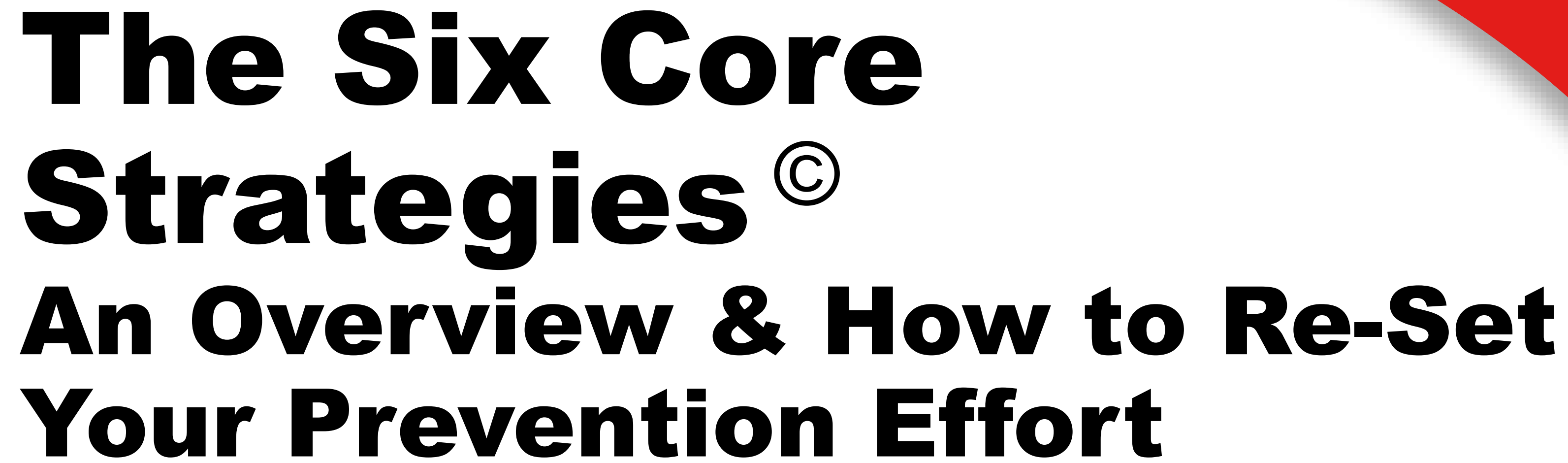

The Six Core Strategies©

An Overview & How to Re-Set Your Prevention Effort

An Evidence-based Practice to Prevent Conflict, Violence, and the use of Seclusion and Restraint

VT EIP Meeting: December 13, 2024

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History of US Prevention Work

- 1998: Hartford Courant (1998)
- US Governmental Accountability Office (1999)
- NASMHPD gathered the (SME's) experts, identified by the USGAO, to brainstorm and 6CS emerged.
- NASMHPD Medical Directors Council (1999, 2001)
- NASMHPD Policy Statement (2002)
- HCFA, now CMS, Rule and COP changes (2001, 2003, 2007)
- NASMHPD funding leads to development of 6CS Curriculum and training for all states, starting in 2002, by regions in North America.
- In 2004, SAMHSA decided to fund a large-scale research project in eight states to determine effectiveness of Six Core Strategies.

Research Basis

- Five-year US research project undertaken (2004–2009)
- Research data gathering and analysis by HSRI in Cambridge, MA
- Eight states and forty-three facilities participated, twenty-eight completed
- Over 50% significantly reduced use of restraint by hours and individuals
- Over 70% significantly reduced use of seclusion by hours and individuals
- Findings were considered “robust” and led to adoption of these practices as a national evidence-based model (2012)

Framing the Issue

- 6CS model requires a **culture change** in behavioral treatment settings
  - Resulting changes can extend beyond reducing seclusion and restraint (**S/R**)
    (Huckshorn, 2006; 2013; LeBel & Goldstein, 2015)
- Culture change, in this model, include an examination of staff-client interactions, staff skills, and definition and implementation of recovery, resiliency, and transformation principles

Development of the Curriculum

- Ongoing review of literature (1935–present)
- Faculty best-practice information taken from individuals with direct experience with the Six Core Strategies (6CS©)
  - Included service users, such as patients/clients and families
- Service user and staff experiences describe what these events feel like, both to be restrained and to participate, as staff
- Three focus groups held (2001–2002)
- Core strategies:

-Leadership Toward Organizational Change
-Use of Data to Inform Practice
-Workforce Development
-Prevention Tools
-Inclusion of Clients and Families
-Rigorous Debriefing

Foundational Beliefs for EBP

These are the theoretical beliefs upon which 6CS's were established

Leadership principles for effective change

- The Public Health Prevention approach
- Recovery and resiliency principles
- Consumer and staff reports have value
- Trauma knowledge operationalized
- Commitment to continuous quality improvement (**CQI**) principles
  - Staff must be able to be honest and take risks, mistakes assessed to inform improvements

(Anthony & Huckshorn, 2008; IOM, 2005; New Freedom Report, 2003; Caldwell & LeBel, 2013; Huckshorn, LeBel & Caldwell, 2019)

Public Health Prevention Model

Public Health Prevention Model

- A model of disease prevention and health promotion
  - A logical fit with a practice issue such as reducing use of S/R or using Trauma-Informed Care (**TIC**) in practice
- Designed to keep large populations well
  - Identifies contributing factors and creates remedies to prevent, minimize, or mitigate the problem if it occurs

Model Application to Primary Health

- Primary Prevention (Universal Precautions)
  - Interventions designed to prevent disease from occurring, at all, by anticipating population risk factors (e.g., hand washing, vaccinations, condoms)
- Secondary Prevention (Selected Interventions)
  - Early interventions to minimize and resolve specific risk factors for a disease when they occur to prevent health deterioration (e.g., clean needle exchanges, osteoporosis prevention)
- Tertiary Prevention (Indicated Interventions)
  - Interventions designed to mitigate disease effects, analyze events, take corrective actions, and avoid disease reoccurrences (e.g., meds for diabetes, hypertension, cancer)

Model Application to S/R Reduction

- Primary Prevention (Universal Precautions)
  - Interventions designed to prevent conflict from occurring, at all, by anticipating risk factors (e.g., great customer service at admission, decontaminating past experiences, address needs)
- Secondary Prevention (Selected Interventions)
  - Early interventions to minimize and resolve specific risk factors when they occur to prevent conflict (e.g., use of trauma assessment or safety plans, immediate staff response to needs, engagement strategies with hard-to-reach clients)
- Tertiary Prevention (Indicated Interventions)
  - Post S/R interventions designed to mitigate effects, analyze events, take corrective actions, and avoid reoccurrences (e.g., gathering non jargon info on events; posting data monthly on use and debriefing events rigorously)

Trauma-Informed Care

- Emerging science based on high prevalence of traumatic life experiences
  (Muesar et al, 1998; SAMHSA, 2014)
- Traumatic life experiences cause or complicate mental health or other problems, including treatment resistance
  (Huckshorn, 2013; IOM, 2005; Felitti et al, 1998; SAMHSA, 2014; BBI, 2014)
- Systems of care that are trauma informed recognize that coercive or violent interventions cause trauma and are to be avoided
  (6CS, 2015; SAMHSA TIP 57, 2014)
- Universal precautions required
  (NASMHPD Med Dir, 1999; SAMHSA TIP, 2014; 6CS, 2015)

The Six-Core Strategies to Prevent Violence (S/R)

- **Leadership** toward organizational change
- Use **Data** to inform practices
- Develop your **Workforce**
- Implement **S/R Prevention Tools**
- Full inclusion of **service users (peers) and families** in all activities
- Make **Debriefing** rigorous

Now What?

Use the Core Strategies

If you are using R/S … go back to basics

- Assess
- Prepare
- Teach
- Implement
- Support
- Reassess
- Repeat

Current Assumptions

Evidence-based Practices to Prevent Conflict, Violence, and the use of Seclusion and Restraint

Original work by Evans & Strumpf, 1990 and Mohr & Anderson, 2001

Adapted and approved for use in 2004

Definition

Assumption:
A belief that is supposed to be factual; Something taken for granted. A supposition.

(Webster, 1994)

However, while some assumptions are based on facts, some are based on myths

Restraint and seclusion keep the people we serve safe.

Reality: Data

- 142 deaths in the US from 1988–1998 due to S/R reported by the Hartford Courant

(Weiss et al, 1998)

- 111 fatalities over 10 years in New York facilities due to restraints

(Sundram, 1994 as cited by Zimbroff, 2003)

- 50 to 150 deaths occur in the US each year due to S/R, estimated by the Harvard Ctr. for Risk Analysis (Weiss, 2003)

- Federal Office of the Inspector General identified 42 of 104 (42%) S/R deaths from 08/99–12/04 *were not reported* (OIG, 2006)

Reality: Data

- **USA Today Network (July, 2024) reported the findings of their multi-year investigative report 2020-2023:** ***"Nearly 2,700 patients died while in seclusion or restraints, with another nearly 11,700 deaths occurring within 24 hours of removal from restraint or seclusion.*** *Limited other cases involved a patient death within one week of restraint or seclusion."*
- Why did 14K people die with ties to hospital restraints amid pandemic? (msn.com)

Tragic Reality

Irvo Otieno, 28, was a college graduate. He had a mental illness and was taking medication; though would occasionally have symptoms. A neighbor reported he was taking their solar lights out of the ground and called the police. VA police responded. Irvo hit an officer and was arrested. He was taken to jail and transferred to Central State Hospital. In the admission suite, in handcuffs and leg irons, he was taken to the floor and restrained in the prone position for 12 minutes. The video confirms he was not aggressive. He looked scared. He died from asphyxiation. Three staff and seven deputies were arrested, charged with 2nd degree murder, and are awaiting trial - but that will not bring this young music maker, rapper and reported "very kind soul" back.

(CNN, Friday March 23, 2023, Youtube)

Tragic Reality

William Avant, **35,** had behavioral health challenges and a FSIQ of 65. He was a patient Bryan Psychiatric Hospital in Columbia, SC for several years. He loved card games, Garth Brooks, and was described as a *'gentle soul.'* He became very upset when staff told him he could not attend his grandmother's birthday party. He rushed toward a door and tried to kick and push it open. Staff pushed him to the ground, face down, and restricted his movements for 4 minutes. When they released him, he had no pulse. This event was ruled a homicide, as staff disregarded the hospital policy that prohibited prone restraint. The state was sued and the Court ordered $1.95M be paid to William's family.

(Hood, 2022)

Reported Injuries and Deaths

- Injuries including:
  - Coma
  - Broken bones
  - Bruises
  - Cuts requiring stitches
  - Facial damage
  - Thrombosis

- Deaths due to:
  - Asphyxiation
  - Strangulation
  - Cardiac arrest
  - Blunt trauma
  - Drug overdoses or interactions
  - Choking
  - Neglect

(Mildred 2002; Huckshorn, 2012)

Assumption Two:

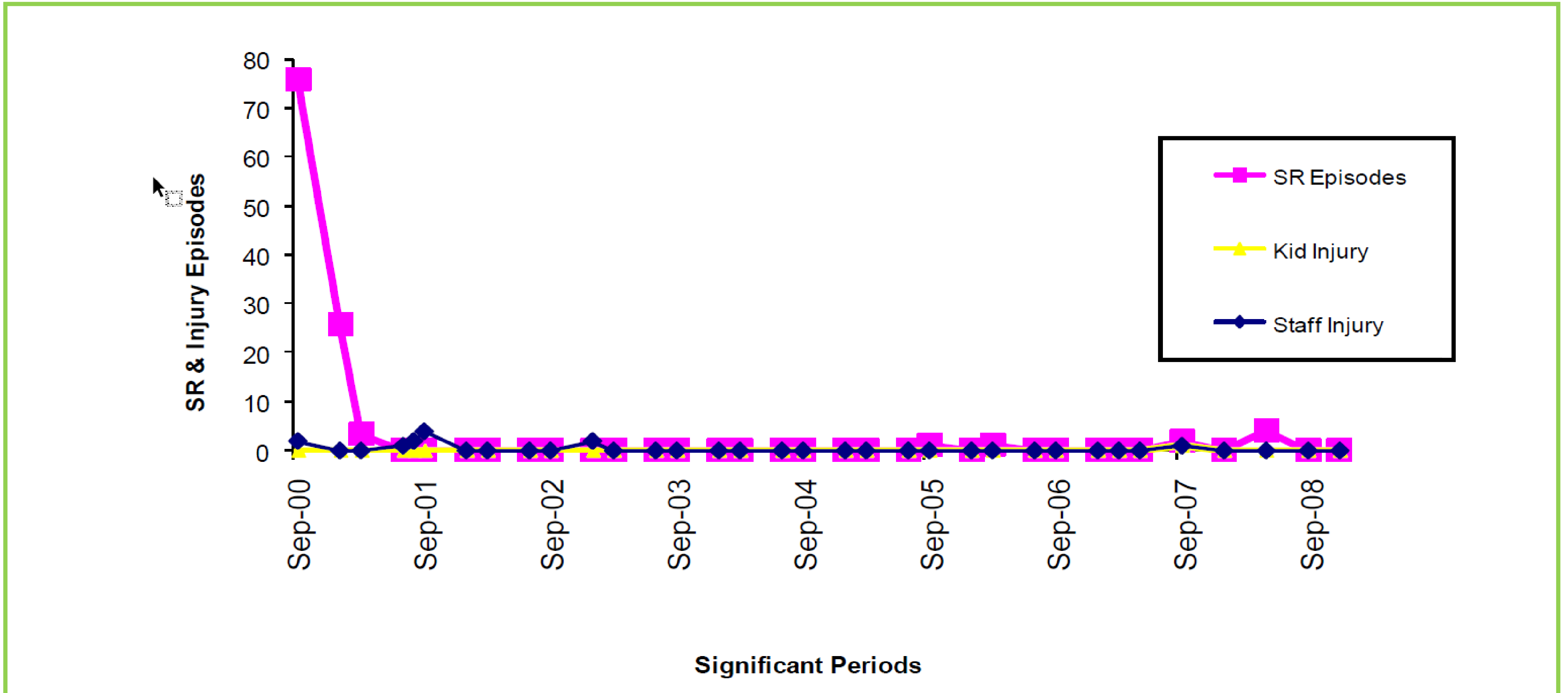
Restraints keep staff safe.

Tragic Reality: Staff Deaths

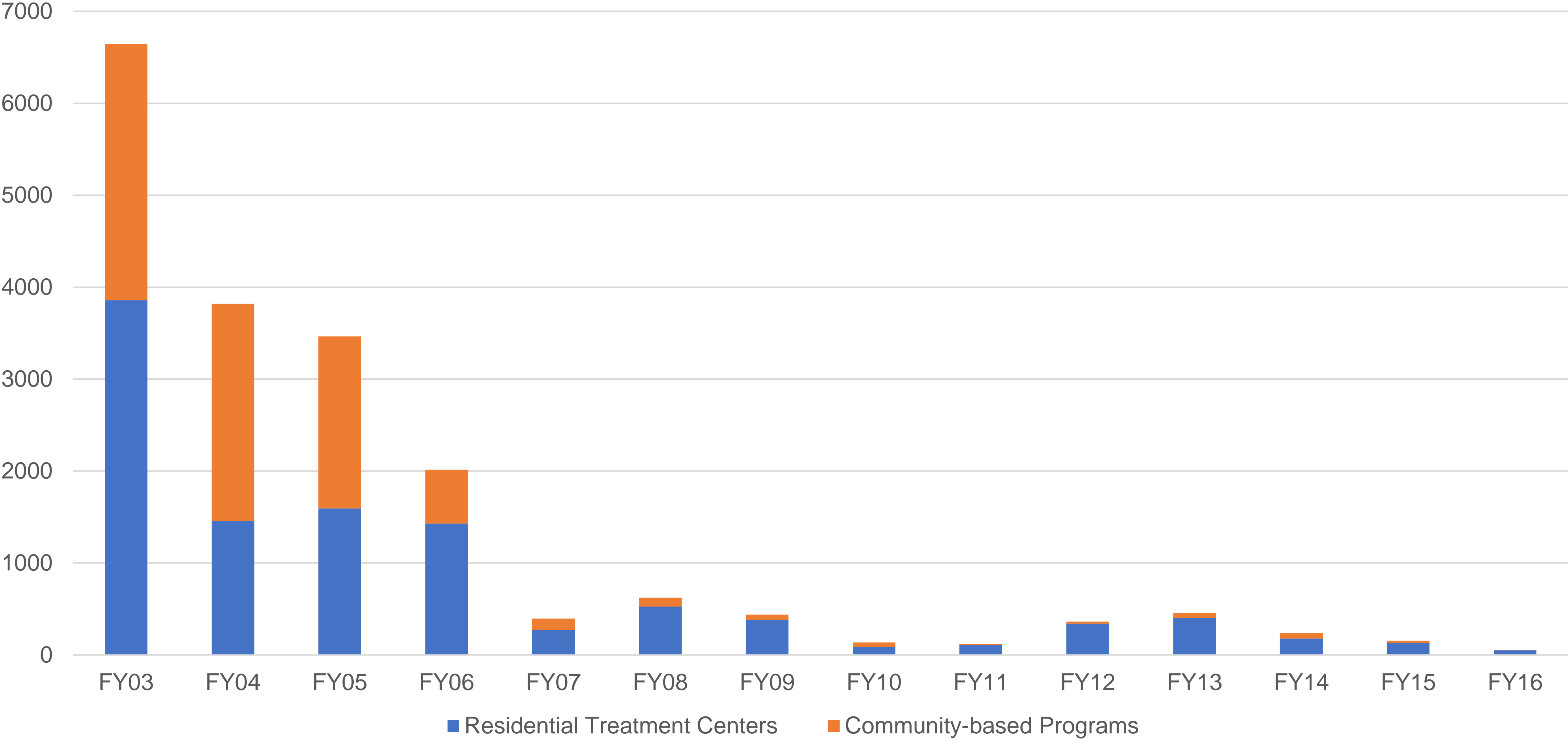
- Kevin Robinson, 40, was struck in the groin while restraining a female patient at Prisma Health Tuomey Hospital in SC. He collapsed, suffered cardiac arrest, and later died (Prisma Health employee dies after mental patient strikes groin (wistv.com))
- A beloved male unit director was kicked in the chest and later died from complications as a result of restraint use in a VT facility (Brattleboro Retreat, VT, 2019)
- Jean-Max Auguste, 50, an MHW was kicked in the chest during a restraint at Greystone Park Psychiatric Center in NJ and died (New York Times, 2002)
- Phil Stubbs, an experienced RN, was also kicked in the chest during a restraint and died at Gold Coast Hospital in Queensland, AU (Gold Coast Bulletin, 2007)
- Lee McDuffy, 39, an MHW at Spring Grove Hospital in MD collapsed and died after physically restraining a consumer (Examiner.com, 2006)
- James T, 34, (security) was jumped from behind at Hampstead Hospital. His shoulder was dislocated, he fainted and went into cardiac arrest. He did not die due to fast response by EMS (Huckshorn, 2023)

Boston Medical Center Intensive Residential Treatment Program

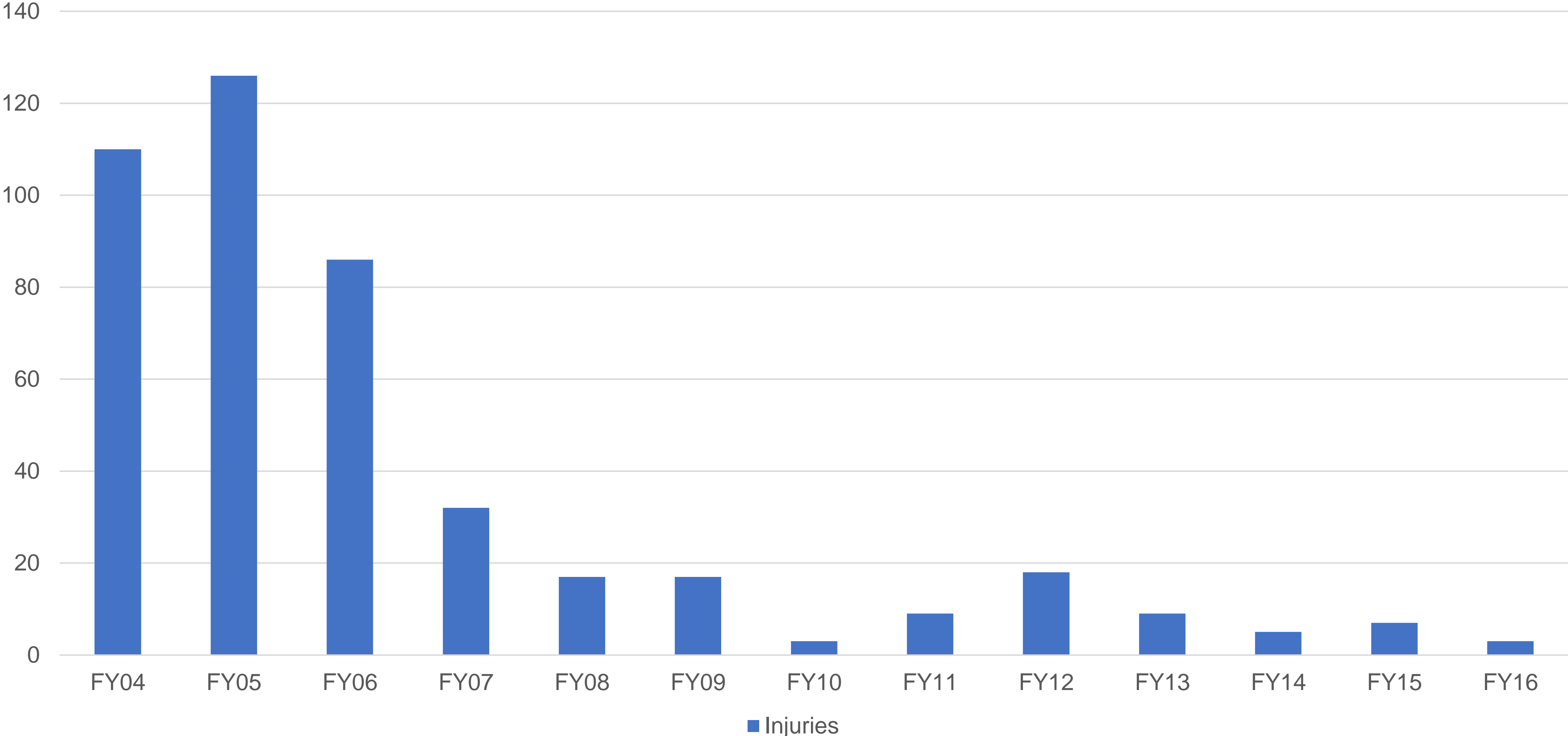
Total seclusion, restraint, and injury episodes



Organization-Wide Physical Restraints



Staff Injuries from Restraints



Staff know how to de-escalate potentially violent situations

(Mohr & Anderson, 2001)

Reality: Research

- Luiselli, Bastien, and Putnam conducted a behavioral analysis to explore contextual variables related to the use of mechanical restraints in a child/adolescent inpatient service (1998).
- Findings: The most frequent antecedent to the use of mechanical restraints was a staff-initiated encounter with the person
- Tormey et al., studied facility restraint patterns and found staff negative interactions (limits, redirections, directives, 'selective ignoring', etc.) preceded > 90% of restraint use (2016).

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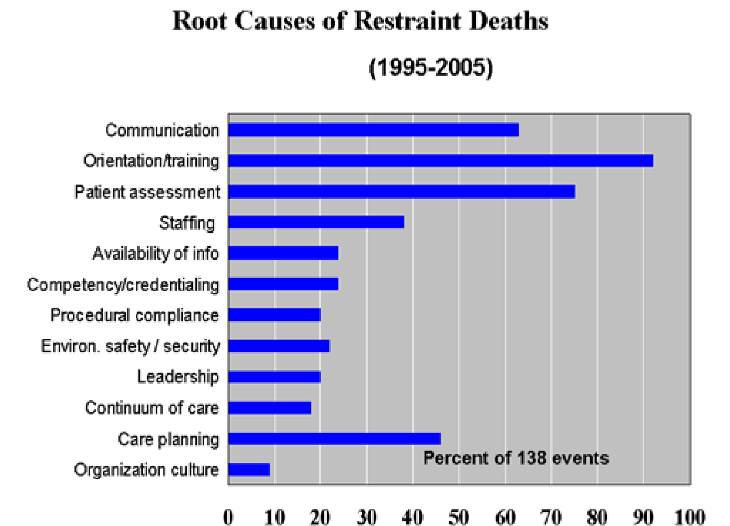
Reality: Research

Joint Commission

- Sentinel Event Database of Restraint Deaths: The **single most frequent contributing factor to restraint deaths** (> 90%) **was a lack of basic staff orientation & training in managing behavioral crises**
- Joint Commission published a complete description of necessary staff training and competencies for effective de-escalation because of **the lack of, or loss of, these core competencies in the behavioral health field**

(TJC, Quick Safety, 2019)



Seclusion and restraint are used without bias and only in response to objective behavior.

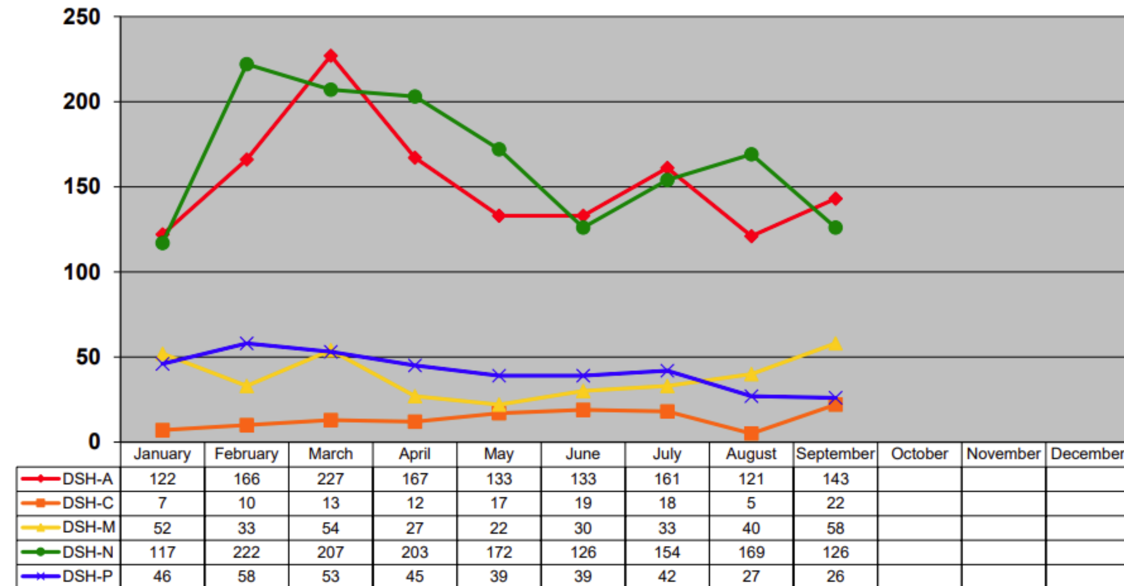
Reality: Research

Research indicates that cultural and social bias exists.

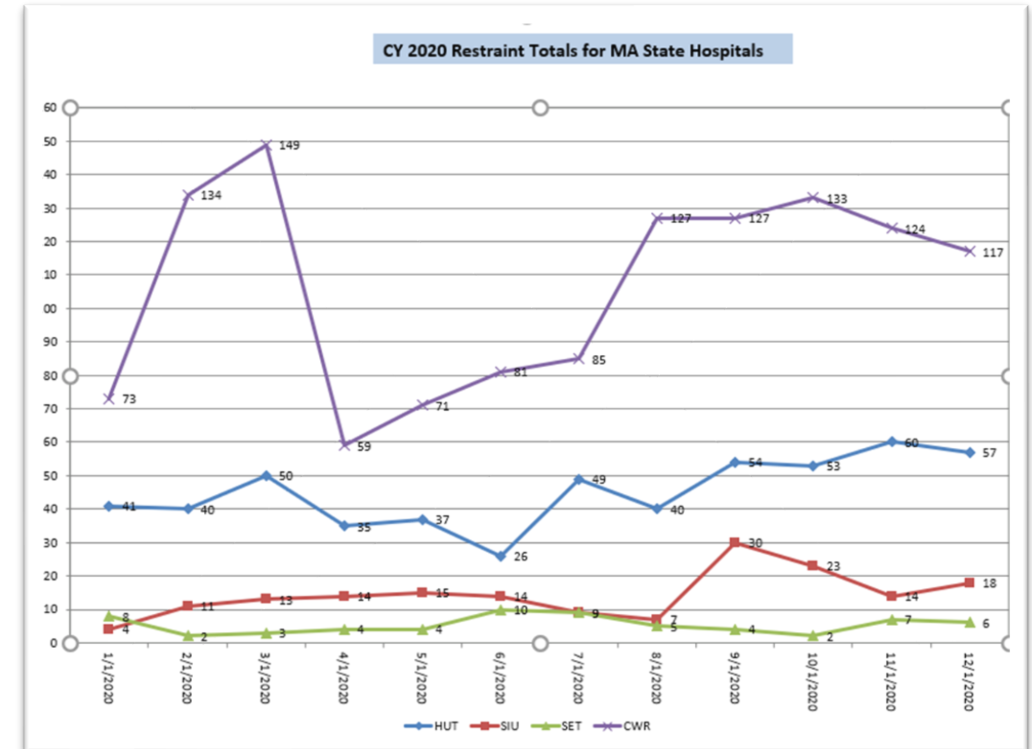
- Those more likely to be secluded:
  - Black and Asian descent (Price, David & Otis, 2004)
- Those more likely to be restrained:
  - Younger and on more medications (LeGris, Walters, & Browne, 1999)
  - Younger, male gender, Black or Hispanic (Donovan et al, 2003; Brooks et al, 1994)
  - Younger, male, Black/AA, Juvenile Justice/Court involved, and had longer LOS*

**(Ortiz & White, 2022: Cross-sectional study by NRI of 2,732 episodes of care from youth treated in 37 state inpatient psychiatric facilities [12-17 years old])*

Reality: States' Divergent Practice



	January	February	March	April	May	June	July	August	September	October	November	December
DSH-A	122	166	227	167	133	133	161	121	143			
DSH-C	7	10	13	12	17	19	18	5	22			
DSH-M	52	33	54	27	22	30	33	40	58			
DSH-N	117	222	207	203	172	126	154	169	126			
DSH-P	46	58	53	45	39	39	42	27	26			



https://www.dsh.ca.gov/Publications/Reports_and_Data/Seclusion_and_Restraint/docs/2020/6.pdf?=0523

Indicators for S/R
Prevention and
Reduction Work

Essential Indicators to do this Work

Operations

- Standard of care imperative
- Prevent toxic culture / hiring impediments / hiring costs
- Prevent/reduce injuries to staff, reduced workers comp / costs and time off
- Redirect staff time / $$ into treatment
- Prevent treatment delay / ensure patient flow

Clinical / Recovery

- Provide effective quality care
- Enhance treatment culture / hiring cache
- Prevent/reduce injuries to patients
- Increase/enhance treatment, alliance, recovery
- Timely treatment / return to community

A few Suggestions:

- TA: External Consultation & On-site training
- TA: Within VT consultation / peer site visits
- Start the conversation: solicit input from staff, persons-served, involved others
- Identify a goal
- Form a deep bench / inclusive team
- Imbed the effort into operations: establish a ‘routine’, put on the schedule, plan for daily discussion, develop a debriefing ritual, write a focused action plan with objective deliverables/staff assigned/dates, promote and follow up, use data (objective/subjective) to guide next steps, solicit input from outside the organization, visit other facilities to learn and develop the team
- Plan formal updates and celebrate success, innovations, and learn from backsliding… and PUBLISH whatever you do and learn

Discussion.
Questions?
Thoughts?

THANK YOU

Contact Information for Any Questions!

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