Peer Involvement Becomes a Reality on the
DMH Restraint and Seclusion Grant
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Background:
Sometimes potential for system change comes in “little” federal packages. Recently, the Massachusetts Department of Mental Health (DMH) won a federal grant to eliminate restraints and seclusion in state inpatient facilities. Massachusetts is one of eight states that won one of these grants and there has been much hope in the advocacy community that it will lead to deep, meaningful changes in the state mental health system. But a culture of violence and coercion has existed for so long that creating an alternative culture of empowerment, respect, support, and healing will not be easy. Fortunately, peer involvement in the grant is finally beginning to happen.

Last spring, three peer members of the grant advisory committee, Jon Delman, director of Consumer Quality Initiatives, Howard Trachtman, chair of the NAMI National Consumer Council Restraint and Seclusion Committee, and Steve Holochuck, DMH Director of Consumer Affairs, sketched out a broad plan for peer involvement. Three others also participated, Walter Noons, attorney at the Disability Law Center, and Ed Wang, DMH Director of Multicultural Affairs, and me.

The broad plan was eventually honed into four priority items, 1) a mediated dialogue between DMH staff and peer advocates, 2) training for new peer debriefer positions, 3) peer-led staff training and technical assistance, and 4) peer involvement in monitoring and evaluation. These priorities are overseen and implemented by a Transformation Center team which includes: Gloria Dickerson, Marina Colonas, Keri Fallon, and I, Team Leader/Coordinator. Deborah Delman, Executive Director of the Transformation Center, is an on-going contributor, as is Steve Holochuck, Howard Tractman, and Jon Delman.

Mediated dialogue
Our first goal is to implement a mediated dialogue for DMH staff and peer advocates; it will be led by a neutral facilitator from the Public Conversation Project. Why? We hope a facilitated dialogue would improve communication. Relations between peer advocates and DMH administrators are often fraught with conflict, high emotions and frustration on both sides. We often don’t feel heard by them and are devalued and tokenized in an environment where we believe there should be “Nothing about us without us.” Administrators, on the other hand, often feel demonized, attacked and misunderstood. The Public Conversation Project has a proven track record in helping two polarized groups (i.e. pro-choice and pro-life) come together to hear one another in a respectful and productive way. The first dialogue will take place this fall with the grant advisory committee members. If this dialogue is successful we hope to see
mediated dialogues replicated at the state inpatient units; participants would include area peer advocates and hospital staff, administrators, and patients.

**Training for new Debriefer positions**
Tewksbury State Hospital and Worcester State Hospital created the first peer Debrief/Operator Liaison position in the nation! Ellen Flowers, Director of Nursing at Tewksbury and Tony Riccitelli, Chief Operating Officer at Worcester State Hospital, developed the "out of the box" idea of hiring a peer debriefer. They hired a person in recovery from a mental illness to debrief patients after restraints and seclusion and provide peer support. The Patient Liaison also works collaboratively with people’s treatment teams in order to advocate for them and strategize techniques to avoid restraints and seclusion. It is a peer/team-centered recovery model. Through a conventional DMH hiring process, Deni Cohodas was the first person hired for this position. Because the role has been so successful, DMH would like to see all inpatient facilities hire Patient Liaison/Debriefers. With this goal in mind, the Transformation Center is planning to hold a training for potential Debriefers/Patient Liaisons in early spring 2007. If you’d like to know more this job and the training, please contact me, Nicki Glasser, at 617-437-6493 or Nicki6000@verizon.net

**Peer-Led trainings and technical assistance**
The team has two projects under this heading. The first is to provide technical assistance for staff on the importance and value of peer support and issues around hiring of persons with mental illness. We are concerned about placing debriefers into environments where staff is not welcoming to a new (and probably their first) peer staff member, and whose day-to-day activities with, and assumptions about, patients can be disturbing to someone in recovery. Our goal is to smooth the way for peer debriefers while also educating hospital staff about these issues.

Second, we are interested in a national training curriculum from the Substance Abuse and Mental Health Services Administration (SAMHSA) called “The Roadmap to Seclusion and Restraint Free Mental Health Services.” Written largely by persons with mental illness, it is an in-depth and enlightened approach to transitioning to recovery-oriented treatment approaches. DMH has suggested we choose a few sections from this three-day training that we feel will be the most helpful for hospital staff.

**Monitoring and Evaluation**
If non-peers are doing all the monitoring and evaluation on the inpatient units, one is left wondering if the assumptions made from those efforts are accurate. While monitors and evaluators claim to be neutral, in fact, no human being is capable of being completely neutral because we all bring our own life experiences into play in everything we do. For this reason, we would like to see more peer involvement in monitoring and evaluation activities. In fact, there is a precedent of successful peer involvement. For example, Consumer Quality
Initiatives (CQI) is a consumer-run and directed organization that conducts mental health quality improvement, evaluation, research and service planning. CQI has been hired by DMH for a number of projects and has been a valuable contributor to DMH policy. We approve of research and evaluation that involve the peer advocacy community in more than token forms.

Final Note
In sum, the restraint and seclusion initiative has an ambitious plan. Our goal is to eliminate restraints and seclusion by helping to change the culture of the mental health system to be more recovery-based. We know that there’s good staff and clinicians out there who believe in clients ability to recover and who set a high standard for their colleagues. But we need every clinician, every administrator, every mental health worker to believe in and know how to support our very human capacities to grow, learn, understand our illness, and ultimately recover. Eliminating restraints and seclusion won’t be attainable overnight but we cannot sit by idly. We must push the process forward at every chance. The restraint and seclusion initiative is another step in the right direction. Every step forward holds the potential to save a life. There is no time to spare.