough to work together with the police officers. She had to compromise and think about what she was doing before she ended up getting hurt and having more of her personal civil rights taken away.

Shelia admits it was extremely hard not to strike the police officer, especially when they were laughing at her, but she knew enough at the time that being cornered or hurt by the police could cause her to have "fight or flight" response, which could make the situation worse. Although she had to admit verbally that she agreed with the civil commitment and agreed to be transported to an acute care facility, Shelia was able to successfully advocate for herself to avoid the use of restraints. She stated that learning more about her illness and hearing from other peers gave her insight to what was happening and helped her negotiate with the police to release the restraints.

Testimonial # 2 – "David"

David is a 54 year old male who has attempted for the last 5 years to control and manage his symptoms of paranoid schizophrenia on his own. When his symptoms began to worsen, he decided to report to an acute care facility and sign himself in for a voluntary 3-Day psychiatric observation in the hope of getting some help. He felt fairly comfortable that he was still in control of the situation and felt that, since he was a voluntary client, that he would have some input regarding his treatment.

However, on the day he was sure he was going to be discharged, staff told him that he was going to have to stay up to 14 days longer and might be evaluated for temporary conservatorship. They explained that, since he kept refusing a certain prn medication, he was displaying “little or no insight” into his condition and that he met the legal standard for being placed on LPS Conservatorship.

David informed staff that he did not agree and wished to be discharged. It was understandable that he felt trapped and began to panic. As a result, staff contacted his physician to order a Prolixin shot in the event that he became agitated. His treatment team began to gather around him, not letting him approach a particular staff member on the hospital unit that he thought could be helpful.

David knew what was going to happen next: He was physically picked up, placed face-down on his bed and given a prn shot. After this incident, while standing next to a pay phone on the unit, he noticed a poster from the Riverside County Patient’s Rights Program and decided to call them to find out about his rights and whether or not he had any other options. He truly believed he did not need the Prolixin shot and felt he would be ok if he was released.

The next day, a Patient’s Rights Program Advocate came to see David and explained his right to refuse medication through a Reize Hearing process. David learned about his right to appeal and/or refuse temporary conservatorship. After the Patient’s Rights Advocate explained all of the steps he would need to follow, David was given a hearing date for the following week.

David began to calm down, knowing that he had some options and didn’t have to be placed on conservatorship. He won the Reize Hearing. David was given information regarding other alternative prn medications and an informed consent form that he could sign to ensure that his wishes regarding the use of medication were respected.

Testimonial # 3 – “Julie”

When I was committed to the psych ward by my parents when I was 13 years old, the staff threatened to put me in a straitjacket if I didn't voluntarily eat the food they gave me. Several times, when I refused to eat or drink anything, I was tackled by as many as 5 staff members who held me down and forced me into a straitjacket so that they could feed me through an NG tube that they inserted down my nose and throat. One time, I was even put in a straitjacket and placed in four-point restraints and bed-sheeted because I refused to eat. I managed to get out of the restraints and just walked out into the hallway with pride as the nurses looked on in disbelief. They couldn't really do anything at that point. But it wasn't until I had made the decision on my own that I needed to eat something to survive that I voluntarily chose to eat for my own health. That's when they stopped trying to restrain me. I ended up getting healthier and got discharged from the hospital 6 months later– it was my decision to cooperate with staff, follow my treatment plan and get better. I had to decide for myself, without being forced or pressured to do things I didn't want to do. That's when I got better.

CHAPTER 8

Advance Directives

What is an Advance Directive?

An Advance Directive, also known as a Durable Power of Attorney for Healthcare, is a legal document. It allows you to state in advance what you want to do about your health care if you become unable to make your own healthcare decisions and lets you pick someone to make decisions for you if you cannot make them for yourself.

What does an Advance Directive do?

An Advance Directive is an important tool for choice and empowerment. It normally goes into effect when:

1. You are in a coma, or you are mentally incapacitated, or you cannot communicate; or
2. A physician finds you incompetent to make medical decisions due to dementia or mental illness.

What is in an Advance Directive?

An Advance Directive has two parts. They are (1) your choice of a healthcare agent; and (2) your healthcare instructions. Either part is legally binding by itself.

What is a “healthcare agent?”

A healthcare agent is a person who makes decisions on your behalf when you cannot do so, based on what that person knows about your wishes and desires. You can limit the power of your healthcare agent.

What are healthcare instructions?

Your healthcare instructions set out your choices about doctors, facilities, medications, and emergency interventions. In most cases, a facility must

follow the instructions of your healthcare agent and your advance directive. Both California law and federal law recognize Advance Directives.

Where can I get an Advance Directive?

Disability Rights California, with the California Network of Mental Health Clients (CNMHC), has developed an Advance Directive form. It is called Advance Healthcare Directive, Disability Rights California publication #5088.01. You can find it on the web at <http://www.disabilityrightsca.org/Pubs/508801.pdf>.

Can I get help with an Advance Directive?

Disability Rights California and CNMHC have begun training mental health clients and professionals about Advance Directives. Disability Rights California staff can also help with implementing and enforcing Advance Directives. If you need help with an Advance Directive, call 1-800-776-5746.

(from a Disability Rights California publication)

CONCLUSION

We hope that this training manual has provided some helpful information and guidance in the event of a crisis situation. Our personal experience as peers and our work with others has shown us the necessity and importance of finding ways to avoid and resolve crisis situations in order to reduce or eliminate the fear, discomfort and trauma that may arise as a result. We know how scary it can be to live in a locked facility and how it feels to have limited power and control over our own lives.

For this reason, we hope that learning about: The definition and your rights and responsibilities regarding seclusion and restraint; how to identify your “triggers”; strategies and tips for preventing or reducing the use of these kinds of extreme measures; personal testimonies about the experience of other peers; and how to create a crisis prevention plan by working together with your treatment team and developing an Advance Directive will help you better prepare and plan ahead in order to prevent the need for crisis intervention measures.

We encourage you to talk with other peers who may have had successful experiences in dealing with these types of situations and discuss your thoughts and concerns with your treatment team to find with more effective solutions.

Remember – you are not alone, and crisis prevention is a team effort that includes your treatment team, family, friends and peers who can help you through difficult or challenging times.

If you have any questions or would like further information, you can refer to the Reference and Resource list for other materials related to crisis prevention. If you have a specific question regarding the information presented in this manual, please feel free to contact one or all of the authors of this manual. If you need assistance with an advocacy issue, you may contact one of our staff members in the Peer/Self-Advocacy Program at Disability Rights California at (916) 488-7787 (we accept collect calls), and/or an advocacy staff member at Disability Rights California at our toll-free number: (800) 776-5746, or TTY at: (800) 719-5798. You may also

access our website at www.disabilityrightsca.org and refer to our Peer/Self-Advocacy Unit webpage for more information and materials.

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