Appendix B
UMASS ADOLESCENT TREATMENT PROGRAM
Description of 24/7 Witnessing to the Program to Reduce and Eliminate Restraint and Seclusion, and Progression Towards Elimination of Mechanical Restraints
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Because the vast majority of youth who come to our program have a trauma history, we provide Universal Care by assuming that all of the youth in our program have a history of trauma and/or have been victims of violence in their past (Saxe and Ellis 2007). One of our main treatment goals is helping our youth learn how to cope with stress without resorting to violence. We can not eliminate the use of restraint and seclusion (R/S) without eliminating violence. However, if we respond to their behaviors by the use of R/S, we are perpetuating the cycle of trauma and violence that has to this point shaped their view of the world. This is why it is important to the adolescent program to have a healing environment free of coercion, including R/S (Bloom 1997).

Our philosophy of care directs us to ensure all staff are proficient in providing trauma informed care and focus on the eventual elimination of R/S. This philosophy of care incorporates the six core strategies the National Technical Assistance Center (NTAC) has developed to reduce/eliminate R/S (Huckshorn 2005):
1. Leadership Towards Organizational Change
2. Using Data to Inform Practice
3. Workforce Development
4. Use of Restraint/Seclusion Reduction Tools
5. Consumer Roles in Inpatient Settings
6. Debriefing Process

The process of on site witnessing is a key element of the first core strategy. Part of “Leadership Towards Organizational Change” is providing 24/7 witnessing to elevate the oversight of restraint and seclusion. This oversight aids in the reduction and elimination of the use of restraints. Witnessing is enhanced with an on site supervisor to aid in prevention of escalation and the de-escalation process of our youth (Huckshorn 2005). Our program currently engages in the following steps to carry out 24/7 witnessing:
1. Witness preparation
2. Pre-witnessing (on and off site)
3. Witnessing (on and off site)
4. Post-witnessing (on and off site, in addition to the debriefing process)

In preparing to be a witness, the on site supervisor is required to be knowledgeable of a plethora of the strategies for prevention of escalation and assisting in de-escalation, as these steps are integral to the success of violence reduction. Violence reduction is key to R/S reduction and elimination (Murphy and Bennington-Davis 2005). Part of this list of strategies is the use of empathy and compassionate alternative techniques (CAT) (Champlin, P, CAT Training Curriculum by Robert Keane, Westborough State Hospital, 2006). Another is using the Individual Crisis Prevention Plan (ICPP), which is generated from the restraint and seclusion prevention tool (Found in MHIS). Further strategies
include understanding the differences between self injury and suicidal ideation (Contario, Lader, and Bloom 1998), use of sensory tools (Champagne & Stromberg 2004), and collaborative problem solving (Greene & Ablon 2006). The list of strategies we have to accomplish our goal is extensive and is important to the integrated process that brings about the culture change necessary to eliminate R/S. All of our staff are given the opportunity to learn these strategies and are taught through in-services, meetings, 1:1 discussion, supervision, and the role modeling of on site supervisors. This teaching is part of Workforce Development, another of NTAC’s Six Core Strategies (Huckshorn 2005).

Once the on site supervisor has prepared to be a witness, we find that pre-witnessing is the most important step, because if the intervention comes early enough there is no escalation. Pre-witnessing can only be accomplished when direct care staff know the individual care plan and continually provide ongoing assessment to our youth. If we have knowledge of our youth’s early signs of dysregulation, we can intervene before they become cognitively, emotionally, and/or behaviorally dysregulated. It may be as simple as identifying what we see, for example:

Staff: “Hi John how are you?”
John: “Oh I’m Ok!”
Staff: “I noticed you were pacing a lot.”
John: “Well my mom called and she’s not coming up to visit tonight and I was hoping to see my little brother.”
Staff: “I’m sorry to hear that. You must miss your family.”

By identifying the behavior of pacing as a coping skill the youth normally utilizes to self soothe, the staff afforded the youth the opportunity to identify the problem and his feelings. This allowed the staff to validate the youth’s feelings. This identification is performed by all of our staff, but it is important for the on site supervisor to act as a role model.

In the above example, the staff (MHC and charge nurse) would then call the supervisor and describe what was happening, and together the three would deliberate if any further intervention was necessary to help the youth remain regulated despite the disappointment (for example, spend some extra time with the youth, play a game with them, etc). This might be done without the supervisor coming to the unit (off site). Pre-witnessing assists the staff to focus on the youth to assist and support youth to avoid escalation. Sometimes the Program Director (PD) is called before escalations to problem solve a potential for escalation. In this way, the PD is involved with pre-witnessing even from off site.

The on site supervisor may receive a call that a youth is escalating and having a hard time identifying a coping skill that will be successful in the de-escalation process. The on site supervisor then works with the staff to problem solve on the best way to de-escalate the youth. It may be that the staff that is attempting to work with the youth has not established a step down approach that will lead to collaborative problem solving. It could
be that for whatever reason, the youth is unable to feel supported by the efforts of the staff in the moment. The on site supervisor offers a “fresh set of eyes” to assist in the de-escalation process to ensure a safe return to baseline function. Sometimes this includes the supervisor personally assisting to support the de-escalation. This is another form of pre-witnessing (on-site).

In the case of a rapid escalation that leads to a hold, someone calls the supervisor on site to the scene to assist in witnessing the event. This ensures a) the R/S is performed according to procedure, b) the safety of youth and staff, and c) a release as soon as possible. This is a case of the supervisor witnessing on-site. If a supervisor is not able to get to the scene in time for the R/S (due to being involved in an incident on another unit or being off campus, or the R/S is very fast), the charge nurse calls the supervisor after notifying the doctor and begins describing the event so the supervisor can give support to begin re-establishing therapeutic rapport, therapeutic milieu, and recovery from the traumatic event. This is an example of witnessing off site. In this way, the PD can also witness off site if the charge nurse calls the PD directly.

After an R/S event, it is time for the debriefing and apology process to begin as well as the post-witnessing process, when the onsite supervisor calls the covering PD and informs the PD of the incident. During post witnessing, the PD asks a comprehensive list of questions to find out subject matter assuring for the safety and care of youth and staff (a sample question would be, “Did anyone get hurt?”), establishing that the danger has passed, identifying antecedents, and problem solving to prevent recurrence of the R/S. This information is made part of the debriefing and apology process. There are times when the PD is available to come to the unit to assist in mitigating the effects of the R/S. However, most of the time post-witnessing happens from on site to off site, ensuring that the experience is communicated to someone who was not present to provide an objective witness and support those who witnessed the event on site. The covering PD is responsible to be a witness to the program 24/7, even without an on site supervisor present. This process of 24/7 witnessing assures that R/S events are elevated to the top of the program’s priorities, up with emergency medical events.

Post witnessing is inclusive of all of the above but may be extended to further responsibility when the care and protection of our youth (patients of Westborough State Hospital) and the safety of our staff has been compromised. This includes but is not limited to physical injury, endangerment, or neglect, whether youth to youth, staff to youth, youth to staff, or staff to staff witnessed by the youth. Any occurrences of this nature will prompt us to involve any of the following stakeholders: legal guardians, the Department of Children and Families (Formally Department of Social Services, or DSS), the Disabled Persons Protection Commission, the Department of Mental Health, UMass Adolescent Unit PD, the youth’s treatment team, the SHARE/MNA Joint Safety Committee, UMass Employee Health, UMass Employee Assistance Program, Westborough State Hospital Administrator, Human Rights Officer, and Doctor On Call (DOC), and any designated persons or representatives. Though prompted under unfortunate circumstances, the Adolescent Units sees this part of the process as being transparent in order for the system to be better informed of its treatment environment and
its served youth. This further effort challenges the broader system to be involved in recovery of individuals from a traumatic event. Including relationships with stakeholders to report incidents is an example of effective risk management (Huber 2000 & Lee 2007).

We recognize that the DOC is an integral part of our approach when the attending physician and the Medical Director are not available. Problems can arise if the DOC has not been oriented to the NTAC core strategies. For example, the DOC may not understand who is in charge of the acute unsafe situation on the unit, i.e., is it the Charge Nurse or the Supervisor. Ultimately, the charge nurse is in charge of the unit, with the supervisor there to support the charge nurse (and the rest of the unit). The supervisor would not over-ride the charge nurse unless there is imminent risk of harm without over-riding.

When a DOC responds to the unit, the first step is to identify who is in charge and whether or not the supervisor is present. We would then like the DOC to work with us, as we are most familiar with the youth, to determine the next best intervention in order to achieve the least traumatizing event to that youth and the milieu. In addition to ordering R/S, DOCs may also assist us by 1) talking with a youth, 2) helping us brainstorm, 3) consulting on the phone with the attending physician or our Medical Director, 4) assessing agitation with a “fresh set of eyes,” 5) assessing any injuries that may have occurred to youth or staff, and/or 6) ordering a STAT medication or medication restraint. We recognize that the DOCS are covering the entire hospital and those other responsibilities or urgencies may require their time. Therefore, we will aim for needing their assistance on the unit for the least amount of time.

In the event of a R/S during off hours, the DOC writes the R/S order, writes a descriptive note in MHIS, and assesses the youth in what ever stage of restraint process they are in. It is important we communicate to the DOC the information regarding the youth’s status and collaborate in the decision making process what is best for the youth utilizing our knowledge of individual treatment plans, trauma informed care, strength based treatment, and the six core strategies.

Our philosophy of care has brought us to the conclusion that to progress towards the elimination of restraints and seclusion, we will start with the elimination of mechanical restraints. We have lowered our rate of use to the point that we have almost eliminated the use of mechanical restraint. We are therefore removing the mechanical restraints to an off-unit location, to symbolize our commitment. Also, whenever a person brings up the suggestion of the use of a mechanical restraint to manage a situation, the Medical Director or Program Director must be contacted for consultation of the situation. Many times a few extra hands or a different strategy seen with “fresh eyes” can avert the need for the mechanical restraint.
References


