

Creating Violence Free and Coercion Free
Mental Health Treatment Environments for the
Reduction of Seclusion and Restraint

Debriefing Activities
A Core Strategies ©
A Tertiary Prevention Tool

Module created by Goetz, Huckshorn, 2003



We're going to begin the section on 'Debriefing' now. Do all of you use in your hospitals or residential programs some sort of a debriefing process after an incident of restraint or seclusion? Well, then, let this national standard help serve to debrief your current debriefing process. Across the country, almost everybody has a check list that they sign off on after each incident, right? I have observed staff after a restraint or seclusion in at least 20 or 30 hospitals. Most of the staff filled out the checklist, with a "check, check, check, check, check". It used to be that everything was always fine; we did everything we possibly could have to avoid the restraint and everything was done right afterwards and it was all appropriate. At least that's how it used to be every time I reviewed one of those checklists, and I've reviewed hundreds and hundreds of them. They all were checked the same way.

We are going to be asking you to be prepared to either throw out your current debriefing process or to really look at it and evaluate it and see how you can improve it.

Any work used from this document should
be referenced as follows:

“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)”

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Definition of Debriefing

- A stepwise tool designed to rigorously analyze a critical event, to examine what occurred and to facilitate an improved outcome next time (manage events better or avoid event).

(Scholtes et al., 1998)

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So the formal definition for debriefing is on the screen. Really, the two critical words or parts of the definition are 'that debriefing is 'step wise'', meaning that there are going to be different steps you take in debriefing; AND that debriefing is 'rigorous', like the word 'meticulous' that was used yesterday. We really want to make debriefing a very rigorous activity.

It must be noted that this debriefing process is not the same as the Critical Incident Stress Debriefing Process that comes out of disaster planning initiatives. The debriefing process we will be discussing is specifically related to mental health treatment settings and incidents related to coercive interventions.

Debriefing Questions

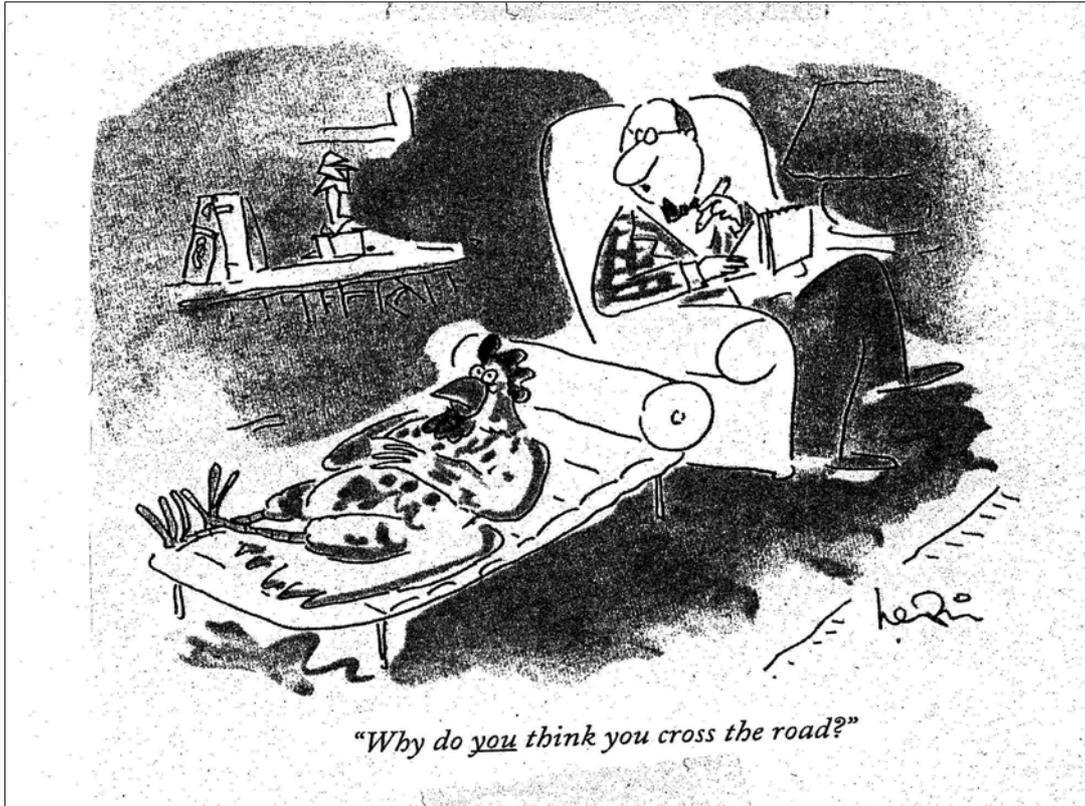
- Debriefing will answer these questions:
 - Who was involved?
 - What happened?
 - Where did it happen?
 - *Why did it happen?*
 - *What did we learn?*

(Cook et al., 2002; Hardenstine, 2001)

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Other parts of the definition include finding answers to a number of questions. The last two on this slide are the most important questions. If we let every debriefing serve to answer these questions, “Why did it happen?”, and “What did we learn?”, then debriefing really becomes an opportunity to make sure restraint or seclusion never happen again with that person and with that staff.

And the third part of the definition and probably the most important is that it really provides an opportunity to learn from and honor the people who went through the process and involve them in the solutions.



"Why do you think you cross the road?"

Debriefing Goals

- To reverse or minimize the negative effects of the use of seclusion and restraint.
 - Evaluate the physical and emotional impact on all involved individuals
 - Identify need for (and provide) counseling or support for the individuals (and staff) involved for any trauma that may have resulted (or emerged) from the incident.

(Massachusetts DMH, 2001; Huckshorn, 2001; Cook et al., 2002; Hardenstine, 2001; Goetz, 2000.)

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So, the goals of our newly thought out and our newly developed, trained and supervised debriefing process are:

The first goal is: we must recognize that there is an emotional impact after a restraint or seclusion and our goal is to support the people we serve and the staff involved in the event to heal; and to support all of the witnesses. Remember from the earlier presentation, in a study of staff in Massachusetts, one out of four staff had symptoms of PTSD.

Debriefing Goals

- To prevent the future use of seclusion and restraint.
 - Assist the individual and staff in identifying what led to the incident and what could have been done differently.
 - Determine if all alternatives to seclusion and restraint were considered.

(Ibid)

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Our second goal is to prevent the future use of seclusion and restraint;

Debriefing Goals

- To address organizational problems and make appropriate changes.
 - Determine what organizational barriers may exist to avoiding seclusion and restraint in the future.
 - Recommend changes to the organization's philosophy, policies and procedures, environments of care, treatment approaches, staff education and training.

(Ibid)

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And the third goal is to address organizational problems.

So, your new debriefing framework has three goals: begin the healing process; prevent it from ever happening again (This goal goes back to yesterday's presentation on developing both neuroregulatory and environmental interventions - so we're going to do meticulous interviewing with the people we serve and with our staff. We're going to find out what was in their environment; what didn't work and then we're going to make sure that we address organizational issues that were outlined in Leadership.) And that is the third goal again, address organizational problems.

Know the Process you wish to change

- The events leading to the use of seclusion or restraint can be broken down into steps
- A review of each discrete step leads to a more thorough analysis
- Questions emerge throughout the stepwise process that clarify what occurred
- Makes the point that there are multiple opportunities for effective interventions

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You need to know the process you want to change.



***“We just haven’t been flapping
them hard enough.”***

Understanding The S/R Process (See Debriefing P & P Guide)

Step 1: Had a treatment environment been created where conflict was minimized (or not)?

Step 2: Could the trigger for conflict (disease, personal, environmental) have been prevented (or not)?

Step 3: Did staff notice and respond to events (or not)?

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You have an example of a debriefing policy in your materials – these are some of the questions we will address by the debriefing process.

The S/R Process

Step 4: Did staff choose an effective intervention (or not)?

Step 5: If the intervention was unsuccessful was another chosen (or not)?

Step 6: Did staff order S/R only in response to imminent danger (or not)?

Step 7: Was S/R applied safely (or not)?

The S/R Process

Step 8: Was the individual monitored safely (or not)?

Step 9: Was individual released ASAP (or not)?

Step 10: Did post-event activities occur (or not)?

Step 11: Did learning occur and was it integrated into the treatment plan and practice (or not)?

Types of Debriefing

- Immediate “post acute event” debriefing
 - Include consumer interview
- Formal debriefing the next working day
 - Include consumer’s debriefing, if possible

(Ibid)

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So there are two types of debriefing:

There is an immediate debriefing that happens right after the incident, right after the restraint or seclusion is over.

Then, there is the second type that happens the next working day.

Post Acute Event Debriefing

- Emotions are often high and range from:
 - Anxiety
 - Anger
 - Fear
 - Irrational thinking
 - Shame
 - Numbness
 - Denial
 - Stoicism

(Ibid)

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With the immediate or Post Event debriefing, the one that happens right after the restraint or seclusion, we really should focus on surviving a traumatic event. In some Massachusetts programs now, after a restraint or seclusion, a staff member says to the person served, “I’m sorry. I’m sorry that it got to this point, that we were not able to prevent a restraint. Our job is to help you to learn skills and to give you tools so that you can remain in control. I’m really sorry that this happened.”

This is a totally different way of reacting and interacting with a person after a restraint or seclusion.

“We want to make this unit a restraint free environment; we want to work with you to support you in choosing tools that help you remain in control. I’m sorry that you had to go through this process.” This allows us to begin to heal; and to begin to help, calm and nurture the people we serve.

In Chinese, there is word that is the same for crisis as it is for opportunity. It is the same word because crisis is also considered an opportunity. We must use the restraint event as an opportunity, not only to begin to heal the persons we serve and staff, but also to begin to find out what the precursors were and then begin to really work with the person served and staff to identify solutions to make sure that it doesn’t happen again. So in Chinese again, an event is a crisis but it is also an opportunity.

Post Acute Event Debriefing

- Who should be present?
 - At a minimum:
 - Key individuals involved, including staff who authorized the restraint
 - Supervisor (on site)
 - An individual from outside the treatment team can often help with objective facts and feelings (if available)

(Huckshorn, 2001; Goetz, 2000)

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So, when you have this post event debriefing, who should be there? Obviously the people involved in the restraint/seclusion, including the on-site nursing supervisor. Notice the bottom bullet identifies an individual from outside the treatment team. Why do you want somebody from outside the treatment team? Our units often have staff who have worked together for years, who socialize together, who care about each other. You become friends with other staff when you work on a unit. When we work together we care about each other so much that sometimes we are not able to be objective. So when that event happens we want somebody from outside the treatment team to come and begin to talk – someone who can be objective.

Post Acute Event Debriefing

- Focus on hierarchy of needs first:
 - Survival
 - Safety, security
 - Direct care staff health (often do not recognize injury)
- Return to pre-crisis milieu
- Communicate event with administration, unit staff, family

(Ibid)

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Immediately after an event emotions are often so “high” that blaming, denial, and other defenses may occur. Stay with facts.

We want to, of course, focus on Maslow’s hierarchy, the health needs; not only of the person served, but of the staff. Staff often do not recognize their own physical or emotional needs. I have been in numerous hospitals throughout the United States and often after an event people are just emotionally drained and physically tired. Yet, they often go right back to work. We want to find the best way to put that milieu back together; really try to get the milieu healed and back to some positive engagement between staff and the persons served. We want to return to the pre-crisis milieu; *(take out the cat hair - remember the cat hair from Neurobiology presentation)*, give massages, pass around some soothing tools to everybody; let everybody take a breath. Otherwise, what we’re finding is that as restraints and seclusions increase, so do behavioral problems. So you want to get that milieu back to normal if you can. It is actually, in the long run, easier to take those two or three staff off the unit for fifteen minutes than have another restraint for a half hour or more. Do whatever you can to really make sure that people catch a breath and can start anew and afresh.

Post Acute Event Debriefing

- Assure that documentation requirements are met
- Begin to evaluate the need for emotional support up to trauma treatment
 - Individual (victim)
 - Witnesses/observers
 - Staff involved (EAP)

(Ibid)

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We obviously want to communicate and document everything that needs to occur and we want to make sure that we give the staff time to really reframe. Staff and the people we serve must also hear that this (this restraint or seclusion) was not effective treatment. They should hear also that we all did the best with what we had and we're going to do better now. When you can do all of this, then goal No. 1 is accomplished. We've healed the milieu; we've gotten past it; we apologized; we listened; we took out the cat hair and we began the healing process. Now you're ready for the formal debriefing.

Formal Debriefing

- Consider place, size of meeting, ambience, privacy.
- Led by senior manager, not involved in event, trained in process.
- Set context:
 - Explain situation, purpose of meeting

(Ibid)

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The formal debriefing addresses the second two goals of the debriefing process: prevent the future use of seclusion and restraint and address organizational problems.

If we were to only have one word to describe what needs to be done to ensure that the debriefing process results in restraint or seclusion not happening again, the word would be 'preparation'. Prepare ahead of time for the debriefing process. Set it up ahead of time so that you can make sure that this process is really a formal process.

You want to make sure that the debriefing process is lead by a senior manager, so that that person can do a root cause analysis. The senior manager is going to have been trained on how to do debriefing. You do not want to just send somebody/anybody out there to conduct the debriefing session. They have to really know how to effectively do a root cause analysis. They have to know how to be sensitive to staff and be sensitive to the people served. They have to know that they are not there to make staff feel guilty. They have to make sure that they use a clear debriefing process and not be waylaid by special relationships with certain staff.

Formal Debriefing

- Include a broader group of people
 - Mandatory attendance by clinical lead, other treatment members, executive staff representative (champion), consumer advocates
 - Encourage adult, child, family involvement (independent session or formal meeting)

(Ibid)

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We want to also have an executive level staff attend because they will make sure that we address that third goal of addressing organizational issues; they can model, they can set the tone, they can keep the focus.

You might need to have a separate meeting with the consumer. You may not be able to have the consumer there at the formal debriefing with all of the staff. The person who is leading the meeting may have to have two meetings, one with the consumer and one with everybody else. This is when it is really helpful to have a consumer advocate, because sometimes consumers, the people we serve, will relax more if they're sitting there with somebody who is really their peer and can help them feel supported, and less anxious. Remember we showed you the slide yesterday about when people remember their trauma, that their amygdala starts firing. The more that we can set up a situation where consumers feel safe and supported, the more likely it will be that we will find out what we should have/could have done differently. Many hospitals report that having a consumer advocate in the meeting is extremely helpful.

Formal Debriefing

Note!

The presence of senior clinical (Masters or Ph.D.) staff in the formal debriefing can help identify need for clinical interventions. Staff and consumers will not self-identify this usually.

(Huckshorn, 2001; Goetz, 2000; Massachusetts DMH., 2001)

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You want to make sure that the restraint or seclusion does not happen again, so you always have the senior clinical person from the treatment team there. This will ensure that a senior person can take back the solutions identified and make sure that the solutions are shared with the treatment team and fully integrated into the treatment plan.

Formal Debriefing

- Set ground rules:
 - Voluntary, confidential, nobody forced to talk
 - Respectful communication (emotional safety)
 - Close meeting after beginning (stability, group process)
- Explain process:
 - Outline steps

(Cook et al., 2002; Goetz, 2000)

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You want to make sure that you set ground rules for the meeting and that people follow this process.

Debriefing Strategies

- Explicitly separate the following issues during process:
 - Facts
 - Feelings
 - Planning

(Ibid)

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The person who is leading the meeting must be very skilled. He/she will need to know how to separate facts from feelings. He/she will need to lead a discussion about the facts, without addressing feelings. Then he/she will need to allow talking about feelings without the facts. Finally, the lead must be efficient at knowing how to plan.

Debriefing Strategies

- Rationale:
 - Respects feelings without sacrificing facts
 - Promotes critical thinking in a non-punitive environment
 - Allows safe discussion of issues, mistakes, misunderstandings, self assessment
 - Encourages problem solving and changes in hospital operations
 - Identifies training needs

(Ibid)

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This slide shares reasons for separating facts and feelings. We want to allow safe discussion and we want to encourage great problem solving. We want to recognize that people are going to be at really different stages during the debriefing process. The leader may decide that he/she needs to go back and revisit some issues with some staff and/or some witnesses. Again, you may actually have a different meeting with the consumer and his/her advocate.

Debriefing Strategies

- Facts: What do we know that happened?
- Feelings: How do you feel about the events that happened?
- Planning: What can/should we do next?
 - Operational Issues
 - Training Issues

(Goetz, 2000)

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There are specific questions we want to answer through the debriefing process. We want to find out “What happened?” and how people feel about the event. Finally, we need to address what to do next.

Discussion Points

- Identification of triggers
- Antecedent behaviors
- Alternatives used and responses

(Crisis Prevention Institute, 1995)

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These next three slides are really cue cards or discussion points that you can use in your planning. The leader will want to ensure that each of these points are covered in the formal debriefing meeting.

Discussion Points

- De-escalation preferences and responses
- What behavior was being controlled for?
- Was anyone in imminent danger?
- Could consumer been allowed to “win”?

(Crisis Prevention Institute, 1995; Fishkind, 2002)

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The last point on this second slide is probably the most important issue you will need to address with staff. You have heard this a couple of times in this training. The leader wants to ask very sensitively, “How could we have allowed the person served to win in this situation?”

Discussion Points

- Medication history and response
- Event time chart
- Documentation (timely, sufficient)
- Notifications made and response

(Crisis Prevention Institute, 1995; Fishkind, A., 2002)

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And more discussion points! These slides really serve as a cheat sheet for you when you train your staff. The discussion points help frame the debriefing process and help the leader prepare.

Staff Debriefing Issues

Staff

- May be afraid of repercussions/punishment
- May feel ashamed or angry
- May have personal trauma history that affects ability to analyze event objectively
- Interventions need to avoid blame, threats or defensive reactions
- Set up group process rules first (*Hardenstine, 2001*)

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The two slides on staff questions and the upcoming slides on consumer questions also serve as cheat sheets/cue cards for the person leading the debriefing meeting. It is important to remember, as a hospital or residential administrative team, that you must ensure that staff feel comfortable answering these questions. If your organization has not fully implemented a culture that promotes staff support, then staff will not feel safe answering these questions. When we trained in Oklahoma, the Oklahoma administrative team decided to name their initiative 'Empowerment Squared', because they wanted to empower both staff and the people who they serve.

So we are not going to be able to have staff feel comfortable and be able to ask these questions and get honest and well thought out answers that will ensure that the restraint or seclusion does not happen again, if we do not attend to setting up supportive supervision systems ahead of time.

So again, these questions are cue cards for you. With the most important answer being staff telling us how they think it should be done differently next time.

Questions for Staff

- What were the first signs?
- What de-escalation techniques were used?
- What worked and what did not?
- What would you do differently next time?

(Ibid)

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Again, planning or setting the stage for success is imperative. The lead 'debriefers' should be prepared and ensure that if a consumer needs an advocate or a support person, that one is available.

Questions for Staff

- How would S/R be avoided in this situation in the future?
- What emotional impact does putting someone in restraints have on you?
- What was your emotional state at the time of the escalation?

(Ibid)

Consumer Debriefing Issues

- Use a staff person not directly involved in the S/R event.
- Customize approach (setting, attention span, memory, etc.)
- Do an immediate post event debriefing to “check-in” at a minimum.
- Formal Debriefing may need to be delayed up to 48 hours
- Avoid blame

(Ibid)

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More cheat sheets or cue cards for you – this time for supporting the persons served. You want to make sure that they know that there’s no blame; that we have meticulously kind questioning and that each consumer, each person we work with, every question we ask, becomes a part of that cognitive wedge for them and that we’re really helping them to understand themselves. We’re actually just going back to that risk assessment that Janice just talked about and said, “Why didn’t it work”? This is a learning opportunity. So this is a wonderful opportunity; we ask all these different questions and then we can begin to see what parts of the treatment plan may need to be changed and what operational issues may have been barriers.

Consumer Questions

- “How did we fail to understand what you needed?”
- “What upset you most?”
- “What did we do that was helpful?”
- “What did we do that got in the way?”
- “What can we do better next time?”

(Massachusetts DMH, 2001)

Consumer Questions

- “Is there anything that you would do differently?”
- “Would you do something differently next time?”
- “What could we have done to make the restraint/hold (or seclusion) less hurtful?”

(Ibid)

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Again, these are cues for you to utilize in your own newly developed debriefing protocols. You need to make sure that treatment plan issues are identified. If necessary changes do not go back into the treatment plan, then the debriefing process will have been a waste of time, and we will have compromised the trust of the consumers and staff.

Treatment Plan Revisions

- How do comments, such as the ones below, get translated into treatment revisions?
 - “If only they let me make a phone call”
 - “I wanted to listen to music and they were telling me to go to my room ...”
 - “Staff were yelling and I got angry/scared...”

(Ibid)

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And, finally - we get to the operational issues. If you as an organization (and this message is for the administrators in the room, the nurse managers, the psychiatrists, all of you) only ‘talk the talk’ and do not ‘walk the walk’, then again we compromise the trust of those we serve and our staff. We need to assess for needed improvements in all of the areas on these slides and we then need to very carefully spell out what these improvements should be and then develop specific plans to make sure that all recommended improvements are fully operationalized. We do not want a new policy that is not fully implemented. After we have listened, we have to identify the solutions. Obviously issues of training will need to be addressed. We already discussed the importance of supervision and we may find that we are not supervising actively.

Treatment Plan Revisions

- Revisit safety plans with service recipient and families
- Include changes in approach on Kardex and in treatment plan
- Provide copies to service recipients

(Ibid)

Operational Revisions Include Modification to (Examples):

- Supervision Policy
 - e.g., “onsite supervisor takes the lead”
- Staff Training Activities
 - E.g., “S/R reduction project addressed in new employer orientation”

(Huckshorn, 2001)

Operational Revisions

- Policies/procedures
 - e.g., “direct care staff can allow child to leave group and go swing outside during community meeting if, in their opinion, this will avoid an event.”
- Unit milieu/environment
 - e.g., “creating comfort rooms”

(Huckshorn, 2001)

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Policies and procedures must be consistent with practice – we may need to change them. How could we improve the milieu to support a calmer and more supportive physical environment? Do we need comfort rooms or sensory items? Do we need more activities?

Operational Revisions

- Staffing Patterns
 - e.g., “per diem staff will have assigned units”
- Staff Competencies/Skills
 - e.g., “de-escalation training/documentation added”

(Huckshorn, 2001)

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Do we need changes in staff or staffing? Do we allow staff to continue working without reaching competency in critical skills?

Operational Revisions

- Communication procedures
 - e.g., “on call executive will be notified for all events”
- Physician/treatment team/treatment planning
 - e.g., “positive trauma assessment *responses* will be included in the treatment plan problem list”

(Huckshorn, 2001)

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And address communication and treatment issues.

Event Observers

- Don't forget the "Event Observers"
- Observing a seclusion or restraint event (violence) is just as traumatic to observers as to direct participants
- Need to be Debriefed also
- Consumer/advocates and assigned staff can help here

(Huckshorn, 2001; Bluebird & Huckshorn, 2000)

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And don't forget to assess for supports that are needed for the people who observed; those witnesses. Those are the ones that sometimes are traumatized, they were not directly involved in the restraint, but they were impacted - both the consumers who observed and staff who observed.

Summary: Debriefing

- Do an immediate post event analysis, as well as a formal Debriefing the next working day
 - Keep facts and feelings separate
 - Respect emotions
 - Address physical and emotional needs
- Consumers and staff have different needs and require different approaches

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So once we do all this, once we've put all of these ideas in place, then we will have a successful debriefing process. In summary, we are going to conduct a 'healing' post-event analysis and a formal debriefing the next day. We are going to make sure that we take into consideration the differences and the different needs after an event for the people we serve and the staff.

Summary

- Must include executive management involvement (not delegated)
- Information gathered must be used to identify, evaluate, and modify:
 - Facility policies and procedures
 - Unit environments and rules
 - Staff interactions
 - Individual treatment plans
 - Training needs, and more

(Goetz, 2000)

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We're going to insure that executive management is involved; that we address different issues related to policies, the milieu, treatment plans and training.

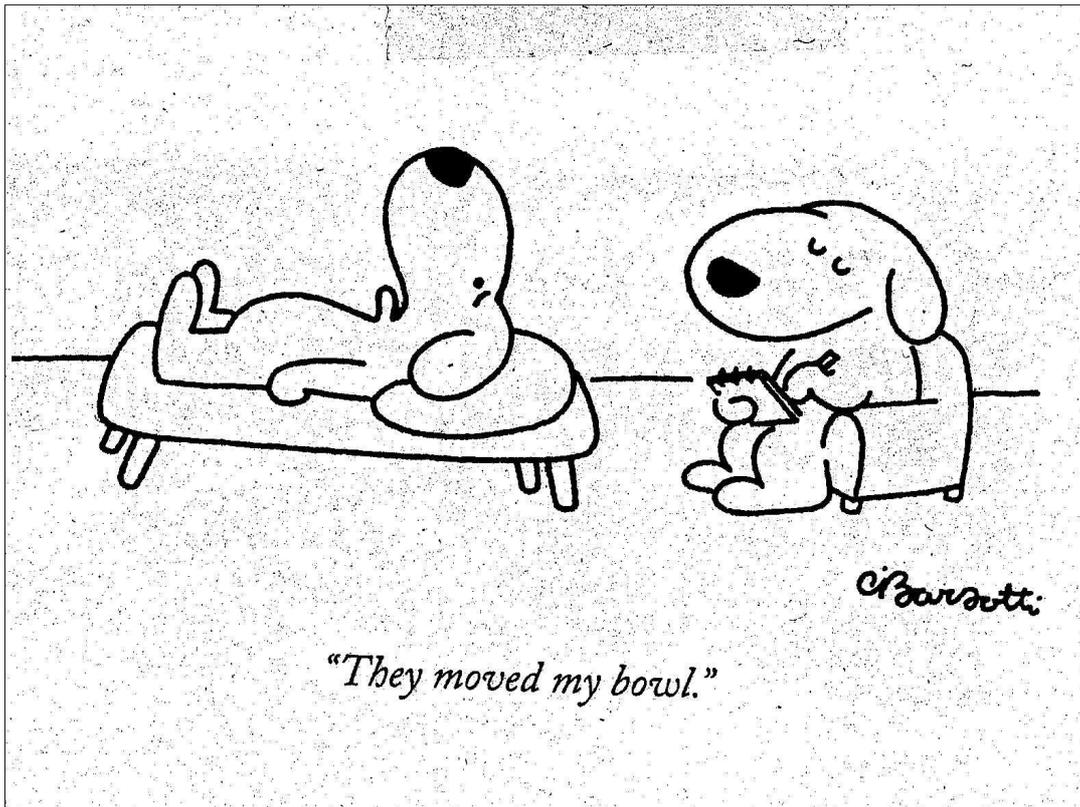
Summary

- Assure feedback loops are closed to executive management, risk management, QM, advocates, middle management, general staff
- Use consumer/family advocates to assist in Debriefing procedures and follow-up with all involved parties

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We are going to ensure that feedback loops are closed and consumer advocates are trained and used.

We are going to truly heal the milieu for everybody involved and learn all that we can so that this event will not happen again with this consumer and these staff. If you are stuck, if you are still doing mechanical restraints, a lot of physical holds or seclusion, I ask you to review your debriefing process and to really formalize it. It's a fabulous learning tool.



"They moved my bowl."