Overview of the Six Core Strategies©

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

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Welcome and Good Morning

- Introduction to the Six Core Strategies!
- Six Core, or 6CS, have been around since 2002.
- Accepted as an Evidence-based Best Practice in 2012.
- Implementation of this model has seen many successes in multiple states and a variety of settings: child, adolescent, adult, forensic, Eds, IDD/DD and geriatric psychiatric facilities.
- **Pandemic hit!!!** Resulting in significant losses in our workforce; financial stress; loss of historical agency knowledge; and competing priorities.
- And the never-ending focus on our work by states, the media, legislators and funders.
- Talk about a S—T Storm! Took us back years… Recovery Mode now!

History of S/R Prevention Work

- 1998: Hartford Courant (1998)
- US Governmental Accountability Office followed (1999)
- Surgeon General's Report (1999) [*highlighting violence and S/R reduction]*
- NASMHPD Medical Directors Council (1999, 2001, 2002)
- CMS Emergency Rules (2001)
- Additional CMS Rule changes (2003-2005)
- SAMHSA funding led to development of 6CS Curriculum, 5 years of research and training for all states (2003-2012)
- Research and publications still growing (Smith et al, 2024; Atdjian & Huckshorn, 2023; St. Mary's, 2021; Widom et al, 2015; Barton et al, 2009; et. al.)

Research Basis for 6CS

- 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 S/R Prevention Issue

- Any systemic change in an agency's practice requires a **culture change that includes training, new practice and is reflected in policies.**
- **For Six Core Strategies** this culture change includes examination of leadership roles, staff-client interactions, staff skills, clear definitions, and the focused implementation of recovery, resiliency, and transformation principles
- **Best practice core strategies** to prevent violence and better assure safety for individuals in care and staff have been identified and are available.

Development of 6CS Curriculum

- Ongoing review of literature (1950–present ***2024***)
- Best-practice information learned from subject matter experts (SME's) with direct experience in effectively preventing violence and use of S/R (6CS©)
  - Three focus groups held (2001–2002). Participants **all** had hands-on experience with successful reduction projects and included peer specialists and family advocates.
- Service user, family members, and staff experiences described what these events felt like, both to be restrained and to participate (as staff).
- Core strategies emerged from themes defined over time.
- Turned out successful S/R reduction "projects" used the same methods; just named them differently.

Foundational Beliefs for 6CS Curriculum

- Leadership Principles for effective change
- The Public Health Prevention Model
- Beliefs by leaders and staff that, with help, children in care can build resiliency competencies and can get better
- Beliefs by leadership and staff that children's statements, and staff reports, have great value that help leaders learn…
- Beliefs that Trauma Knowledge can be operationalized
- Leadership Commitment to Continuous Quality Improvement (**CQI**) principles
    - Staff must be able to be honest and take risks; mistakes assessed to inform improvements in practice

(Anthony & Huckshorn, 2008; IOM, 2005; Dahlberg & Krug, 2022; Huckshorn, LeBel & Caldwell, 2019; Dewar, Doucette & Epstein, 2019)

IMPORTANT: The Public Health Prevention Model

Public Health Prevention Model

- A model of disease prevention and health promotion
  - A logical fit with a practice challenge such as preventing violence to reduce the use of S/R and injuries to person's served and staff
- Designed to keep large populations well
  - Identifies contributing factors and creates remedies to prevent, minimize, or mitigate a problem before it occurs
- This model "focuses us on prevention" while maintaining safe use, as first noted in 1999 (NASMHPD Medical Directors S/R Series [1], 1999; 2001)

Model Application in Primary Health
PANDEMIC!! You are already experts!

- **Primary Prevention** (Universal Precautions)
  - Interventions designed to prevent disease from occurring, at all, by anticipating population risk factors (e.g., hand washing, vaccinations, social distancing, condoms)
- **Secondary Prevention** (Selective 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)
  - The "disease" happened! These interventions designed to mitigate disease effects, analyze events, take corrective actions, and avoid disease worsening (e.g., meds for diabetes, hypertension, cancer)

Model Application in 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 in involuntary care, addressing individual needs asap; rapid engagement)
- **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, use of peer support)
- **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; avoiding group think documentation post events, posting data monthly on use and debriefing events rigorously)

Trauma-Informed Care

- Emerging science based on high prevalence of traumatic life experiences starting with Kim Muesar in1998. (Menschner & Maul, 2016; SAMHSA TIP 57, 2014)
- Traumatic life experiences cause or complicate mental health or other problems, including adding treatment resistance
  (Huckshorn, 2013; Felitti et al, 1998; SAMHSA, 2014; Muller, Kenney, et, al., 2020)
- Systems of care that are trauma informed recognize that coercive or violent interventions cause re-traumatization and are to be avoided
  (6CS, 2023, SAMHSA TIP 57, 2014)
- Universal precautions required
  (NASMHPD Med Dir, 1999, SAMHSA TIP 57, 2014, 6CS, 2023)

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

I want to Reframe Six Core Strategies © for you.

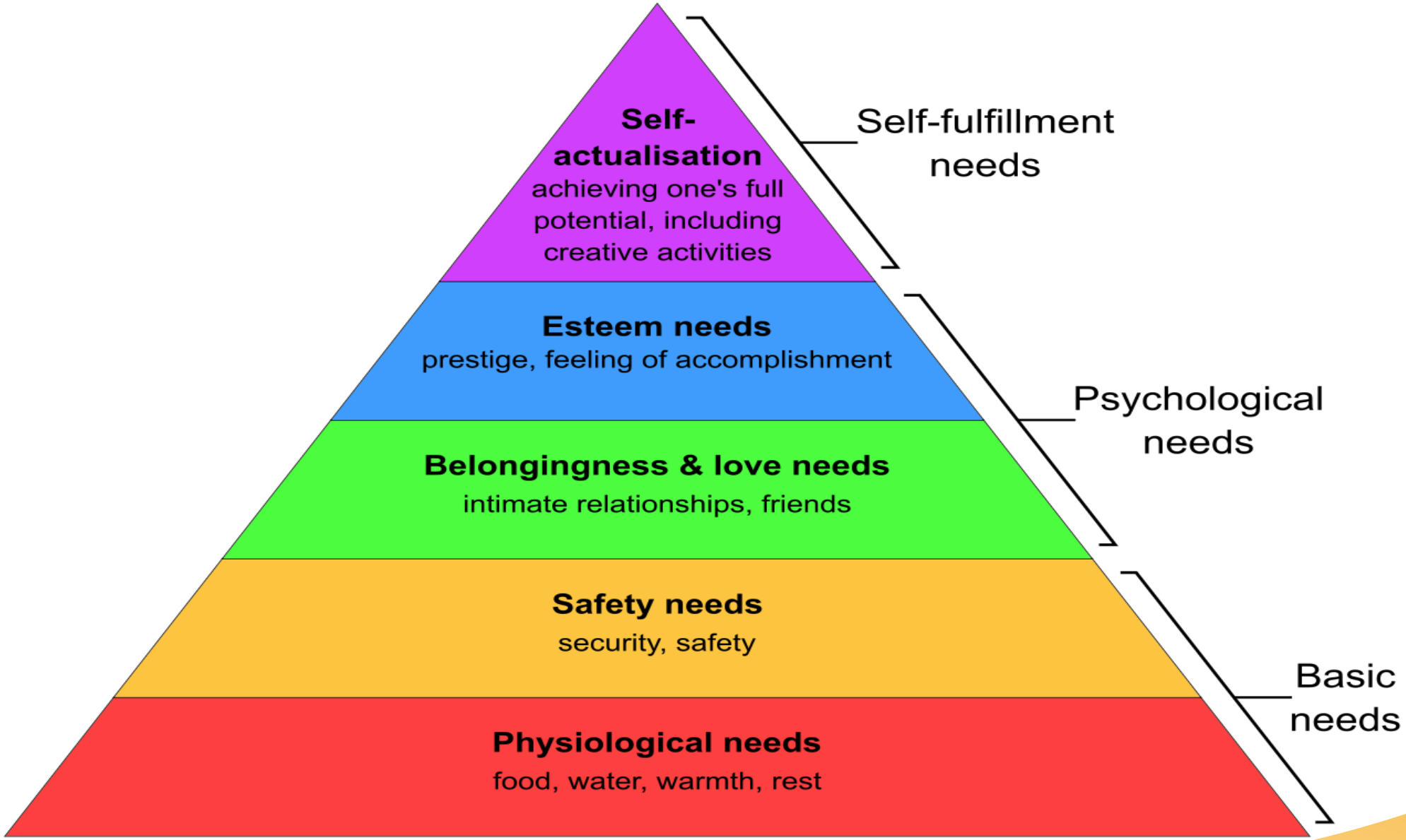
- *Let's talk about the following goals that we, hopefully, share. We have learned a lot, through the Pandemic, and before. We are now going back to basics:*

1. **Safety** for all the children in our care and our staff.
2. **Leadership** roles that need to be clear.
3. The importance of high-quality **Customer Services**.
4. The need for **Programming** that includes gross motor movement, sensory modulation skills, and interesting, engaging activities.
5. The need for **consistent follow-up** on adverse events that "closes the loops" and leads to learning and practice changes.

The Assurance of Safety is Paramount in our Service Systems

- When we (leaders) cannot provide a consistently safe environment for children and staff, the following happens:
  - Staff and children get hurt
  - Children cannot engage or learn; *Maslow's Hierarchy-survival* ***RULES***
  - Staff leave, stressing out remaining staff to cover shifts
  - Negative media that affects morale and staff confidence
  - Focused oversight by accrediting agencies and funders leading to corrective action plans and paperwork distractions
  - Distressed families and advocates
  - Lawsuits and loss of precious funding

Maslow's Hierarchy



So how do we Assure a Safe EOC?

- This goal is complicated and multi-faceted and, in my experience, rests on a few mandates:

1. A focused understanding, by agency leaders, of their roles

A very brilliant mentor of mine said, years ago. The work of a leader is to work daily and "bend over backwards" to make sure that their staff get the training and support to, individually…:

a) *Be competent in the needed skills to do their work well,*

b) *Feel productive, supported and listened to, at work, and,*

c) *Feel proud and successful.* *(Alan Braunstein, PhD, 1982)*

Are you able to do this and, if not, why not? What are your challenges?

So how do we Assure a Safe EOC?

2. Leaders are clear on the organization's values, and they work to assure that practices match these values:

a) If a value is to provide **trauma-informed care**, how is that being done?

b) If a value is to provide "**voice and choice**" to kids/families in care, how is that done?

c) If a value is to provide "**best practices**" what are these and how are staff trained?

d) If a value is to provide services that help children **learn to manage their emotions** and behaviors, how is this done?

e) If a value is to **retain staff**, what processes are in place to do this?

f) If a value is to **prevent adverse events**, including use of restraint, how is that being done?

So how do we Assure Safe EOC?

3. Leaders assure that all staff have a clear job description (contract) that describes their roles and expected competencies.

a) These job descriptions need to state expected competencies including:
   i) Person-first language,
   ii) Skills to prevent conflicts or rapidly de-escalate conflicts,
   iii) Personal skills where the staff person demonstrates abilities to self regulate in crisis,
   iv) Immediate engagement of kids in care, within 15 minutes of arrival,
   v) How to negotiate and not use the word “NO”,
   vi) How to use an “apology” to decontaminate a situation,
   vii) How to participate in a debriefing, etc.

High Quality Customer Services

- Most of our publicly funded behavioral health services, adults or children, never got the message on **the importance of "Customer Service**."
- **Why?** Because, mostly, only commercial for-profit organizations ever had to worry about customer service as they **WANTED** more customers.
- In public sector Behavioral Health, we already had customers, sometimes too many to serve well. So, we never paid attention to this critical, trauma-informed approach to the children, families, and agencies we serve.
- Nationally, we have greatly suffered from this lack of knowledge, lack of training, and lack of competencies and we have not held ourselves accountable for "good to great" customer services.
- Leading to a very dissatisfied public audience and a lot of national criticism.
- **Great Customer Service is actually Trauma-informed Care.**

High Quality Customer Services

- Imagine how it would feel to be brought to a facility, involuntarily or voluntarily, and be met immediately with:
  a) A peer support youth or a very customer-service oriented staff who said "Welcome, we are glad you are here." And then, "What happened to bring you here?"
  b) "I have hot chocolate or tea if you want some"?
  c) "Do you need to wash up or are you hungry? I can get you some food right now?"
  d) "What is that smell?" "Staff are making popcorn (or brownies) in the microwave, do you want some?"
  e) "I need to ask you a lot of questions, sorry about that. If you get too tired, we can finish up tomorrow."
  f) "How can I help you feel better right now?" I know this all must seem weird and scary?"

High Quality Customer Service Means:

1. Executive Leaders understand the importance of *excellent customer services starting at admission:*

   - ❑ Staff are trained to “never say no” and how to negotiate win-win resolutions to conflicts.
   - ❑ All efforts are made to make newly admitted children comfortable and to feel safe.
   - ❑ Family phone calls are taken or responded to, immediately, and taken seriously with follow-up.
   - ❑ Requests for admissions are promptly responded to and met with very clear admission guidelines and clear reasons for denials.
   - ❑ Every child in care has an *individualized treatment plan and an admission calming plan to start.* These are undated as we learn about the child in care.
   - ❑ No child is subject to S/R unless their behavior reaches the *imminent danger* threshold.
   - ❑ Staff also receive customer service when injured or traumatized by any event onsite.

The “uncomfortable and dangerous” *power differential* between staff and the children we are serving

1. **What are you doing** to guard against your staff “making up rules” to control behaviors?
2. **What are you doing** to make sure that your staff understand that they are “NOT Parents” and not there to “punish or discipline behaviors?”
3. These are very tricky paths to walk and many of our staff do not have the level of education or training that would help to guide them. This is NOT their fault.
4. This is on us, *leaders,* to assure that our staff get this kind of training, mentoring, support, on the spot corrections and that *you have a programmatic model that is based on evidence* that your staff have to follow when they need guidance at 11 pm on a Saturday night.

The Power Imbalance in Mental Health Settings can easily lead to an abuse of Power.

1. Even before the pandemic, most behavioral health agencies were finding it very hard to attract staff. Many of our positions are minimum wage and, often, these are the staff that spend the most time with the kiddos we serve.
2. We need to do a better job in interviewing, hiring and training staff. And we need to offer them additional training and **the potential of a career** in our field.
3. We can do part of this work through imbedding agency goals and values in our new employee training and assuring good supervision.
4. We also need to work on paying more than fast food restaurants.
5. Using family advocates and youth peer support staff in interviews helps.
6. Make a policy that you always use 2-3 staff in new applicant interviews.

The Importance of Staff Self-Regulation

1. **Self-regulation competencies**, in crisis situations, are NOT INNATE to most humans.
2. We all grew up in different environments and, half of us, have childhood/adult traumatic life experiences, according to the literature.
3. What this means is complicated in our field. Our staff need to be able to "self-regulate" when facing crisis situations or they will default to what makes them feel personally safe. E.G.:
   A) Trying to enforce rules
   B) Directing behaviors
   C) Setting limits
   D) Threatening consequences
   E) Getting upset or angry

The Importance of Staff Self-Regulation

4. That said, there is much we can do to assist in <u>teaching our staff self-regulation skills:</u>

   A) Assure that exec leaders attend your de-escalation/S/R training, for staff, to make sure your staff are learning what you want them to. Training should include role plays.

   B) Start a PERT (Psych Emergency Response Team) where only highly skilled staff are first responders and can model, in real time, how to self-regulate and negotiate. You can then create more PERT members over time.

   C) Do not allow new staff to take active roles in crisis events without supervision.

   D) Include “Tap Outs” in your policies and enforce this policy.

   E) Immediately follow-up with concerns on staff responses in crisis; not to blame but to train…

Programming Needs for C/A Services

1. Your agency's "activity programming" must include interesting and non-didactic activities. Get Creative!
   A. Providing activities that include gross motor movement helps to grow new brain pathways. Walks, runs, basketball, volleyball, ANYTHING that gets a child's heartrate up.
   B. Go to your community and see what activities can be contracted for: Canine, Equine, Swimming, Yoga, Gardening, Music/dancing. Programming should be FUN, in between treatment and/or school!!!
   C. Have an overall treatment model that integrates fun activities beyond treatment and school. Help kids have fun and succeed.
   D. Don't make them earn these activities. If they are safe let them access.

Close the Loops

1. If you do not have systems in place that can identify "what went wrong" you will never fix these gaps in knowledge
   A. Event Debriefing is critical. Debriefings need to tell "the story" on what happened. We know this is work.
   B. Event Debriefing should uncover info on adverse events that occurred due to staff a) trying to enforce agency or unit rules; b) staff getting dysregulated during an event; c) staff getting scared and making up rules or not knowing how to respond; d) staff not knowing how to intervene in a de-escalation; e) staff threatening child to stop that or else"…
   C. These events should be discussed in a safe and non-punitive way. Most of our staff do what they think is right in the moment. These are mostly training issues.

Thanks for your Precious Time Today

- It is such an honor to speak with you all this morning.
- ACRC and BBI are tremendous resources and assets for all of us.
- I learned this, over the last 5 months, while managing a C/A acute care facility in the Northeast. What an incredible group of experts you have. What great help they provided to me in that role! Shout Outs!
- Your commitment to the children you serve is, frankly, beyond the pale.
- I know how hard this work is and I just want to thank you for your work, every day.
- It was an honor to talk to you this morning. Have a great conference!
- Please focus on Safety and the Prevention of Violence.
- Here to Help! Kevin

Contact me with Questions

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