Implementing alternatives to coercion in mental health care: A growing list of tools and resources

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Pennsylvania Family Group Decision Making Toolkit: A Resource to Guide and Support Best Practice Implementation

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Link to resource

http://www.pacwrc.pitt.edu/Organizational%20Effectiveness/FGDM%20Evaluation%20PDFs/FGDM%20Toolkit.pdf

Synopsis

This toolkit can be drawn on by any person (mental health practitioner or non-mental health practitioner) that wants a resource for adopting a strengths-based, family and community oriented intervention, where family members of the patient are at the forefront of decision-making, and problem-solution negotiations.

Audience	Year	Type of resource
Wide-range For example, referring worker Family and friends Social workers Psychologists psychiatrists	2008	Toolkit

Description

This 402-page **toolkit** created by the Pennsylvania Family Group Decision Making Leadership Team is a comprehensive guide to **Family Group Decision Making (FGDM)** in a number of settings, including in the mental healthcare of **children**. FGDM is a gathering that takes place, where usually a referring mental healthcare professional or social worker will recommend FGDM as an alternative intervention method that involves the child's family (and social network) in decision-making surrounding treatment. It could also be instigated by the child's family or network.

FGDM takes a **strengths-based approach**, where strengths are discovered through listening noticing and paying attention to people. Moreover, family members are viewed as being the primary decision-makers for their family, where all families have the greatest investment in seeing their children safe and successful.

The purpose of FGDM within the mental health sector is:

- To establish a process for families to join with relatives and friends to develop a plan for treatment that ensures children are cared for and protected from future harm in ways which fit their culture and situation.
- To extend the responsibility for child safety, well-being and permanence to families, communities and natural support systems.
- To meet the mental health needs of children, youth and family members

The FGDM meeting itself is divided into three main phases, each of which encompasses equal value for the process. The guiding principal should be that the meeting is a **family-driven and professionally-infused process**. Families must have a say in what their family meeting looks like and what they need in order to make decisions about their family members.

Tools & Activities

The toolkit holds resources for implementation and evaluation in sections III and V.
Below is an example of a survey tool that could be used for an evaluation of family members' perceptions of the intervention, and whether the plan created addresses the needs and concerns of the family.

Family and Friend Survey

County: _____ **Date:** _____

Form ID: (County Code, year, and conference #): _____

1. What is your relationship to the child(ren) at the family conference? (Please check one)

Child/youth for whom conference was held

☐ Sister ☐ Brother ☐ Mother ☐ Father

☐ Parent's significant other ☐ Friend ☐ Step-parent ☐ Faith-based Foster parent

☐ Maternal Grandparent ☐ Maternal Aunt/Uncle ☐ Cousin ☐

☐ Paternal Grandparent ☐ Paternal Aunt/Uncle ☐ Other Maternal Relative: _____

☐ ☐ ☐ Other Paternal Relative: _____

2. What do you think about the family conference? Please check the best response for each question:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
I understood its purpose.					
I felt prepared.					
I agreed to attend of my own free will.					
Everyone who needed to be there was.					
I like where it was held.					
I like when it was held.					
I felt comfortable saying what I think.					
Everyone was given enough time to talk.					
I felt like part of the team.					
It built on our family's strengths.					
I felt free to disagree.					
The plan considered our family's culture or religion.					
It helped family and worker get along.					
Our family made decisions.					
We agreed on a plan.					
Our plan addresses my concerns.					
Our plan protects the children's safety.					
Our plan protects the community's safety.					
I know what to do if the child/youth is at risk again.					
Our plan helps family members develop needed skills.					
I understand what will happen next with our plan.					
I know what to do if people don't follow through.					
I would recommend family conferences to others.					

Additional Comments:

Restraint Reduction Network (RRN) Restrictive Practices Review Tool

Link to Resource

https://restraintreductionnetwork.org/wp-content/uploads/2016/11/Reducing-Restrictive-Practices-Checklist.pdf

Synopsis

This self-assessment tool is namely for any institution or group part of the Restraint Reduction Network, who has made a public commitment to working with service users, families, leaders, managers and frontline staff to ensure coercive and restrictive practice is minimised and the misuse and abuse of restraint is prevented.

Audience	Year	Type of resource
Narrow-range, with potential for wider application For example, a psychiatric institution's administration & management	2016	Self-assessment tool

Description

This 7-page **self-assessment tool (**16-page document in total) is a checklist to reducing restrictive practices, for administration and management level staff part of the **Restraint Reduction Network (RRN),** to utilise to inform their organisation's learnings, and apply to any improvement/development plans. It has also been developed for member organisations to share their performance so that service users and families, frontline staff, commissioners and regulators can easily see what is happening: what is ***going well*** and what aspects are ***being improved***. Some organisations may also wish to use the findings of the self-assessment tool to benchmark their service with other members of the Restraint Reduction Network (RRN).

The self-assessment tool is divided into **six assessment criteria sections**. These thematic areas are:

(1) Leadership and Governance

The organisation develops a mission, vision and set of guiding values which promote non-coercion and the avoidance of restrictive practices.

(2) Performance Management

The organisation uses a 'systems thinking' approach and identifies the key performance measures.

(3) Learning and Development

The organisation ensures its workforce has the necessary knowledge and skills to improve workplace performance.

(4) Personalised Support

Staff focus on providing personalised support that 'works' for individuals using services.

(5) Customer Involvement

The organisation fully involves the people who use services and establishes a clear understanding of their needs.

(6) Continuous Improvement

The organisation adopts a culture of reflection and learning in order to improve how it operates.

Tools & Activities

The self-assessment tool spans from pages 5-11. Checklists are divided into the 6 self-assessment areas. Below is the checklist provided for area/strategy 3, relating to learning and development.

Strategy 3: LEARNING AND DEVELOPMENT > The organisation ensures its workforce has the necessary knowledge and skills to improve workplace performance.				
Criteria	**Score**			
	Yes	**Partly**	**No**	**N/A**
The organisation has a workforce development plan which sets out the training required to develop and maintain the knowledge and skills staff need to support service users effectively.				
As part of the workforce development plan, staff receive an appropriate level of training in person-centred values, recovery and restraint reduction.				
As part of the workforce development plan, staff receive an appropriate level of training in Positive Behaviour Support.				
As part of the workforce development plan, staff receive training in a range of preventative measures which focus on conflict avoidance and resolution including: • Understanding the nature and cause of conflict, aggression and violence. • Effective interpersonal skills. • Effective listening skills. • Verbal de-escalation. • Trauma-informed care. • Delivering person-centred support. • Collaborative problem solving. • Risk assessment and positive risk taking. • Debriefing.				
As part of the workforce development plan, staff receive training in crisis prevention and management, including the use of physical interventions where required.				
Staff training is accredited and/or linked to national or sector-specific guidance.				
Staff training provides evidence of competence which enables the organisation to deliver outcomes which meet national, regulatory or sector-specific guidance.				
Staff receive effective ongoing supervision, support and workplace coaching to ensure learning is transferred into practice.				
The organisation implements an ongoing training cycle which ensures that staff maintain their competencies and continue to develop their knowledge and skills.				
Staff receive workplace support which enables them to apply their learning to the specific needs of individuals they support.				
TOTAL SCORE Add all scores above for Raw Score. Divide by 10 for Mean.	Raw		Mean (Raw/10)	

AREAS FOR IMPROVEMENT

Strategy 3: LEARNING AND DEVELOPMENT > In order of priority, list the potential areas for improvement.
1.
2.
3.

Crisis Prevention – 5 Tips for Reducing Violence in Your Hospital

Link to resource

https://www.crisisprevention.com/CPI/media/Media/download/PDF_RVH.pdf

Synopsis

A 5 tip guide for reducing violence in a hospital setting.

Audience	Year	Type of resource
Clinical staff & those working in a psychiatric setting For example, Psychiatric nurses Psychiatrists Security staff Social workers	2021	Tip sheet

Description

This **tip-sheet** by **Crisis Prevention Institute** provides 5 tips to consider for managing and de-escalating crisis moments with patients. It is built on the idea that: "Violence is not an acceptable part of your job".

> *It's not enough to say, "We have a zero-tolerance policy for violence." The truth is that everyone does—but how do we actualize that? How do we work together throughout the hospital to ensure that nonviolent outcomes are a reality? Balancing outstanding patient care, meeting regulatory requirements, and providing for patient and staff safety is a tricky balancing act.*

Tools & Activities

1 Redirect or Refocus Challenging Questions.

"Who's going to make me?" "Why do I have to do that?" While some questions are genuinely information-seeking in nature, others are meant to challenge your authority in a variety of ways. Resist the urge to say, "Because I said so." A more useful approach is to restate your request or your directive. Ignore the challenge, but not the person.

2 Use Teamwork.

Sometimes a fresh face brings a fresh approach to a situation. If you find yourself caught up in a power struggle, a great way out is to say, "You know what, I don't think I'm being very helpful to you right now. Can I see if my colleague can help you?" Even if a second person gives the same response to the person's issue or concern that you did, it can often somehow become acceptable.

3 Isolate Venting Individuals if Possible.

Allowing an individual to vent is a great way to de-escalate the situation. But, in many settings, there are others around who could be bothered by it. Validate the importance of the issue for the venting individual, but try to discuss the issue somewhere where there's more privacy and fewer distractions. This will allow you to really focus on what the person is telling you, and it will help you find a solution.

4 Take All Threats Seriously and Assess for Their Validity.

Threats come in a variety of nonverbal and verbal ways. The scary thing about it is that there is no way to predict who or when someone might follow through on a threat they've made. Make sure your organization has clear protocols for staff to follow in the event that a threat is made.

5 Take Care of Yourself.

The job of a health care worker, regardless of the setting, is stressful and at times, dangerous. We must come to work mentally and physically prepared for our day. Find positive outlets for the negative energy that you have to absorb during your day so that you can stay in control of your own behaviors during a crisis moment.

Skills for care - A positive and proactive workforce. A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health

Link to resource

https://www.skillsforcare.org.uk/Documents/Topics/Restrictive-practices/A-positive-and-proactive-workforce.pdf

Synopsis

This guide is concerned with developing workers so that they can work in a positive and pro-active way to minimise the use of all forms of restrictive practices.

Audience	Year	Type of resource
Commissioners and employers responsible for developing adult social care and health workforce, Psychiatric administration and management team	2014	Guide

Description

This **76-page guide** produced by **Skills for care**, **Skills for Health** and the **UK Department of Health** includes: how to identify when a practice is a restrictive practice (2.6), key questions important when considering restrictive practices, case studies (for example: page 17), workforce development (3.0). It promotes person-centred thinking (page 22), and a human-rights based model of positive and proactive support (page 12).

Tools & Activities

This guide contains summary pages with links out to further relevant toolkits and resources (for example: pages 40-41). Below is a brief case example that applies alternatives to coercion.

Edie's story

Throughout this guide we consider briefly how a team in a residential care home learned to positively support a woman whose distress and behaviour presented the team with challenges in how they could best offer care to her.

On the Skills for Care and Skills for Health website Edie's story is available as a supporting resource for the guide as a full 'case study' along with other case studies and vignettes from other people. These are in written and video format. For more information see www.skillsforcare.org.uk/cbcasestudies

All of the case studies and vignettes are anonymous and full permission for their use has been granted.

We would encourage people to submit further examples in order to share good practice.

Edie is 82, she is widowed, has dementia, and lives in a residential care home. She was placed there reluctantly by her family as she had been assessed as not having the capacity to make the decision to move by herself.

During her first year there she became increasingly distressed and anxious. This seemed to happen most in her bedroom when she needed personal care such as help with washing and dressing. She was incontinent of both urine and faeces and workers believed that it was in her best interests to wash her and change her clothing.

She would resist any help by screaming, biting and pushing workers, and so workers became scared of going into her room to support her.

Edie's story continued:

Edie became more isolated, staying in her room and with workers tending to avoid her.

With the help of the local challenging behaviour service a holistic assessment was carried out including work to capture Edie's life story and, views from her daughter who visited her often. This revealed particular triggers for Edie, such as feeling her personal room was being "invaded" and the cultural practice in the home of getting people dressed by a certain time.

A detailed individual support plan was put in place which allowed Edie to rise and dress in her own time and allowing her to eat breakfast in her dressing gown if she chose. It also specified proactive strategies for workers to offer personal care; only entering the room individually, using and avoiding specific language (both verbal and non-verbal), and leaving if Edie indicated that she was not ready, coming back 10 minutes later.

Changes to her environment were also made; the wall behind her toilet was painted a dark colour so that she could see the toilet better and the workers played quiet background music when they offered her personal care.

Edie's story continued: supporting workers to minimise restrictive practices

Workers who supported Edie had become very scared of working with her and their behaviour reflected this, such as showing fear or bravado or wearing outdoor clothing to protect themselves.

In response to this culture of fear the care team worked alongside the challenging behaviour specialists and Edie's daughter to develop Edie's care plan.

Workers and Edie's daughter needed support individually and as a team to implement the plan. The manager also prepared a one page profile to help workers see Edie as an individual with a history and a range of experiences and to put her behaviour into context. For example, explaining that she likes to sing along to music, but may stop if others join in.

Edie's story continued: lessons learned

The best way to develop Edie's care and support plan was by holding a staff development day with the challenging behaviour team and developing the plan during the day.

Many of the aspects of the plan appeared to not only help Edie be calm but also made it much easier and more pleasant for workers, allowing them to 'let go' of the negative emotions when an incident had occurred.

"It's been like everyone has breathed a sigh of relief," said the manager.

Six Core Strategies to Reduce Seclusion and Restraint Use

Link to resource

https://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf

Synopsis

These strategies were developed through extensive literature reviews (available upon request from joan.gillece@nasmhpd.org) and dialogues with experts who have successfully reduced the use of S/R in a variety of mental health settings for children and adults across the United States and internationally.

Audience	Year	Type of resource
Psychiatric administration and management team Psychiatrists Nursing staff Family and friends	2008	Strategy doc & Planning Tool

Description

This 23-page **strategy document** and **Planning Tool** compiled by the **National Association of State Mental Health Program Directors (NASMHPD)** provides six strategies with a breakdown of goals and question-based tasks for mental healthcare practitioners and management to action to reduce S/R practices. It adopts a **trauma-informed care** approach and a **prevention approach**.

The six core strategies comprise:

(1) Leadership toward organizational change

(2) Use data to inform practices

(3) Develop your workforce

(4) Implement S/R Prevention Tools
(5) Full inclusion of service users (peers) and families in all activities
(6) Make debriefing rigorous

The Planning Tool is designed for use as a template or checklist that guides the design of a seclusion and restraint (S/R) reduction plan that incorporates the use of a **prevention approach**, includes the six core strategies to reduce the use of S/R© described in the NASMHPD curriculum, and ascribes to the principles of continuous quality improvement. Additionally, it may be used as a **monitoring tool** to supervise implementation of a reduction plan and identify problems, issues, barriers and successes. It is stated as best used as a working guide by an assigned Performance Improvement/Seclusion and Restraint Reduction Team or Task Force.

Tools & Activities

This strategy document contains a Planning Tool, starting on page 4. It follows the format of Strategy – Goal – Checklist tasks. Below is an example.

Strategy Two: Using Data to Inform Practice

GOAL TWO: To reduce the use of S/R by using data in an empirical, non-punitive, manner. Includes using data to analyze characteristics of facility usage by unit, shift day, and staff member; identifying facility baseline; setting improvement goals and comparatively monitoring use over time in all care areas, units and/or state system's like facilities.

1. Has the facility collected and graphed baseline data on S/R events to include at a minimum, incidents, hours, use of involuntary medication, and injuries?

2. Has the facility set goals and communicated these to staff, setting realistic data improvement thresholds? Has the facility created non-punitive, healthy competition among units or sister facilities by posting data in general treatment areas and through letters of agreement with external facilities?

3. Has the facility chosen standard core and supplemental measures including seclusion and restraint incidents and hours by shift, day, unit, time; use of involuntary IM medications; consumer and staff related injury rates; type of restraint, consumer involvement in event debriefing activities; grievances, consumer demographics including gender, race; diagnosis insurance type; and other measures as desired?

4. Does leadership have access to data that represents individual staff member involvement in S/R events and is this information kept confidential and used to identify training needs for individual staff members? (For supervisors only.)

5. Is the facility able to observe and record "near misses" and the processes involved in those successful events to assist in leadership and staff learning of best practices to reduce S/R use?

WHO QualityRights E-training on Mental Health

Link to resources

https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training

Synopsis

This innovative online course produced by the World Health Organization focuses on rights-based approaches to mental health, recovery and inclusion. It is available in 11 languages and can be accessed free of charge.

Audience	Year	Type of resource
Wide-range For low-, middle- and high-income countries To be used by health workers, policy makers, persons with lived experience and their family or community members	2022	Training course

Description

The World Health Organization (WHO) QualityRights initiative aims to improve the quality of care in mental health and related services and to promote the rights of people with psychosocial, intellectual and cognitive disabilities.

The associated QualityRights e-training is available in 11 languages and covers:

- Taking care of one's own mental health;
- Supporting friends, family and colleagues with their mental health;
- Tackling stigma, discrimination, abuse and coercion in mental health services; and
- Taking action in support of transformation of mental health services towards a person-centred, rights-based recovery approach.

The training has been developed for a wide variety of groups, including people involved in making decisions about mental health care provision, those who provide mental health care and psychosocial support, and people who have received or are receiving support for their mental health.

The e-training is available free of charge, and offers learners an opportunity to earn an official certificate from the WHO.

Safewards handbook. Training and implementation resource for Safewards in Victoria

Link to resource

https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/s/safewards-victoria-handbook-2016.pdf

Synopsis

Safewards is a model that was developed in the United Kingdom by Professor Len Bowers and colleagues. It specifically examines events known in the model as 'conflict' (events that threaten staff and patient safety, such as self-harm, suicide, aggression, absconding) and 'containment' (things staff do to prevent or reduce harm to staff and patients, such as increased observation, use of extra medication, use of restrictive interventions) (Bowers 2012).

Audience	Year	Type of resource
Nurses in psychiatric care Psychiatrists Administration and management of mental healthcare facilities	2016	Handbook

Description

This 78-page **handbook** is designed by the **Department of Health and Human Services Victoria** to assist with the implementation of **Safewards** in mental health services service.

It contains:

- an overview of the Safewards model
- a description of the 10 interventions commonly used in association with the model
- recommended readings
- tips for education and implementation
- templates to support training and implementation of Safewards.

All of the Safewards interventions have been designed to address the various **flashpoints** outlined in the model and to **reduce conflict-originating factors**. The model does not recommend the use of restrictive interventions; it ensures if restrictive interventions or containment are used, they do not lead to further conflict (Bowers, 2014).

The ten Safewards interventions are:

- Know each other
- Clear mutual expectations
- Mutual help meeting
- Calm down methods
- Bad news mitigation
- Soft words
- Talk Down
- Reassurance
- Discharge messages
- Positive words

Tools & Activities

The Safewards Handbook contains guidance for the 10 interventions, and seven appendices, including a Safewards preparation checklist (Appendix 2), Safeward intervention implemental plans (appendix 5), an activity template (appendix 6) and handover prompts (appendix 7 – see below).

Appendix 7: Handover prompts

Three of the interventions (positive words, bad news mitigation, reassurance) require specific action at the nursing handovers, three per day.

This prompt sheet is a resource for the leads of those three interventions and for the nursing staff leading handover. These questions reflect the items for these interventions in the Safewards fidelity checklist.

Bad news mitigation

1. Are any patients likely to receive bad news during the next shift?
    a. Discuss potential strategies that may help to mitigate the bad news for this patient

    Yes ☐ No ☐

2. Did anyone receive bad news during the previous shift?
    a. Discuss the strategies that were used and how these worked

    Yes ☐ No ☐

Reassurance

1. Did any of the following incidents occur? Tick all that apply

Physical aggression	
Attempted suicide	
Seclusion	
Restraint	
Coerced IM medication	
Transfer to HDU or elsewhere	

2. If any of the above occurred, did Reassurance take place?

    Yes ☐ No ☐

Positive words

1. Were positive words used when discussing each patient?

    Yes ☐ No ☐

WPA/RANZCP Case Study of Alternatives to Coercion in Mental Health Care: Quality Rights Gujarat, India

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Link to resource

https://3ba346de-fde6-473f-b1da-536498661f9c.filesusr.com/ugd/e172f3_50e9fa3b3482459e9ca40e1adcfbaaff.pdf

Synopsis

This case study is part of a three-part series commissioned by the World Psychiatric Association (WPA) and the Royal Australian and New Zealand College of Psychiatry (RANZCP) to examine how alternatives to coercion have been implemented in a variety of mental health care settings. This study describes work led by The Centre for Mental Health Law and Policy in Pune, India. In just two years, QualityRights Gujarat led to a culture shift towards recovery-oriented care and a change in the way mental health services are delivered. This example offers a set of lessons for how to get rights-oriented interventions legislated at state level, affect a culture change at implementing facilities and make change sustainable.

Audience	**Year**	**Type of resource**
Mental health professionals People with lived experience Administration and management of mental healthcare facilities	2020	Case study

Links to additional resources

Compendium report: Good practices in the Council of Europe to promote Voluntary Measures in Mental Health Services (such as Open Door Policies)

https://www.coe.int/en/web/bioethics/compendium-report-good-practices-in-the-council-of-europe-to-promote-voluntary-measures-in-mental-health-

This report provides a compendium of good practices to promote voluntary measures in mental health care and support. The practices may directly aim to reduce, prevent, or even eliminate coercive practices in mental health settings, and others will indirectly result in similar outcomes by advancing the general aim to promote voluntary mental health care and support.

Trauma-informed Care and Practice Organisational Toolkit (TICPOT)

https://www.mhcc.org.au/resource/ticpot-stage-1-2-3/

TICP is a strengths-based framework that emphasises physical and psychological safety, creating opportunities for people with lived experience to rebuild a sense of control and empowerment. TICP supports services in moving from a caretaker to a collaborator role, as well as providing a supportive environment for workers, reducing the risk of vicarious and secondary trauma.

Developing open dialogue

http://developingopendialogue.com

DEVELOPING OPEN DIALOGUE (DoD) has been created from a passion to find different ways of understanding mental health difficulties. Open Dialogue is a social network approach to mental health difficulties, involving family members, friends and others who are concerned.

Emerging Minds: Supporting children's participation through shared decision-making in child mental health care

https://emergingminds.com.au/resources/supporting-childrens-participation-through-shared-decision-making-in-child-mental-health-care/

This resource introduces practitioners to the concepts of children's participation and shared decision making in children's mental health care.1 It discusses the benefits of involving children in decisions related to their own mental health care, as well as the challenges practitioners may face when doing so. It also considers the ways practitioners can support children's participation in decision-making processes related to their mental health care.

Centre for Mental Health Law & Policy – 'Atmiyata' project

https://cmhlp.org/projects/atmiyata/

Atmiyata is an innovative, evidence-based, high impact, community-led model to reduce the mental health and social care gap in rural communities. The World Health Organization has listed Atmiyata as one of the 25 good practices for community outreach mental health services around the world.
