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Alternatives to Seclusion and Restraint in Behavioral Health Care

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Substance Abuse and Mental Health Service Administration (SAMHSA)

Interagency Autism Coordinating Committee (IACC) Services and Safety Subcommittee

May 19, 2011

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Urgency to Address S&R in Behavioral Health Treatment Settings

- Approximately 50-150 Americans die annually from S&R – thousands others are injured and traumatized (Harvard Center for Risk Analysis)
- S&R should be viewed as a treatment failure that creates barriers to recovery
- May be detrimental to recovery or persons with mental illness; retraumatizing (for consumers and staff)
- Facilities have successfully reduced and eliminated SR (Bennington-Davis; Huckshorn; LeBel)
- Focus on the prevention of the use of SR
- Less recognized: multi-level economic burden

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Ongoing Stories in the News

- *Virginia mental hospital violated state law holding a mentally ill patient in solitary confinement for 20 years* *(Assoc Press, June 2008)*
- *Georgia mental hospital investigation uncovers repeated misuse of seclusion and restraint practices, leading to patient injury and death* *(Atlanta Journal Constitution, June 4, 2008)*
- *Caregivers abuse patients, and usually get away with it* *(Raleigh News and Observer, March 1 2008)*
- *Patients die from poor care; families don't hear whole story* *(Raleigh News and Observer, March 2, 2008)*

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Definitions of SR

(From CMS Hospital Conditions of Participation, 2006)

- **Seclusion**: The **involuntary confinement of a patient alone** in a room or area from which the patient is physically prevented from leaving.
- **Restraint: Any manual method or physical or mechanical device, material or equipment, that immobilizes or reduces the ability of a patient to move** his or her arms, legs, body or head freely, attached or adjacent to the patient's body, that he or she cannot easily remove that restricts freedom of movement or normal access to one's body; or a **drug or medication** when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

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History and Context

- 1998 Hartford Courant Series
- 2000 Children's Health Act – language re SR for inpatient and community-based facilities
- 2003: SAMHSA - along with NASMHPD - convened a national summit with 200 stakeholders and issued a Call to Eliminate S&R in Behavioral Healthcare.
- 2003: A *National Action Plan* to reach this goal identified the need for a multifaceted approach including: training and technical assistance, data collection, evidence-based practices and guidelines, leadership and partnership development, and rights protection

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SAMHSA's Approach to Seclusion and Restraint Use

- SR in mental health treatment is viewed as a safety intervention of last resort, not a treatment modality
- To provide training, technical assistance, and other support to States, providers, facilities, consumers, and families in order to reduce, and ultimately, eliminate seclusion and restraint in mental health and substance abuse treatment;
- To implement changes re SR at the clinical, programmatic and organizational level

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National Public S/R Rates:

(NASMHPD/NRI Performance Measurement System, Feb 2008 and May 2010)

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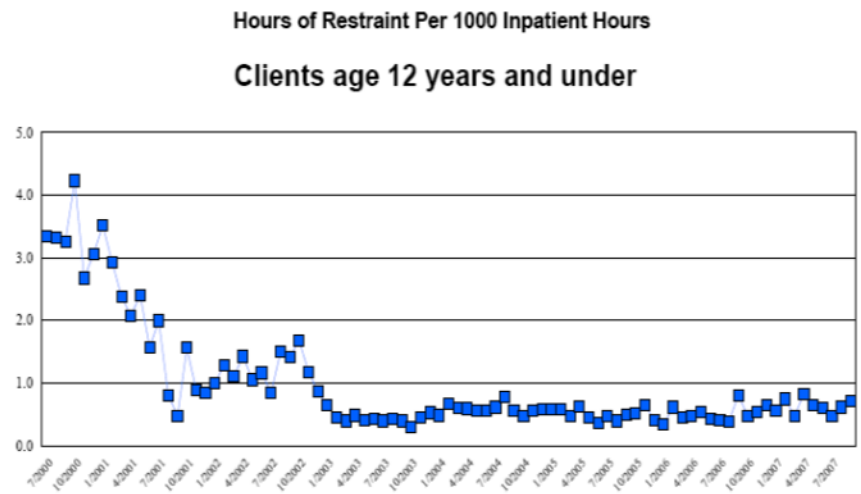
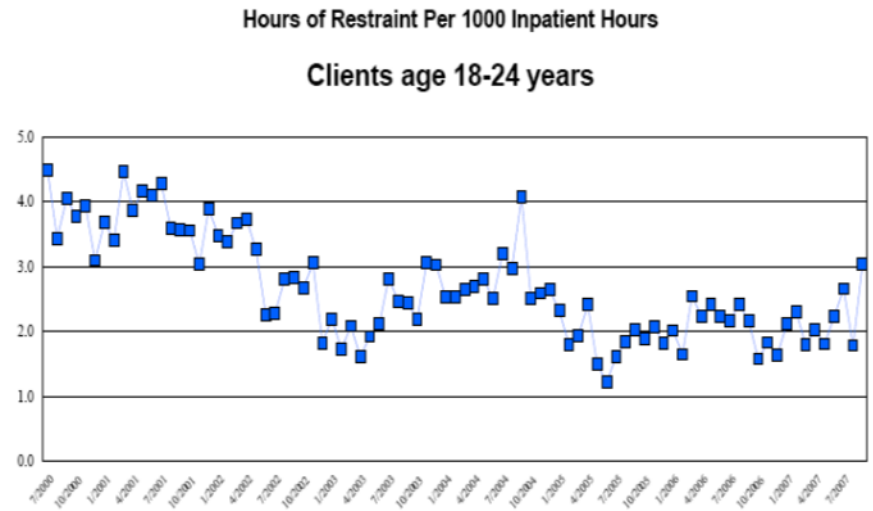
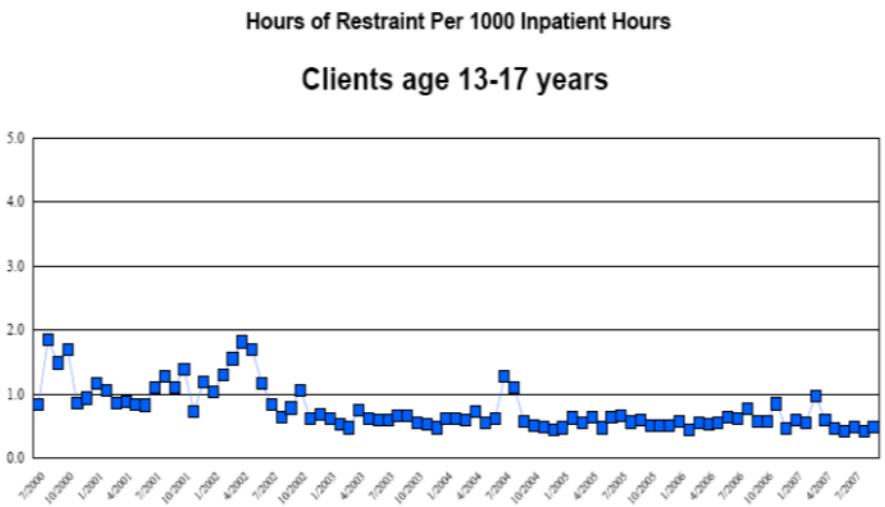
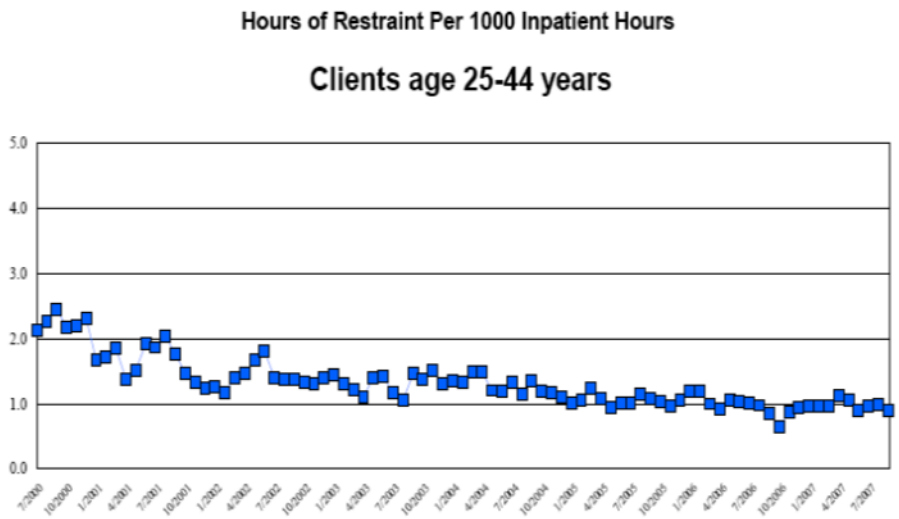
Hours of Restraint /1000 Inpatient Hours (2008, By Age)

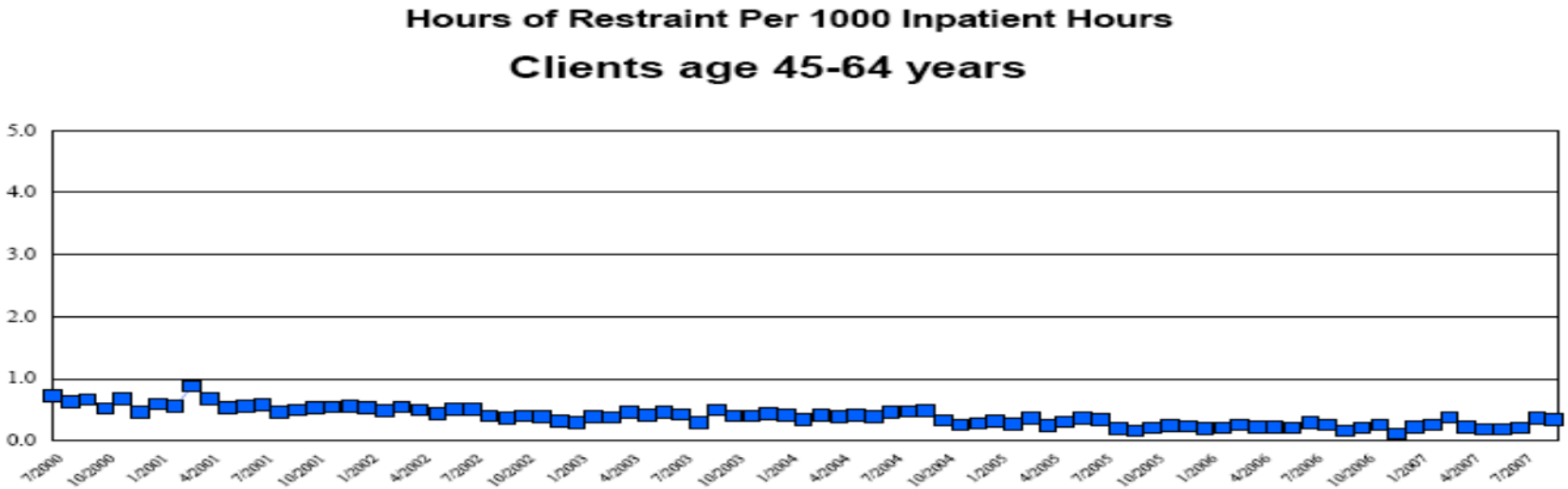


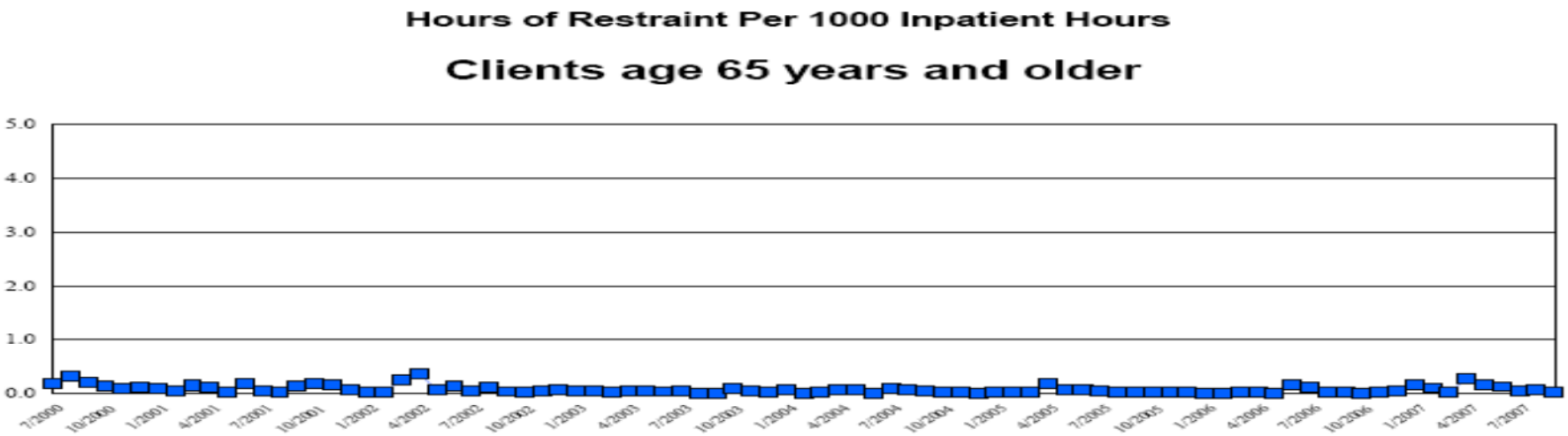




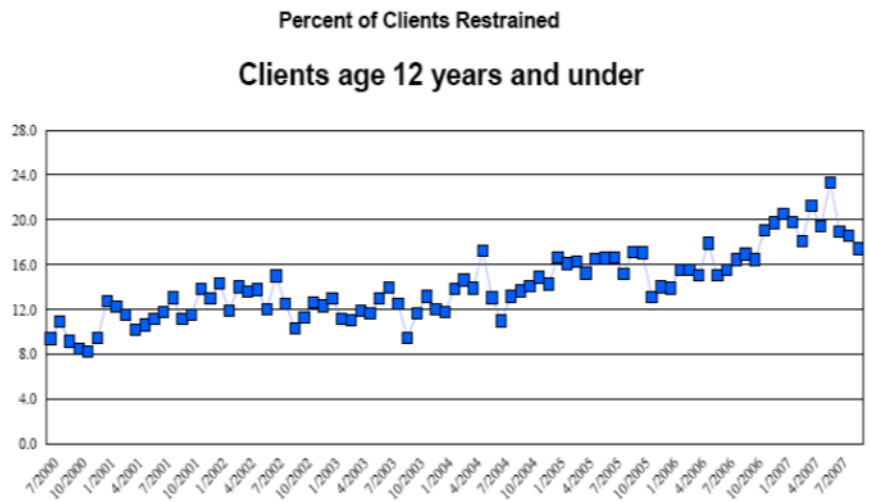


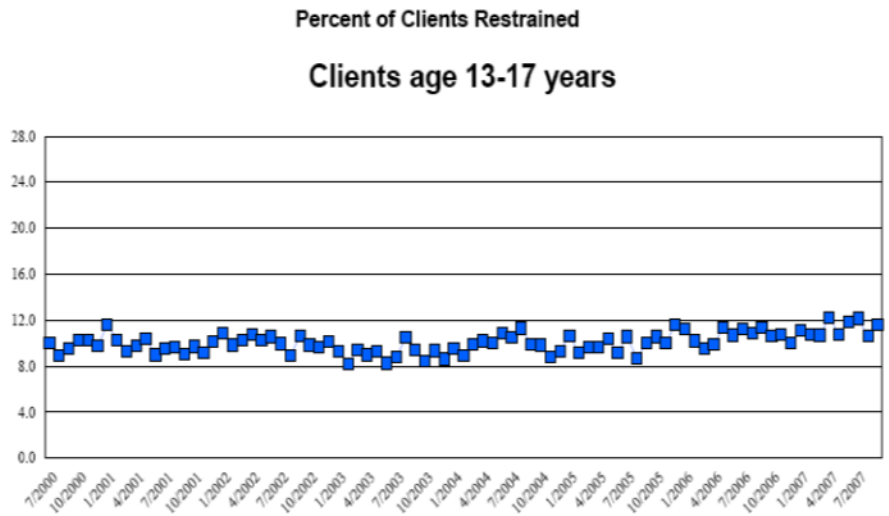
Hours of Restraint /1000 Inpatient Hours (2008, By Age) continued

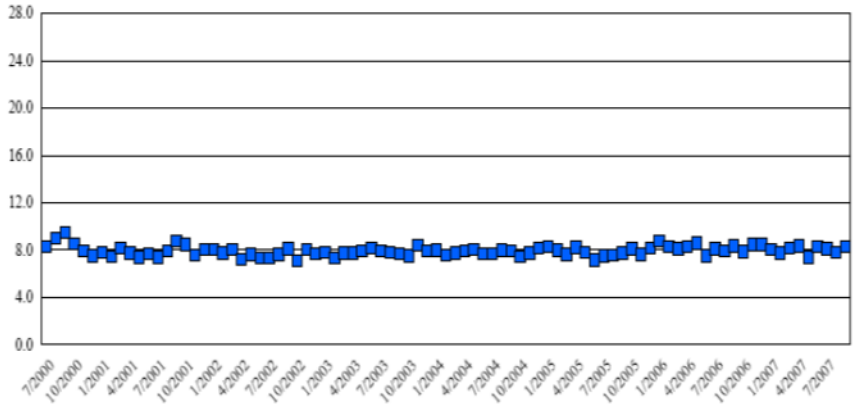


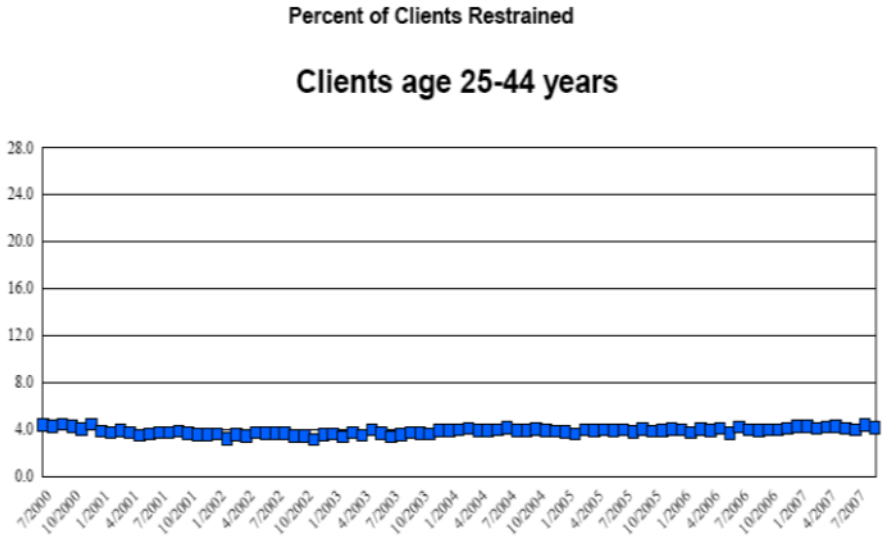


Percent of Clients Restrained (2008, By Age)

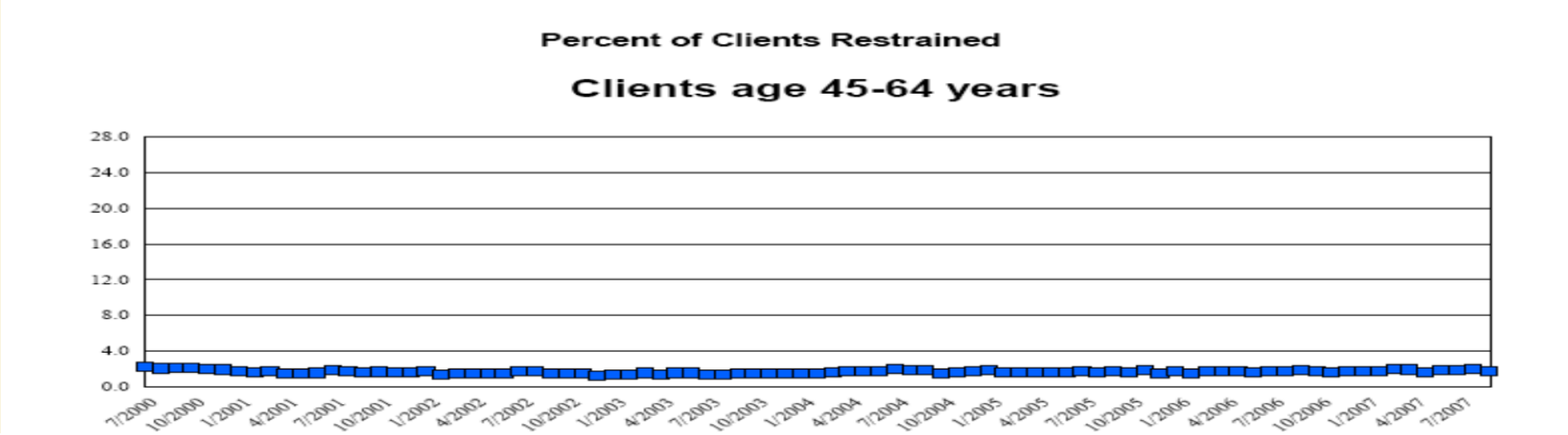


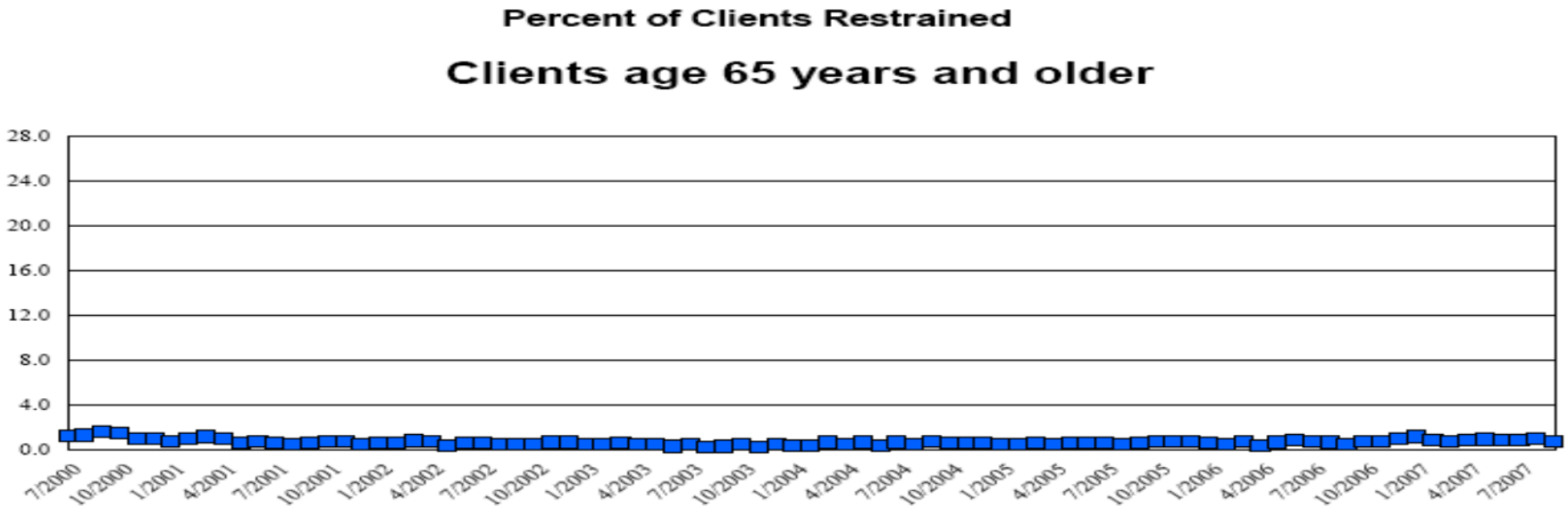




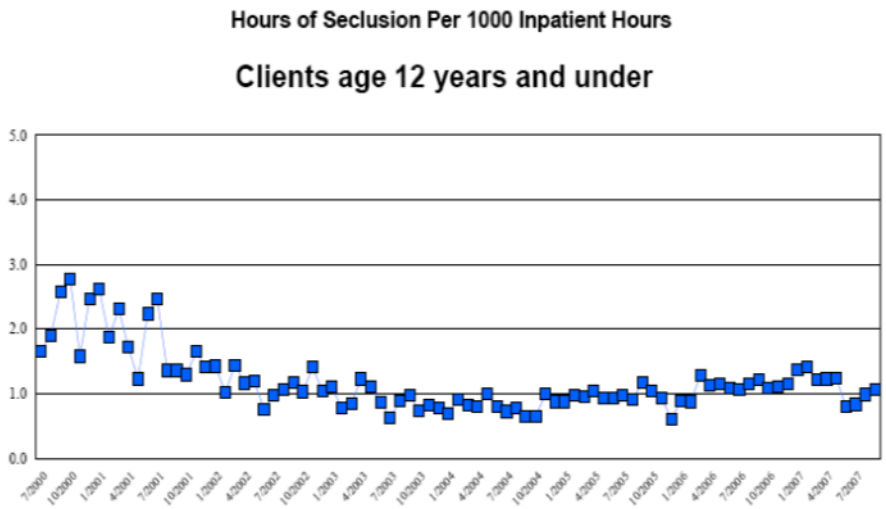


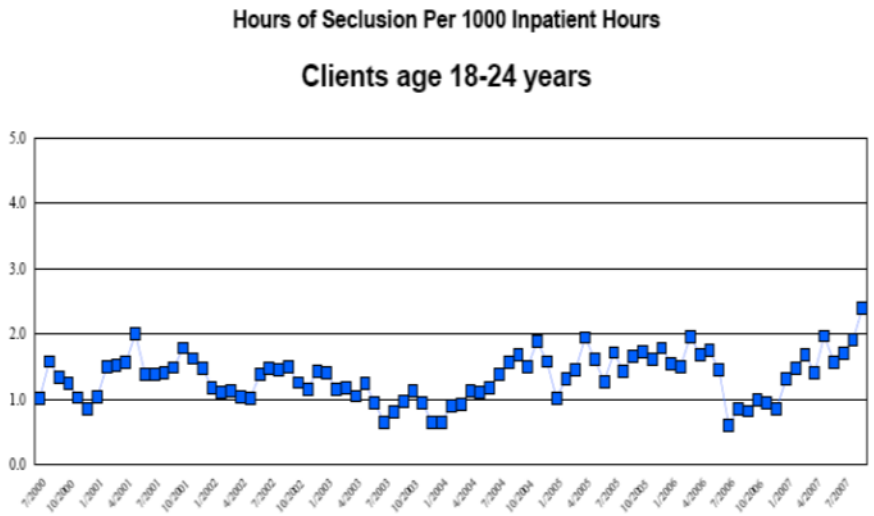
Percent of Clients Restrained (2008, By Age) continued

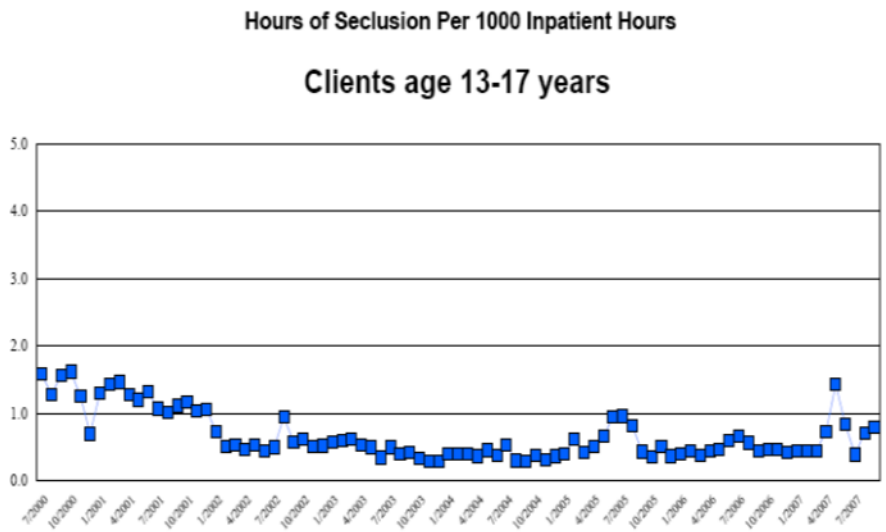


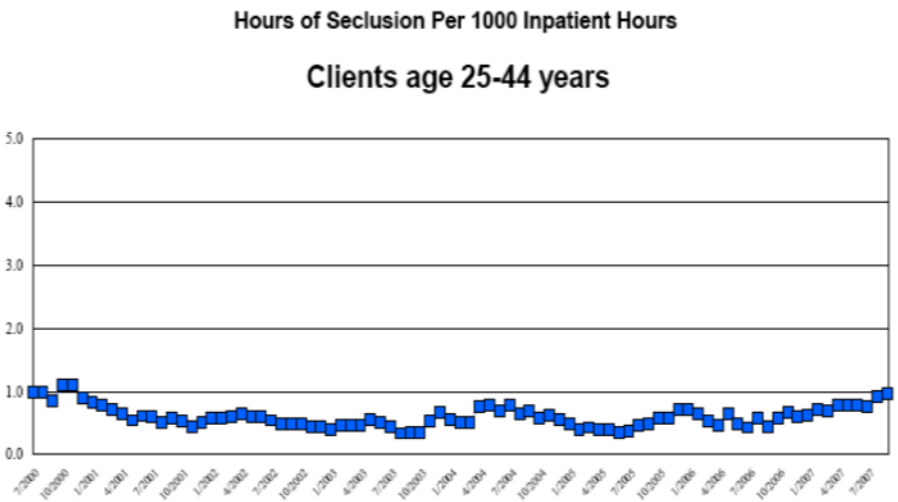


Seclusion Hours (2008, By Age)

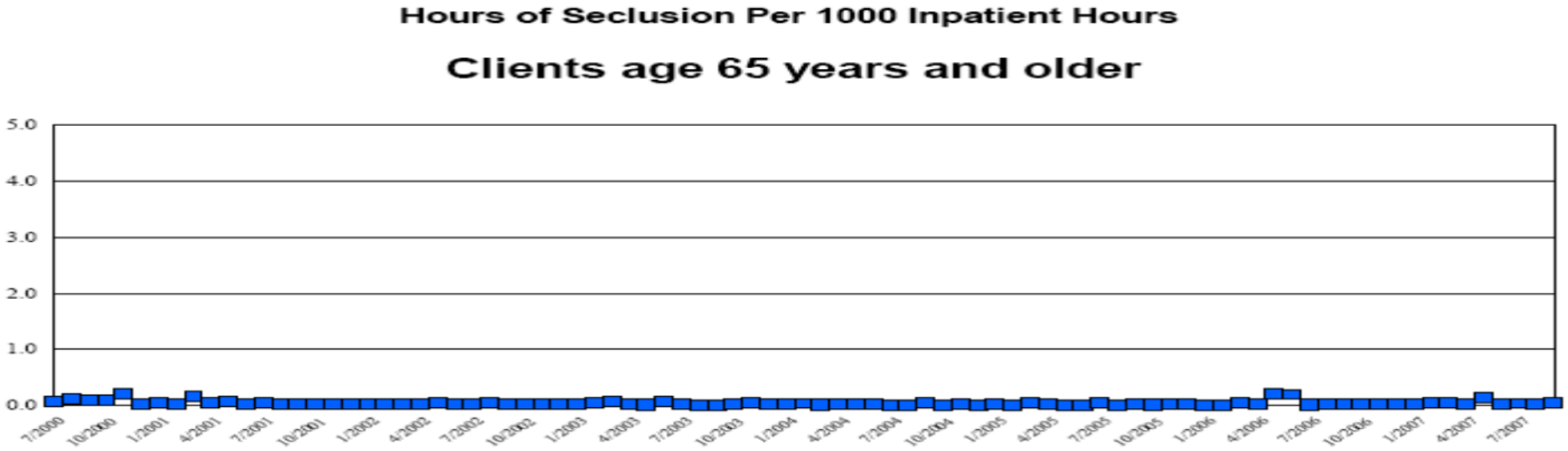


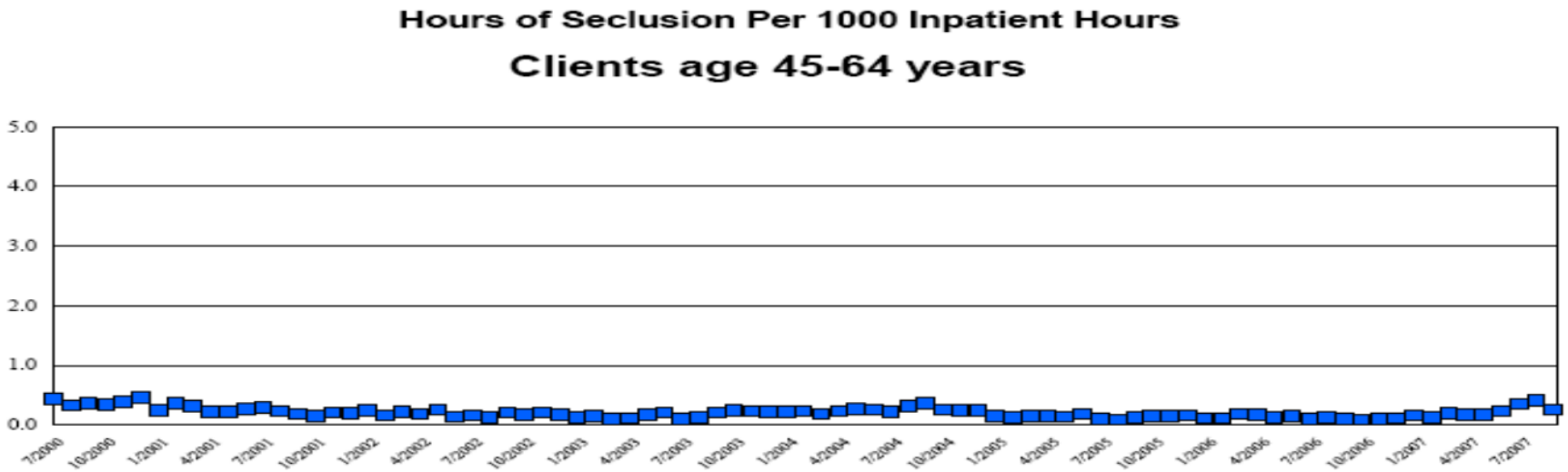




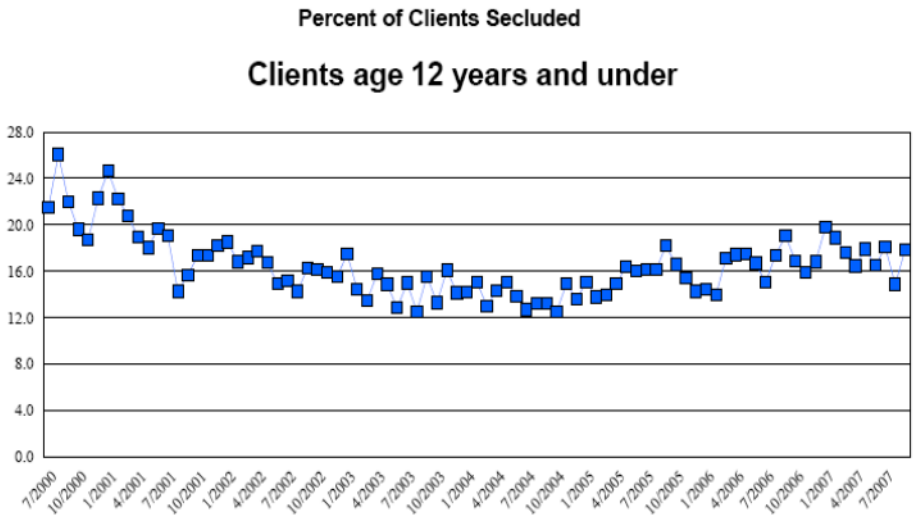


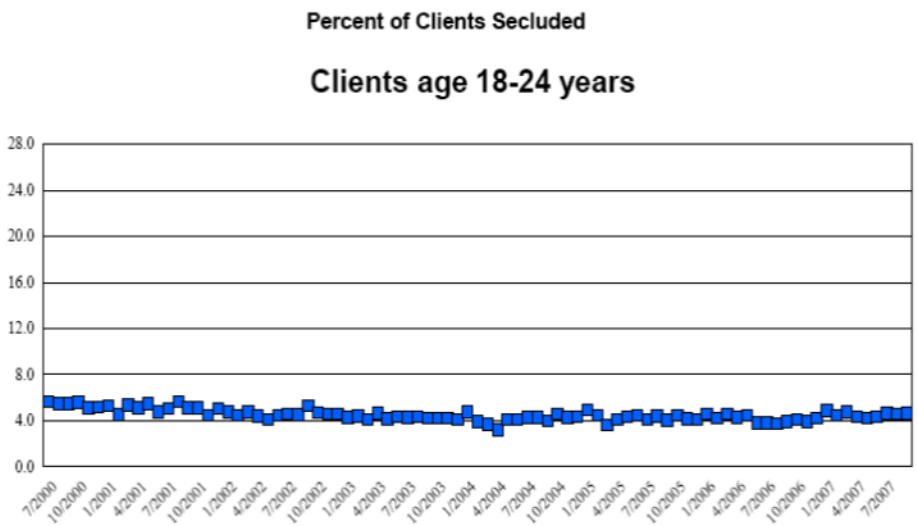
Seclusion Hours (2008, By Age) continued

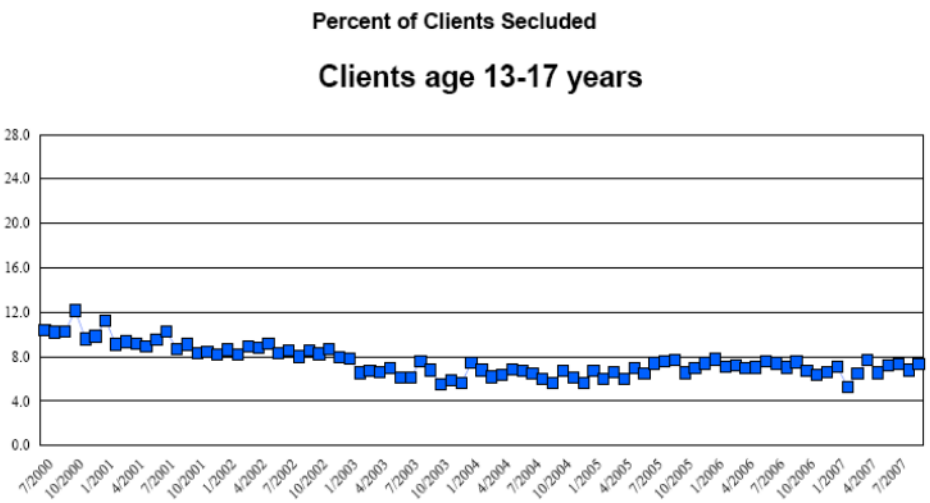


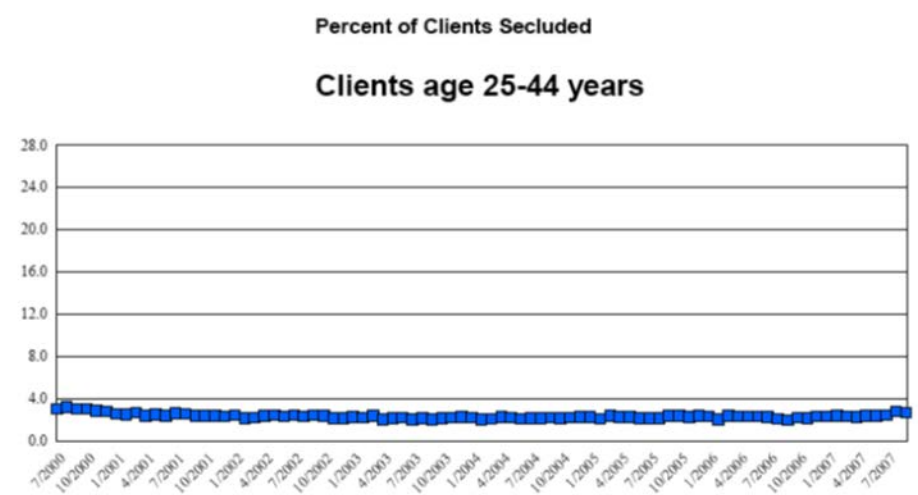


Percent of Clients Secluded (2008, By Age)

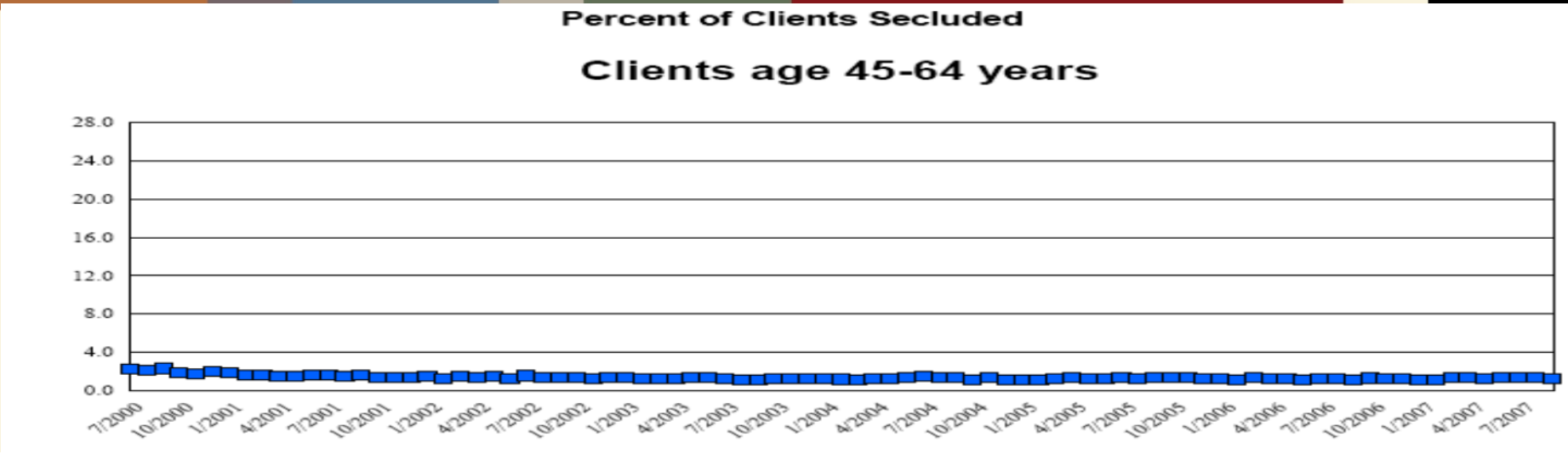


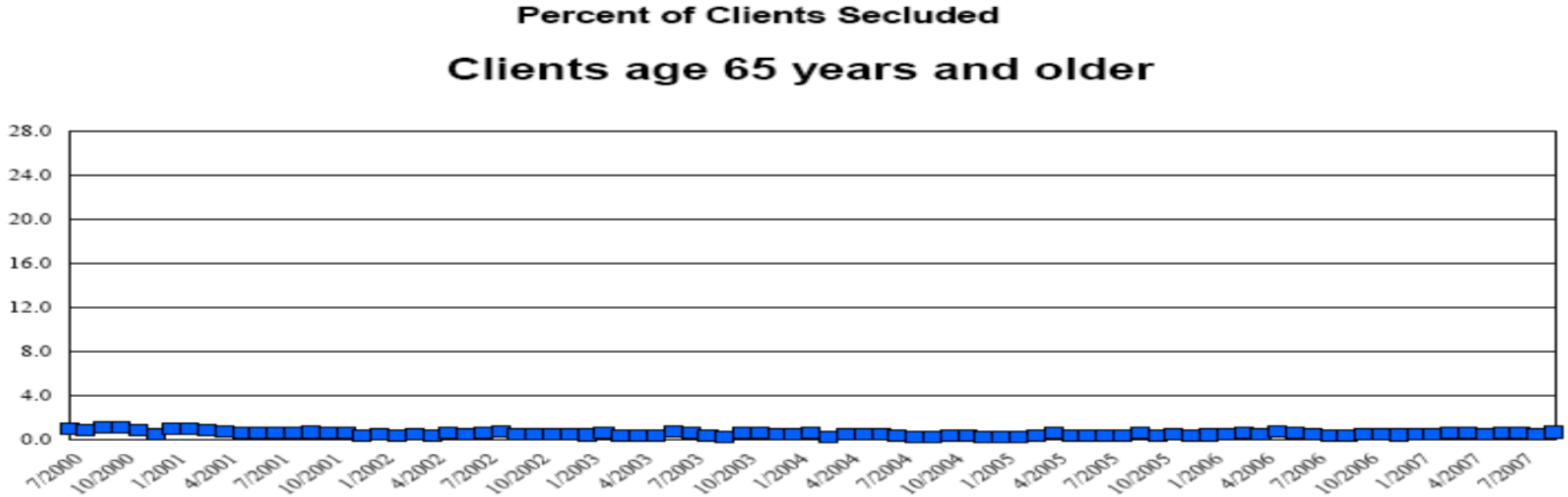






Percent of Clients Secluded (2008, By Age) continued





Summary of Data Reports

- Hours of restraint/1000 inpatient hours varies significantly by age group
- 12 yrs and under: from 2000 to 2007, hours of restraint decreased, but percentage of clients restrained increased
- 18-24 yrs: highest times in restraints, yet percent of clients restrained remained level
- Hours of seclusion/1000 inpatient hours decreased for all age groups between 2000 and 2007, except 18-24 yr olds
- Percent of clients secluded remained level in all groups except 12 years and under; highest rates in this age group

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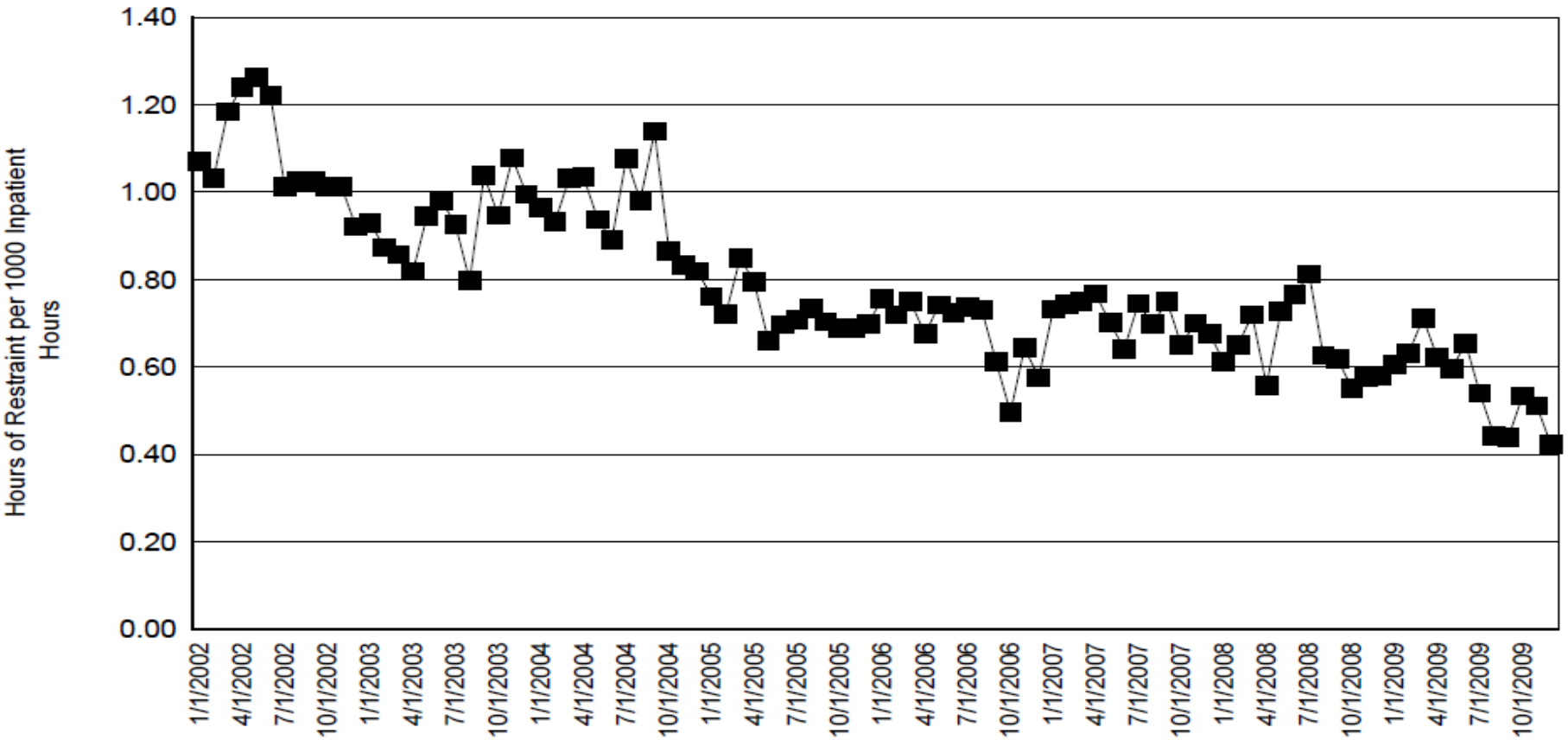
Restraint Hours (2010)



Labels on the chart are provided at three month intervals, each square represents the rate for a month.

NRI Performance Measurement System National Public Rates: Restraint Hours. Alexandria, Virginia: National Association of State Mental Health Program Directors Research Institute, May 2010.

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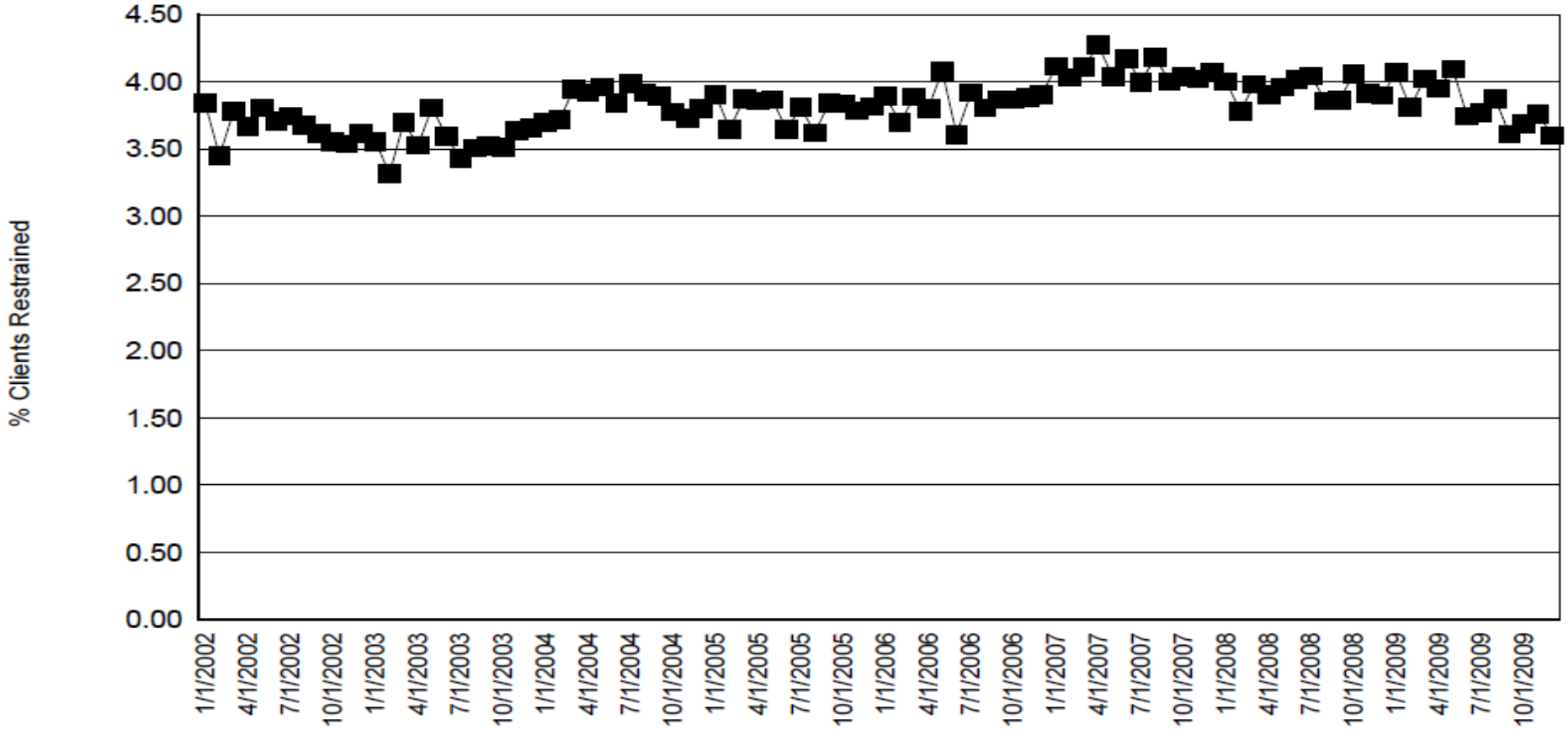
Percent of Clients Restrained (2010)



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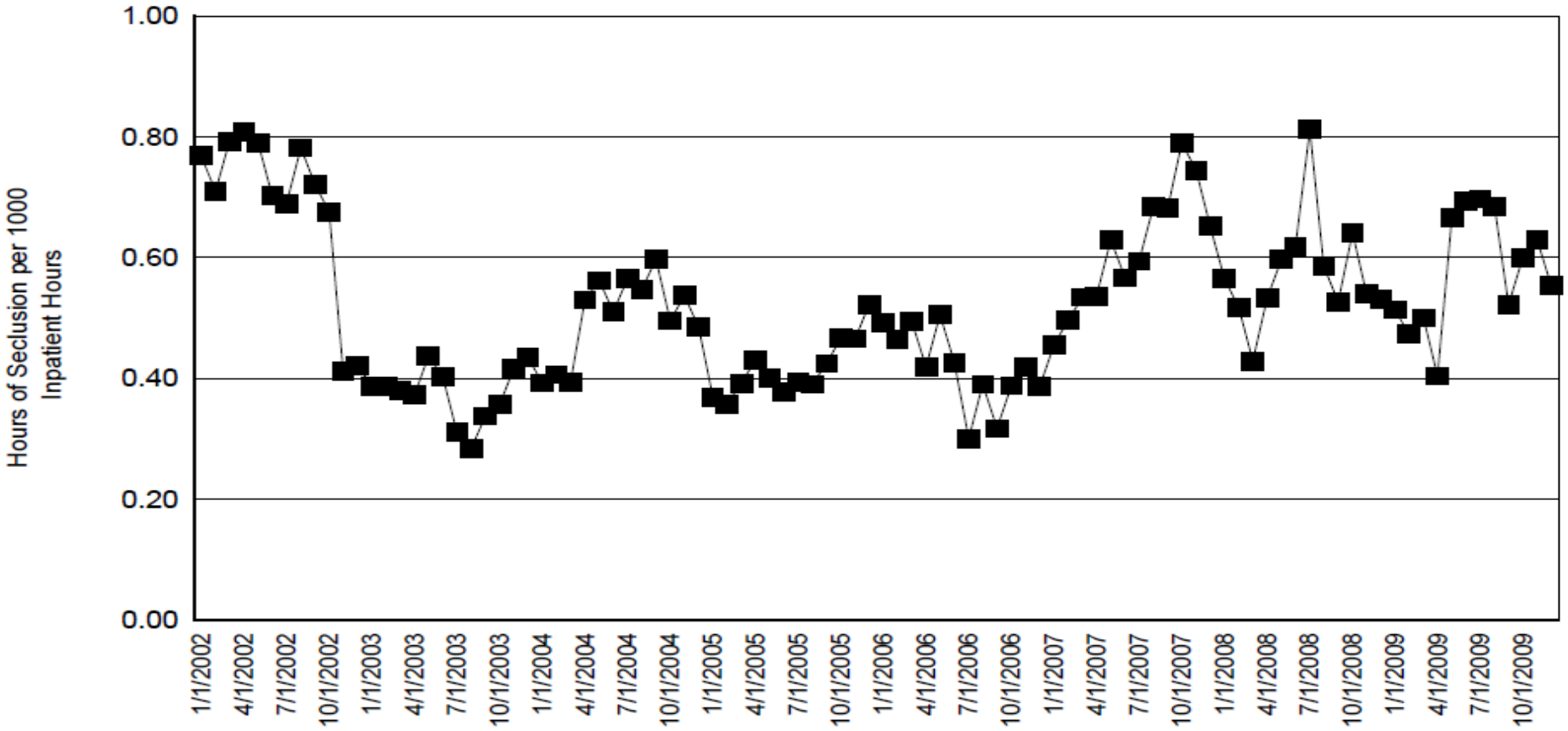
Seclusion Hours (2010)



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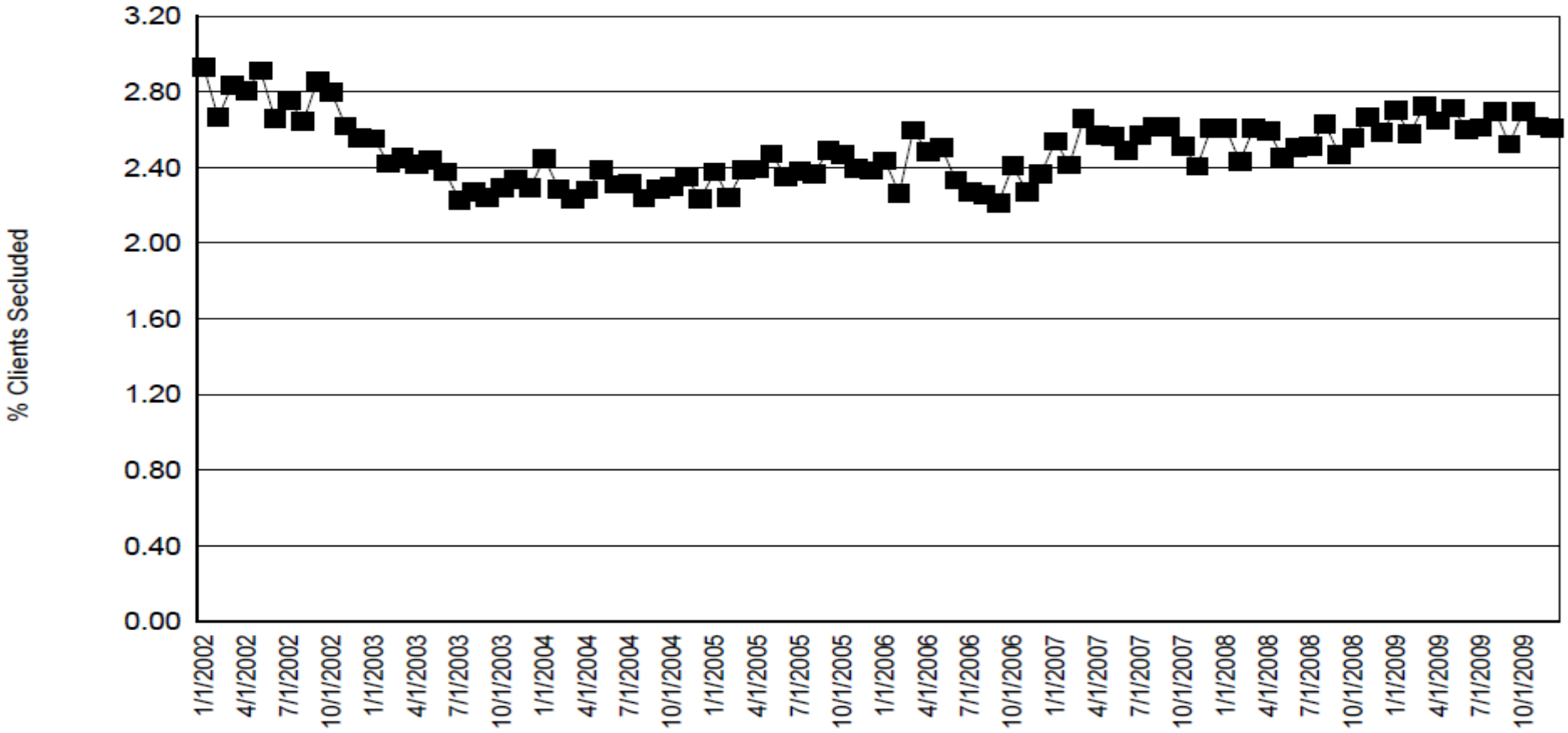
Percent of Clients Secluded (2010)



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SAMHSA Key Activities

1. State Grant Program and PAIMI Grants
2. Training and TA - National TA Center; uptake of effective strategies to prevent use of SR; communities of practice
3. Addictions Roundtable
4. Facilitate Development of Federal Regulations
5. Data Elements in Facilities Surveys

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S/R-Related Budget

Budget for SR Activities at SAMHSA	2006	2008	2010
CMHS: Alternatives to Restraint and Seclusion SIG	$1.7 million	$2.33 million	_____
CMHS: PAIMI	$34 million ($33.3 to State P&A Systems; $680,000 TA/Training)	$34 million	$36 million
CMHS: NTAC Coordinating Center for SIG	$392,000	$324,000	$2.4 million
CMHS: Contractor to Process SIG Data	$175,000	$150,000	_____

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(1) Training and TA Grant Program

- Alternatives to SR SIG Grant Program (two cohorts, total of 16 states)
- National SR Coordinating Center, NTAC/Natl Association of State Mental Health Program Directors (NASMHPD)
- National Evaluation
- PAIMI Program (Protection and Advocacy for Individuals with Mental Illness)

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(1) State Grant Program: Alternatives to Seclusion and Restraint

2004

- Hawaii
- Illinois
- Kentucky
- Louisiana
- Maryland
- Massachusetts
- Missouri
- Washington

2007

- Connecticut
- Indiana
- New Jersey
- New York
- Oklahoma
- Texas
- Vermont
- Virginia

Red: State also has a MH Transformation Grant

Green: State proposal to connect MHT and SR efforts

(2) Training/TA

- NTAC/Coordinating Center "Six Core Strategies": Regional Trainings, limited State and facility TA; prevention strategies; de-escalation, crisis plans, identifying triggers, organizational cultures; reduce coercive care, etc.
- SAMHSA Roadmap Training Curriculum (Consumer-developed)
- Training Video on S&R Alternatives
- National Disability Rights Network's Training and Advocacy Support Center Provides TA to Protection and Advocacy Agencies re S&R investigations
- National Center for Trauma-Informed Care

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Sample Intervention: "Six Core Strategies"

Core Strategies

- Leadership for Organizational Change
- Rigorous Debriefing
- Use of Data to Inform Practice
- Workforce Development
- Use of SR Prevention Tools (e.g, crisis plans, identify triggers, comfort/sensory rooms, etc.)
- Full Inclusion of Consumers and Families

Results:

- Facilities can successfully implement strategies
- Results in significant reduction in use of SR
- Some facilities have eliminated SR
- Reduced conflict in Tx settings

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(3) Addictions Roundtable

- 2006 Report and Key Recommendations:
  - Need for data and extent of SR in substance abuse treatment
  - SA field unaware of new and pending regulations; need to prepare treatment facilities and Single State Agencies

(4) Regulations

- CMS Hospital Conditions of Participation
  - -final standard issued 12/06
  - -one hour rule change
  - -new training requirements
  - -reporting of deaths
  - -interpretive guidelines
- Children's Health Act Regulations
  - CHA Part I for Non-Medical, Children's Residential Settings
    - NPRM submitted (Dec 2006)
    - Covered facilities
    - State, facility, and PAIMI responsibilities (specificity of orders, monitoring, training, etc.)
    - SAMHSA implementation costs

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(5)Data Elements

- **Data Elements – N-MHSS; N-SSATS:**

In the 12-month period beginning January 1, 2007 and ending December 31, 2007:

(a)Has your staff used seclusion or restraint practices with clients?

Yes___ No___

(b) Has your facility adopted any initiatives toward the reduction of seclusion and restraint practices?

Yes___ No___

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Making the Business Case

- Organizational Costs
  - Staff time managing SR procedures
  - Time/motion/task analysis: 1hour restraint involved 25 different activities, claimed ~12 hours of staff time to manage and process event
  - Restraint claims >23% staff time; 50% nursing resources to manage SR
  - Opportunity costs – treatment not being provided
  - Client injuries → liability and legal costs
  - Staff injuries→turnover, absenteeism; workforce instability and dissatisfaction

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Making the Business Case

- Client/Consumer Costs
  - Physical injury, sometimes death
  - Traumatized/retraumatized
  - Disruption of therapeutic relationships and mistrust of caregivers
  - Loss time for quality care and treatment

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Benefits to Clients Associated with Reduction/Prevention of SR Use

- Fewer injuries
- Shorter lengths of stay
- Decreased re-hospitalization
- Less medication use
- Higher levels of functioning at time of discharge
  - (LeBel & Goldstein, 2005; Murphy and Benningto-Davis, 2005; Thomann, 2009; Paxton, 2009)

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Concerns and Issues:

- Data Challenges
- Dissemination and uptake of effective approaches to reducing and eliminating SR
- For children: proliferation of unlicensed/unregulated residential treatment centers that move across state boundaries and use coercive techniques
- Expansion into schools and older adult settings; work with Federal partners, Federation of Families
- Coordination with CMS around regulatory actions
- Strengthen linkage with trauma-informed care approaches

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Recent Issue Briefs on "Promoting Alternatives to the Use of Seclusion and Restraint"

- *A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services (2010)*
- *Major Findings from SAMHSA's Alternatives to Restraint and Seclusion State Incentive Grants Program (2010)*
- *Making the Business Case for Preventing and Reducing the Restraint and Seclusion Use (2010)*

Web link to SAMHSA Seclusion and Restraint Publications and Resources:
http://www.samhsa.gov/matrix2/seclusion_matrix.aspx

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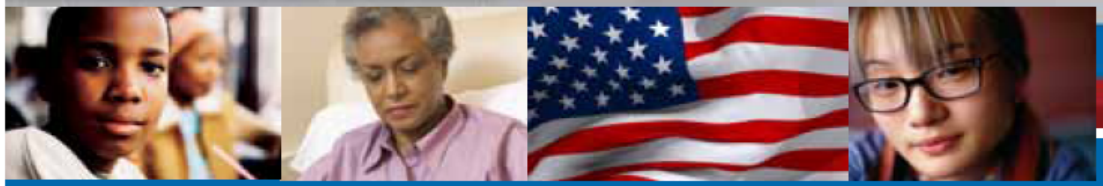
Promoting Alternatives to the Use of Seclusion and Restraint

Issue Brief #1

A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services



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

Introduction

In the United States each year, it is estimated that 50 to 150 individuals die as a result of seclusion and restraint practices in mental health inpatient residential facilities and many others are injured or traumatized by these events (Weiss et al., 1998). In fact, seclusion and restraint are dangerous and traumatic not only to the individuals subjected to these practices, but also for the staff implementing them. The Government Accountability Office (GAO; 1999a) noted that seclusion and restraint continue to be used in these facilities despite the psychological and physical harm they cause to consumers. The Cochrane Collaboration, which provides reviews of the evidence of health care practices, noted of seclusion and restraint: "few other forms of treatment which are applied to patients with various psychiatric diagnoses are so lacking in basic information about their proper use and efficacy" (Sailas and Fenton, 2000, p.4). In addition, surprisingly, there is no uniform method for tracking these injuries or deaths within States or across the country. The GAO (1999a) highlighted insufficient monitoring and reporting of the use of seclusion and restraint and inconsistent standards for using these practices and reporting their use.

The Substance Abuse Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services and the National Association

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Promoting Alternatives to the Use of Seclusion and Restraint

Issue Brief #2

Major Findings from SAMHSA's Alternatives to Restraint and Seclusion State Incentive Grants (SIG) Program

MARCH 2010

Photo collage of diverse people.

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

Introduction

Over the past decade, there has been a significant shift in attitude and practice on the use of seclusion and restraint in mental health treatment settings. In 2002, the Substance Abuse and Mental Health Services Administration (SAMHSA) identified the reduction and eventual elimination of seclusion and restraint in mental health and substance abuse treatment as a key priority. Accordingly, SAMHSA developed the Alternatives to Restraint and Seclusion (ARS) State Incentive Grants (SIG) program, with the purpose "to support States in their efforts to reduce and ultimately eliminate the use of restraint and seclusion in institutional and community-based settings that provide mental health services (including services for people with co-occurring substance abuse and mental health disorders)" (Center for Mental Health Services, 2004).

This issue brief, the second in a series on the use of seclusion and restraint, provides a summary of evaluation data from this first cohort of State grantees funded through SAMHSA's ARS SIG program.

SAMHSA's SIG Program

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Promoting Alternatives to the Use of Seclusion and Restraint

Issue Brief #4

Making the Business Case

MARCH 2010

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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

The Business Case for Preventing and Reducing Restraint and Seclusion Use

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