Positive Approaches in Crisis Situations

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1.5 hours
Positive Approaches in Crisis Situations

Introduction: What will be accomplished in the Training

- **Current Directions in treating persons in acute inpatient psychiatric settings**
- Incorporating Positive Approaches in Crisis Situations
- Definition of a restrictive procedure
- Definition of restraint
- Meeting criteria for restraint
- Trauma Informed Care
- Differentiating challenging behavior from psychiatric symptoms in crisis situations
- Operating from a Least Restrictive Treatment Model
- Access resources and support in the community
- Debriefing following a crisis
- Working with First Responders and Emergency Room staff during a crisis
- Case Examples
## Changing Times

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Wellness Recovery Action Plan should include:

- **Promoting Hope** of the individual and encouraging them to work actively toward wellness
- **Providing Tools** - Decrease the need for costly, repetitive and invasive therapies
- **Removing Barriers** - Increase knowledge and understanding of the illness and decrease stigma
- Decrease exposure to traumatic life events caused by severe symptoms
- Promote higher levels of wellness, stability and quality of life

OMHSAS
OMHSAS Guiding Principles

- Facilitate recovery for adults and resiliency for children

- Plan of Care is responsive to individuals’ unique strengths and changing needs throughout their lives

- Focus is on prevention and early intervention

- Plan of care recognizes, respects and accommodates differences as they relate to culture/ethnicity/race, religion, gender identity and sexual orientation
OMHSAS Guiding Principles, continued

- The plan ensures individual human rights and eliminates discrimination and stigma

- Services are provided in a comprehensive array by unifying programs and funding that build on natural and community supports unique to each individual and family

- Services and supports are developed, monitored and evaluated in partnership with consumers, families and advocates

- Represent collaboration across agencies, levels of care and service systems.
Things You Can Do to Assist People in Their Recovery

Get to know the person. Look beyond the diagnoses, symptoms, and behaviors.

Do not make assumptions or value judgments about the person or behavior.

Encourage the person and family (on their ability to participate) to be involved in the development of the plan of care.

Have an understanding of basic human rights. No different than our experiences: choice/options, relationships, gender, interests/passions, sexuality, religion, culture and values.
Assisting people in their recovery, continued

- Dignity and respect in all aspects of care
- Offer the person a pain and restriction free environment
- Instead of control and contingencies, offer choice and support
- Understand that all behavior serves a function for the person: psychiatric, medical, attention, sensory, control, lifestyle, self esteem
- Do not take the challenging behaviors of the person as a personal attack on you
- Walk a mile in the person’s/family’s shoes. Put yourself or a family member in their situation
Changing the Seclusion/Restraint Mindset

Old way of thinking:
- person acts out = Put the person in seclusion/restraint
- Seen as Positive and Therapeutic – Teaches the person a lesson
- The staff controls the behavior and the person
- Pain and punishment are an acceptable byproduct of treatment

New way of thinking:
- person acts out = The person is communicating a need
- what is the reason for the behavior
- Viewed as Non-therapeutic, can cause trauma for person and staff, adds to the emotional distress of the person
- Staff gives up control
- Encouragement and support are byproducts of the treatment
Positive Approaches Individual Values

Side Effects of the Restraint Experience (McGonigle)

- Freedom    →  Restricts it
- Choice / options →  Eliminates it
- Relationships    →  Destroys it
- Privacy      →  Loss of dignity / respect
- Control      →  Give it up
- Individuality →  Damaged self esteem
- Recognition  →  As a problem
- Prosperity   →  Limits opportunities
- Permanency   →  Multiple placements
- Passion..to dream →  Traumatic / nightmare
Before the Existence of Positive Approaches

**Past Practices**

- Consequence → Reduce behavior → Elimination = Control
- Punishment

**Current Practices**

- Reinforcement → Increase behavior → Increase = Choice/option

Old Way Enforcer → New Way Counselor
Positive Approaches

**Old way: Punishment/Reduction**
- about control
- teach the person a lesson
- coercive
- doing to
- teaches what not to do
- we wouldn’t want done to us
- may further emotional distress

**New way: Therapeutic/increase alternatives**
- about change
- supportive/educational
- influencing
- doing with
- teaches alternatives
- we wouldn’t mind if done to us
- may heal emotional wounds
Goals of the public mental health system

- To treat people with empathy, dignity and respect
- To provide best quality of care possible
- To protect people’s rights
- To assist people in their recovery

* Any use of restraint must be rigorously scrutinized
Creating Supportive Environments

Change in Culture / Staff training

- Knowledge of the person
- Functional Behavior Assessment (FBA)
- Understanding of what the problem behavior means to the person
- Identify the alternative or replacement behavior
- Individualized and person specific plan
- Assess for antecedent and triggering events
- Risk of intervention vs. Risk of injury
- Plan for generalization of the treatments / Interventions
- Crisis Plan and diversion from hospital
Timeline of events that lead to the reduction of the use of restrictive interventions and prn medication

**1970’s**

- Restrictive techniques acceptable
- Physical restraint as a contingency (prolonged physical holds)
- Mechanical restraint
- Chemical restraint: A medication used to control behavior or to restrict the person's freedom of movement and is not a standard treatment for the person's medical or psychological condition.
- Seclusionary time out
- Aversive stimuli
1980’s REVISED POLICIES

*(more sensitive to individual issues)*

- Added functional assessment
- Use of restraint only as a part of an individualized treatment plan
- Less restrictive means to intervene on problem behavior
- Drug-free holidays and side effect profiles
- Significant increase in positive interventions
1990’s

- Positive approaches movement
- Human right issues (choice / options – self-determination person centered)
- Functional behavior Assessments (attempt to find etiology for the problem)
- Intervene using a least restrictive treatment model
- Change in culture and push for staff training
- Media raised awareness (60 minutes–Hartford Courant series reported 142 people died shortly after being restrained or secluded in facilities serving mentally ill individuals. Deaths were reported in all 50 states 1998)
- Person’s rights violations
Current Directions

Prevention

- Develop a collaborative relationship with the person and family
- Develop and utilize comprehensive evaluations and ongoing assessments
- Assessing the person’s unique strengths, needs, and talents within the individual’s treatment plan
- Recognize verbal and non-verbal signs of distress or change in the person
- Use a wide range of verbal de-escalation, problem solving, and conflict resolution techniques
- Enlist the cooperation of the person in developing the crisis plan
- Operate from a least restrictive model (OMHSAS)
Current Directions

- Restraints are justified only if they are being used for the clearly defined purpose of maintaining safety and if all other less intrusive interventions have failed.

- Regardless of the context, it is critical that restraint be used only as a last resort measure to maintain safety.

- Restraint should only be used in situations of imminent risk to self or others.

- Restraint should never be included as a part of a behavior modification / behavior support plan, or as part of the day-to-day management of the program.

- Restraint should in no way be used as a threat (either implicit or explicit) as coercion (bribery) or used as punishment.

- Should not be used in lieu of active treatment.

OMHSAS Bulletin 4/8/02
American Psychiatric Nurses Association (APNA)

- Collaborative work with persons and families upon admission
- Discuss the organization’s philosophy on the use of seclusion, restraint, prn medications, and restrictive programs
- **Ascertain the existence of any applicable advanced directive**
- Assess the person’s risk factor for a behavioral emergency and gather data on effective strategies that have been used by family and caregivers to reduce and prevent behavioral emergencies
- Formulate individualized behavior plan that emphasizes the person’s strengths and minimizes the potential for behavioral emergencies
- Discuss with the family and person, methods that are used in the treatment setting to promote safety/risk management
- Discuss the role of the family and the person’s wish for family/significant other’s notification of a seclusion or restraint episode
The Merging Science of Trauma Informed Care

NASMHPD, 2004 Best Practice Symposium- Atlanta Georgia

Key Principles

Trauma Informed Care Systems

• Integrates philosophies of care that guide all clinical interventions

• Treatments / Interventions / Supports are based on current literature and are evidenced based

• Recognize that coercive interventions cause trauma and are to be avoided

• Persons with serious mental illness are markedly at increased risk for trauma exposure
Trauma Informed Care – Key Features

- Valuing the person in all aspects of care
- Neutral, objective and supportive language focusing questions on what happened to you in place of what’s wrong with you
- Individual, flexible treatment plans and approaches
- Awareness/training on re-traumatizing practices
- Agencies that are open to outside experts: Advocacy and clinical consultants
- Training and supervision in assessment and treatment of people with trauma histories
DIFFERENTIATING BEHAVIOR PROBLEMS FROM PSYCHIATRIC SYNDROMES
Approaches to Challenging Behaviors

1. Identify the problem
2. Differential diagnosis
   - Quality of life or lifestyle issues (cultural)
   - Medical / Neurological / Trauma
   - Addictions
   - Mental Illness
3. Rule out non-psychiatric causes
   (specific vs. non-specific)
4. When challenging behaviors serve multiple functions, address those derived from biological / medical fist
5. Obtain a working diagnosis
6. Tailor treatment to the diagnosis
History

Family: Genetics – siblings

Medical: Prenatal / Birth / Postnatal

Development: language, hearing, fine/gross motor

Behavior play skills / peer interactions / rituals / attention

Mental Health: anxiety / depression / trauma / mood

Education: cognitive / processing / psychological
Specific Information

- Interviews and Direct Observation
- Functional Behavior Assessments
- Antecedent – Behavior – Consequence
- Onset – Regression
- Acute – Chronic
- Diagnosis & co-occurring mental health issues
Treating the Underlying Syndrome: The Process

- Assessment → Symptoms → Differential Diagnosis → Working Diagnosis → Treatment → Psychopharmacology → Partial response → Response
- Is this an adequate Medication trial
- What else could be tried
CAUTION WHEN USING RESTRAINTS IN THE CRISIS SITUATION
TYPES OF RESTRAINT

- **Prone Restraint** means that the child is laid in the facedown position.
- **Supine Restraint** means that the child is laid in the face-up position.
- **Physical restraints** involve a person applying various holds using their arms, legs or body weight to immobilize an individual or bring an individual to the floor.
- **Mechanical restraints** include straps, cuffs, body/blanket wraps, helmets and other devices to prevent movement and or sense perception, often by pinning an individual’s limbs to a splint, wall, bed, chair or floor.
- **Chemical restraints** rely on medication to dull an individual’s ability to move and/or think.
Meeting Criteria for Restraint and Seclusion/Restraint

- Does the intervention restrict the person’s ability to move freely and independently?

- Does the intervention restrict or take away the person’s ability to exercise choice/options?

- Is the intervention delivered against the person’s free will? (Is it something the person does not want to do or have done to them?)
Policies Regarding Use of Restraint

- Residential staff embrace the positive approaches philosophy, limiting the use of seclusion and restraint
- Restraints are used for emergency purposes only and used when a person demonstrates imminent risk or danger to self or others
- Dignity and respect, and choice and option is always maintained
- Restraints is not used as a punishment, bribery, or to coerce the person
- Restraints are not used in lieu of inadequate staffing
- Restraint is not used in a way to cause undue physical harm, pain, or discomfort to the person to teach them a lesson.
- Restraint is used for the shortest period of time necessary to provide safety for the person
Policy Position: Restraints have no therapeutic value, contribute to human suffering, and have frequently resulted in severe emotional and physical harm, and death

National Alliance for the Mentally Ill (NAMI)
- Restraints have no therapeutic value and should only be used for emergency safety by order of a physician with competency in psychiatry (2004)

National Association of State Mental Health Program Directors (NASMHPD)
- Believe that restraints (including chemical restraints) are safety intervention of last resort and are not treatment interventions (2004)
- Priority should be placed on “preventing, reducing, and ultimately eliminating the use of restraint...
- When restraints are necessary, they are administered in as safe and humane a manner as possible by appropriately trained personnel.”
Definitions of Restraint

**Restraint:**

- Is any manual method, physical or mechanical device, material or equivalent that immobilizes or reduces the ability of a patient to move his/her arms, legs, body, or head freely;
- Takes away choice/option of the person and is delivered against their free will; the person does not want to engage in the activity

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
Behavioral Health Cautions when implementing restraints

All individuals must be evaluated for medical and behavioral health risk factors that may indicate the need to refrain from using restraints or to use alternative forms of restraint. These conditions include, but are not limited to:

- Cardiovascular Disorders
- Respiratory Disorders (asthma)
- Neurologic (seizures)
- Pregnancy
- Obesity
- Excited Delirium
- Orthopedic Injuries or Disorders
- Head and spinal cord injury
- Pregnancy
- Genetic Syndromes (Lesch-Nyhan, Corenelia de’Lange Syndrome)
- Mental Health Advance Directives
- Trauma – Abuse: physical/emotional, sexual, rape
Debriefing

- Review the Crisis
- Debriefing the individual following a crisis event
- Debriefing the staff/family following a crisis event
- Making changes to the crisis plan
REFERENCES


Autism Services, Education, Resources, and Training (ASERT)

- ASERT is a statewide initiative funded by the Bureau of Autism Services, Pennsylvania Department of Public Welfare.