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Traditional to Evidence-Based Psychiatric Nursing Practice: Use of The Transformative Learning Theory to Promote a Change in Psychiatric Nursing Practice

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TRADITIONAL TO EVIDENCE-BASED PSYCHIATRIC NURSING PRACTICE: USE OF THE TRANSFORMATIVE LEARNING THEORY TO PROMOTE A CHANGE IN PYSCHIATRIC NURSING PRACTICE

by

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Abstract

Background: Nursing leaders, regulatory and government agencies insist nurses incorporate evidence-based nursing interventions into their practice. Nurse educators are challenged to change nurses' use of interventions from those based on tradition to those based on science. Providing adults with new information does not guarantee learners will actualize or even remember new information. Objective: This article describes the use of Transformative Learning theory as framework for an educational event to change current practice of psychiatric nurses. Design: Qualitative, descriptive surveys evaluated the effectiveness of the education to motivate learners' change in practice. Results: Participants recognized gaps between current nursing interventions and those supported by evidence. Conclusion: Transformative Learning theory provided an effective framework for assisting the participants to acknowledge false assumptions in current practice. Identification of false assumptions created discomfort with existing nursing practice and critical evaluation of this current practice led to agreement of the need to adopt evidence-supported interventions.

Keywords: transformative learning theory, evidence-based practice, psychiatric nurses, nurse educator

Nurses make health care decisions for their patients each day and the nursing interventions provided influence the outcome of the health and wellness of the patients. Many of the interventions used are based on tradition versus solid science (Zauszniewski, Suresky, Bekhet, & Kidd, 2007). On the other hand, nursing leaders as well as regulatory and government agencies are insisting that nurses incorporate an evidence-based approach for selecting interventions provided to their patients. Best evidence should verify nursing actions and decisions are appropriate, cost-effective, and leading to the best possible outcome for the patient (Polit & Beck, 2012). The Institute of Medicine (IOM) recommends that by 2020, 90% of all health care decisions made by providers be evidence-based (Melnyk, Fineout-Overholt, Stillwell, & Williamson, 2009). Nurse educators in the clinical setting face the dilemma of how to change nursing behaviors that use tradition as the foundation for providing care to practice that incorporates evidence-based clinical decisions.

Nurses who care for psychiatric patients are no different than nurses in other specialties and often choose interventions that were previously learned through tradition. Psychiatric nurses tend to utilize interventions learned earlier in their career, which may be based on tradition, nursing intuition, or the consensus of the nurses working in the department (Zauszniewski et al., 2007). These interventions may sometimes be successful, thus leading the nurse to believe they are beneficial for the patient, but there is seldom evidence that supports this conclusion. The result of these unsubstantiated conclusions is that psychiatric nursing practice continues to be unsupported by current literature, and may even include questionable nursing practice (Stuart as cited by Zauszniewski et al., 2007).

It is the role of nurse educators based on psychiatric units to take up the charge to create change in the practices of psychiatric nurses. There are several challenges faced by these nurse educators in the effort to convince psychiatric nurses to adopt an evidence-based foundation for practice. One such barrier is the dearth of high-level research to support practice decisions. A bulk of the current research in psychiatric nursing is descriptive and correlational, and there are no models of nursing psychotherapy that are evidence based (Stuart as cited by Zauszniewski et al., 2007).

Learning opportunities that utilize Transformative Learning theory may prove to be useful in promoting a change in the psychiatric nursing practice. The use of Transformative Learning theory assists the learner to actualize the new information through a change in his or her own perspective and ultimately to recognize the need to change practice (McGonigal, 2005).

This article describes the use of Transformational Learning theory to create an educational opportunity for nursing staff intended to challenge current practice and facilitate a change in the use of restraint and seclusion as a nursing intervention. In this case, the goal of transformative learning was to change the nurses' attitude about the importance of incorporating current evidence into the care of psychiatric patients. Generally, the goal was for actualization of the information to lead to behavior change of the psychiatric nurse, which would include implementing interventions that are supported by sound scientific data. The specific aim of the educational event was to decrease the use of seclusion and restraint and replace seclusion and restraint with evidence-based nursing interventions, which are supported by the framework and principles of trauma-informed care.

Literature Review

A thorough literature review was conducted in order to create a solid foundation of evidence for this educational event. Two separate searches were conducted to establish the evidence for both the practice and for the educational effort needed to create a change in practice. The literature searches used the Cochrane Library, CINAHL, PubMed, and Psych Info as appropriate for the terms being searched to access relevant articles. The first search used key words "trauma informed care", "psychiatric hospital", "physical restraint", "patient seclusion", and "psychiatric patients". This search resulted in a total of 5 articles. The second search used keywords "transformative learning theory", "adult education", and a combination of both for a total of 5 articles. Articles were limited to those written in the English language and published after 2000. Due to the low number of pertinent results, no further limits were placed. Additional relevant literature was identified from reference cited in the identified literature. (Table 1). See full details of literature review in Appendix B.

Table 1.

Search 1	**Results-Number of Relevant Articles**
The Cochrane Library	1
CINAHL	1 (Relevant article identified by Cochrane)
PubMed	1 (Relevant article identified by Cochrane)
Psych Info	6 (Inclusive of relevant article identified by Cochrane)
Search 2	**Results-Number of Relevant Articles or Books**
CINAHL	10
PubMed	11 (6 articles inclusive of articles identified in CINAHL search.
Relevant literature identified from references cited in above literature	3 articles 5 books

Tradition or Evidence?

Leaders in healthcare demand that nurses develop and utilize evidence-based practice in providing patient care. Clinical decisions made by nurses must be supported by a systematic use of the current best evidence to lead to positive patient outcomes (Zauszniewski et al., 2007). Unfortunately, this is not currently the case for a variety of reasons that will be briefly discussed. Nursing is an aging profession with the average age of nurses being 47 years old. This is a barrier to using evidence as the foundation for their nursing care because most of these nurses were educated before the concept of evidence-based practice was part of the nursing curriculum (Caldwell, 2012). Consequently, many may practice based on information and standards from more than 30 years ago resulting in selection of nursing interventions based on trial and error or a random application of interventions, rather than those which are based on sound scientific data and principles (Zauszniewski et al., 2007). Although these traditionally based interventions might have seemed to be successful when caring for patients in the past, at times these nursing interventions are questionable in safety and effectiveness, and there is little, if any empirical basis for using them (Zauszniewski et al., 2007).

In 2003, the President's New Freedom Commission on Mental Health discussed the need to develop and implement an evidence-based platform for psychiatric nursing practice. Psychiatric nurses are called to cultivate an evidence base for their practice in order to provide safe and effective nursing care. Education is paramount to achieve this goal; however, the pedagogic approach must include not only the subject matter, (i.e. evidence based treatment and interventions for the mentally ill), but also be directed at changing the attitude and behavior of the psychiatric nurses.

Health care teams on acute care psychiatric units have been challenged by regulatory agencies and professional and advocacy groups to decrease or eliminate the use of seclusion and restraint of psychiatric patients by nursing staff (Barton, Johnson, and Price, 2009). Although it has been an accepted practice on psychiatric units to utilize seclusion and restraints to prevent patients from injuring themselves or others (Ashcroft & Anthony, 2008), recent studies identify the practice as harmful and traumatizing to the patient (Chandler, 2008). Current literature documents effective strategies to manage patient behavior without the use of seclusion or restraints (Chandler, 2008). Educators in the psychiatric settings must create educational events to inform the nursing staff of current evidence that supports a practice change in which the use of seclusion and restraints is reduced or eliminated. Equally important to providing factual and subject specific information is the necessity to create a change in the nursing staff's perspective on use of seclusion and restraints. This pivotal transformation in attitude about this practice, which has been relied upon in the past by nursing staff for managing aggressive and violent patients, now must be regarded by nursing staff as the last resort or even an unacceptable intervention (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010).

Trauma-informed care is a philosophy of care that recognizes the patients' past experiences and the impact these past experiences play in the patients' current negative behaviors (Chandler, 2008). Developing a culture of trauma-informed care on a psychiatric unit begins with the education of staff on the principles of this philosophy (Chandler, 2008) and can lead to the decrease of seclusion and restraint events (Borckardt et al., 2011). Transformative Learning theory is an appropriate framework to use in this type of educational event as it motivates the nurses who are adult learners to use cognitive processes to change their perspective and to use this new viewpoint to guide future practice (Keating, 2011).

Transformative Learning Theory

Providing an adult with new information does not guarantee that the learner will actualize or even remember the new information. To be useful, new information often must replace skills and knowledge that an individual has implemented with success in the past. Use of the Transformative Learning theory assists the learner to actualize or objectify new information by changing the learner's viewpoint (McGonigal, 2005).

Learning involves interpretations of new events or information that either reinforces previous beliefs or forces the creation of a new and different view of the world (Mezirow, 2000). The adult learner has a set of past experiences and personal views that is used to interpret current experiences and judge the importance of new information. Mezirow stated "the most significant learning experiences in adulthood involve critical self-reflections—reassessing the way we have posed problems and reassessing our own orientation to perceiving, knowing, believing, feeling, and acting" (Mezirow, 2000, p. 13). The learner who critically examines his expectations, revises these expectations based on the critical review, and then acts on the revised point of view, has experienced transformative learning (Mezirow, 2000). McGonigal (2005) described a series of conditions or experiences that facilitate the transformation of a learner's perspective. Five distinct experiences sequentially occur in a transformative learning experience.

1. An activating event may be any occurrence that leads the learner to look at their perception and thinking, which may lead to the realization of limitations in their understanding of the event.
2. The opportunity for the learner to identify current assumptions regarding the individual knowledge about the particular topic.

3. The learner is motivated to critically reflect on the origination of the assumptions and the resulting influence on the accuracy of the perceived knowledge.
4. The learner's critical reflection provides an opportunity for critical discourse between learners or educators regarding new thoughts and ideas pertinent to the activating event.
5. The learner has the opportunity to practice or test the new attitude and perspective.

While there is no specific plan that will assure the learner of a transformative learning experience, the above experiences are most likely to create the environment for the learner to challenge and revise their assumptions and adopt and implement a new perspective (Cranton, 2006).

Nurses have had to adapt to a rapidly changing world, which requires that the role of learner be a constant in nursing practice. Transformative Learning theory explicates the adult learning process of revising or replacing prior learning with new learning or new interpretations of events or behaviors (Taylor, 2008). Educational events utilizing Transformative Learning theory facilitate learning by creating an experience that allows each learner to establish a common base of information from which to reconstruct meaning from reflection and discussion with others (Taylor, 2008). It is critical reflection that allows the learner to rationally examine his or her current assumptions and to become aware that these assumptions may no longer be valid (Mezirow as cited in Taylor, 2008). The psychiatric nurses in our institution practiced in the traditional manner, similar to the practice described in the literature (Zauszniewski et al., 2007), and did not consistently utilize an evidence-based practice. Because of this, Transformative Learning theory was selected as the theoretical basis for development of this educational event with the goal to facilitate the change in the psychiatric nurses' perspective and choice of nursing

interventions. The remainder of the article will detail development and evaluation of the educational offering, which utilized transformational learning to facilitate change in the attitudes of nurses related to the practice of implementing seclusion and restraints.

Creating Evidence Based & Transformative Learning Opportunity

The purpose of this evidence-based educational event was to initiate change in the current practice of nursing staff from four mental health units of one urban hospital. The offering, grounded in Transformative Learning theory, presented principles of trauma-informed care. Because an evaluation survey was planned to determine changes in perspective, the protocol was submitted to a university Institutional Review Board for approval prior to implementing the educational offering and evaluating its effectiveness.

The educational offering was presented to eight nursing staff members serving on the hospital's Restraint Advisory Committee and also to five nursing staff members of a mental health professional practice council. The organization of the program was based on the steps to create a transformational learning environment previously described. Evaluation of the effectiveness of the educational offering was studied by data collected through the voluntary completion of a brief, qualitative survey. Following the educational activity, the participants were asked to identify if they would consider changing the nursing interventions used for volatile patients and reasons that they would or would not consider changing practice.

Like most nurses, the nurses at this urban tertiary care hospital strongly values clinical excellence. Planning for this effort aimed at changing current practice began with the participant's review of the American Psychiatric Nurses Association Standards of Care, with particular focus on the nurse's responsibility to maintain a safe and therapeutic environment for caring for patients. Through this lens, participants evaluated the current practice of utilizing

seclusion and restraint as a nursing intervention and discussed regulatory agencies recommendations to reduce if not eliminate the use of these practices in psychiatric settings. This review began to create the dissonance, which is characteristic of an activating event. Specifically, the perception that use of seclusion and restraint created a safe and secure patient care environment was challenged by evidence of high numbers of patient injuries and deaths along with staff injury rates similar to high-risk occupations (SAMHSA, 2010). Ultimately, this activating event helped to expose the nurses' knowledge deficit related to this intervention (McGonigal, 2005).

Exposing the knowledge deficit, while important, was only a beginning. An examination of assumptions held by the nurses was essential to create transformative learning. To uncover current assumptions related to the use of seclusion and restraints with patients, the participants discussed their understanding that the primary rationale for the use of seclusion and restraints was to provide a safe and secure environment for a patient who is not in control of his or her behavior, and also to assure the safety of other patients and staff. The educator challenged this rationale by introducing facts related to both patient and staff safety. Purposely, the participants were confronted with statistics that estimated 50 to 150 deaths occur each year in United States health care facilities as a result of the use of seclusion and restraints (Weiss et al. as cited by SAMHSA, 2010). The use of these measures for the protection and safety of staff was disputed by the review of data that indicated staff employed in the mental health settings have injury rates similar to those workers in high risk industries, such as construction, lumber, and mining industries (Weiss et al. as cited by SAMHSA, 2010).

In order to personalize these statistics, the educator then reviewed the number of injuries that occurred within the institutional staff in the past 6 months during seclusion and restraint

incidents. The rich discussion that followed included thoughtful comments on how behavioral interventions based on unit rules may not always be in the best interest of either patients or staff. The discussion also identified difficulties faced in changing both patient and staff behaviors. Through this reflective process, individual staff members admitted that changing their own behavior when working with a patient who is threatening harm to others would be challenging. This discourse provided opportunities for comparison of the nursing staff's current assumptions regarding appropriate interventions and those supported by evidence. This comparison was important to achieving the second step in the transformational process discussed by McGonigal (2005) and with the goal for facilitating a behavioral change in this practice.

Participants were encouraged to give examples of situations they have personally experienced with aggressive or threatening patient behaviors. Examples of experiences presented by staff members included a patient holding part of a broken chair as a weapon, verbal threats indicating the patient's intent to harm the nursing staff, and a patient stating intentions of self-harm. Specific questions by the educator assisted awareness and identification of emotions experienced by the nursing staff when de-escalating an aggressive patient. The misperception of events by the nursing staff due to their own emotions and past experience, along with the behavioral intensity of the situation were acknowledged by participants as barriers to changing nursing interventions. Participants led these discussions through critical self-reflection and critical discourse (McGonigal, 2005). Specifically, these participants self-directed the discussion to a review of trauma-informed care principles, wondering if earlier and/or different interventions could have prevented injuries. This dialog among participants then progressed to generation of new ideas, in which participants compared current practice with a trauma-informed practice utilizing case studies, and noted the advantages of the trauma-informed practice. This

final experience allowed the individuals to explore a new attitude or perspective and was essential for transformative learning to occur.

Evaluation of Educational Event

Evaluation of the outcome of transformative learning is important to allow for the assessment of the effectiveness of the educational event (Keating, 2011). Evaluation of the effectiveness of this transformational educational event was solicited through an anonymous, voluntary and qualitative survey created by the author. The survey was structured with open-ended questions developed to identify the new knowledge the participants perceived to have acquired from the educational event along with the likelihood of the learner utilizing this information in their practice.

Review and Findings of Evaluations

Qualitative analysis of the surveys was conducted by overall review of the comments and then through sorting and organizing them into the specific steps of transformational learning (See Table A1 in Appendix A). Through the analysis of participant comments it became apparent that following the learning event, participants recognized a disconnect between current nursing interventions used purportedly to provide safe and effective patient care and those supported by current evidence. No participant comment disputed the evidence or the necessity for changes in practice to meet goals of trauma-informed care. Awareness of statistics related to patient deaths per year from restraint and seclusion, along with personalized experiences of local staff injuries seemed to provide a powerful challenge to the assumption that the use of restraints and seclusion was the best measure to maintain patient and staff safety. Participants demonstrated transformed attitude and perspective with expressed agreement that multiple, alternative interventions should be applied prior to the use of seclusion and restraint on a patient.

Limitations

The first major limitation of this evaluation effort was the purposeful selection of participants. The sample of nursing staff for this study consisted of members of the Restraint Advisory Committee and a nursing professional practice council. The purposeful sampling of this project may have created bias in the findings because the members of these committees may have had an investment in the topic. This investment may have increased their motivation to implement alternative evidence-based nursing interventions regardless of the theory behind the presentation. The tool used for data collection presented the second limitation. Data was collected through a brief, author developed qualitative survey, which was not analyzed for validity. The self-report method also may have induced bias. Specifically, the participants who perceived a positive learning experience may have over-estimated the change in their attitude and perspective toward the use of seclusion and restraints. Finally, the qualitative method and small sample size (n=10) prohibits generalization of these findings to the entire population of nursing staff.

Implications for Future Research

Future studies are needed to test the effectiveness of Transformative Learning theory as a framework for educating nurses with the goal of changing practice. These studies would be more robust using a quantitative method and sufficient sample size to enable adequate statistical power. A comparative research design with reliable and valid methods to collect data and sufficient statistical power would improve the evidence related to the influence of transformative learning events in changing attitudes and behavior of nurses to meet the level of scholarly inquiry expected in current nursing practice.

Conclusion

The principles of Transformative Learning theory provided an effective framework for assisting the participants in this educational event to acknowledge false assumptions in current practice. The identification of the false assumptions created discomfort with their existing nursing practice and critical evaluation of this current practice led to discussion of the need to adopt evidence-supported interventions.

Interestingly, all staff participating in this event had attended a mandatory annual education event in the past 12 months, which focused on the management of the aggressive behavior of patients. Standard information on the definition and the principles of trauma informed care was offered to staff during annual mandatory education sessions. Yet participant comments on the surveys and during discussions indicated that some of the participants did not even recall this topic as part of mandatory education. The upshot of this unintended discovery might be to consider that the effectiveness of an educational event depends on engaging participants with passion and critical analysis versus passive delivery of facts. In contrast, it appeared that the mandatory education presentation was structured with passive lecture and did not generate the emotions and critical review, which was central to the learning process described in this paper.

Psychiatric nursing faces many challenges in moving to the implementation of an evidence-based practice. Changing practice from utilizing interventions that are based on tradition to care based upon empirical evidence presents great challenges for the clinical nurse educator. The use of the Transformative Learning theory as the framework of this educational

event for the psychiatric nurses provided an effective format for changing perspective of these psychiatric nurses, which allowed the acceptance of evidence-based trauma-informed care interventions.

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Appendix A
Qualitative Survey Comments

Activating Event	**Evaluation Comments from Nursing Staff**
-Review of Psychiatric Nurses Standard of Care including the nurse providing/maintaining a safe and therapeutic environment -Review of SAMHSA's 2003 recommendation to eliminate all use of restraint and seclusion	-What is trauma-informed care anyway? -Other facilities have used trauma-informed care effectively…so can we.
Identification of Assumptions	
-Challenged the assumption that the use of restraint and seclusion is to provide patient and staff safety with number of patient deaths and the number of staff injuries	-Emphasis on the trauma that restraint/seclusion can create for the staff and the patient experience in a restraint made me think about what I choose to do…. (with an escalation in a patient's behavior). -50 to 150 deaths per year occur from restraint and seclusion--seclusion and restraint needs to be seen as a high risk for patient and staff safety. -We need to stop, listen, and really think about what this patient is going through, and have on-going communication. The correlation between deaths and the use of restraints and seclusion was unexpected.

Critical Reflection	
-Principles of trauma-informed care reviewed	-It is interesting to think that if we decrease our seclusion and restrain incidents, we improve the quality of our patient care. - Even simple changes in the environment can prevent a conflict between staff and patients. - I loved the idea of 'continuous respect' during our patient interactions rather than a focus on 'control' of the patient. - I think it is helpful to have a more preventative approach (re: violent behaviors) to working with our patients in mental health. - The importance of the safety plan as a prevention strategy along with the formal debriefing should be implemented. - The focus of safety planning and the use of CBT and DBT keeps the patient accountable for their own behaviors
Critical Discourse	
-Discussion between staff facilitated using recent restraint and seclusion incidents and identifying options and interventions supported by evidence in the literature -Discussion between staff regarding staff emotions influencing choice of nursing interventions	-Keep the goal of 'hands off' approach in mind for safety rather than using restraints. -The caregiver is looking at the patient's behavior in a holistic way-to see more than just the behavior…you react differently. -We need understanding and compassion for the patient's trauma in their lives and how that trauma greatly impacts their reaction to the environment. We can't help the patient if we are afraid.
Opportunity to Practice New Perspective	
-Scenarios of patients' behavioral escalation and nursing interventions chosen prior to presentation of trauma-informed care principles were reviewed with discussion on implementation of the trauma-informed care principles changing the chosen nursing intervention	-The scenarios given at the beginning of the presentation, and then again at the end really gave specific ideas of how changes in staff perceptions of events impacts the intervention. -The exercise with the individual scenarios had a great impact on how gathering collateral data/background information affects the staff's response to patient behaviors. -We have to reduce our stereotyping of patients based on diagnosis and background. We need

	the preventative approach when working with mental health patients. -The individual scenarios show how gathering collateral data can affect the staff's response to the patient's behavior. -Trying to keep 'situations' that arise 'hands off'. -I will look at dramatic or manipulative behaviors differently now.

Appendix B

Article Matrices

Author (Year) Title/ Journal	Purpose Objective	Study Design	Sample (Setting)	Data Collection/ Methods	Measurement Data Analysis	Results/Findings Implications	Strengths/Limitations
Borckardt, J., Madan, A., Grubaugh, A., Danielson, C., Pelic, C., Hardesty, S., Hanson, R. Herbert, J., Cooney, H., Benson, A., Frueh, B., (2011) Systematic investigation of initiatives to reduce seclusion and restraint in a state psychiatric hospital. Psychiatric Services Level I	The purpose of the study was to examine the effect of an action plan of behavioral interventions on the rate of restraint and seclusion in an inpatient psychiatric hospital.	A variant of the multiple-baseline design Allowing for randomized assignment of interventions across inpatient units and the ability to control for the effects of time, implementation order, and institutional placebo effects, such as observation effects and the unit administration's commitment to change. Authors state this is a randomized controlled study.	Patients and staff at five inpatient units at one psychiatric hospital. All patients and all staff on these units between the study dates of January 2005 and June 2008 were included in the study. No exclusion criteria. Independent variable: education on trauma informed care, rules and language, and patient involvement in treatment planning; and implementing changes in physical environment. Dependent variable: Rate of seclusion and restraint incidents.	*Each unit was assigned an 11-month baseline observation phase, a 2-year implementation phase, and a 6-month follow-up phase. *Each unit served as own control. *Each unit implemented the same interventions over time, but in a different order. *The observation phase with the randomization plan of implementing interventions provided strong control in a real-world setting. *Control: Observation phase *Intervention: Education on trauma informed care, rules and language, patient involvement, and physical changes in environment, *Dependent variable: Rate of restraint and seclusion per patient day per unit.	*Patient and staff completed a Quality of Care form before and after each intervention. This form measured perceptions of the physical environment, trauma sensitivity of the staff, and patient involvement in treatment planning. Paired-sample t tests examined changes in staff QOC rating, One-tailed independent t tests were used to examine changes in patient reported factors due to different patients pre and post intervention *Each unit's monthly data on restraint and seclusion was the primary measure of response to the intervention. Mean seclusion and restraint data	*No statistically significant changes noted in staff QOC ratings after any intervention *Patient ratings of the environmental changes and their involvement in treatment planning increased significantly after intervention. *82.3% (p=.008) reduction in use of restraint and seclusion from baseline to follow-up phases.	<u>Strengths</u> *RTC *Large sample 89,783 days (01/2005-06/2008) *Study design used randomized interventions on units &controlled effects of time, intervention order, 'placebo', & leadership * Unit was own control *Interventions standardized, implementation of study standardized on all units *Use of one-tailed, independent t-test, two-tailed independent t-test &SEM analysis on QOC scores = appropriate when compared with Polit & Beck (2012) Guide <u>Limitations</u> *Staff & patients perceptions were not consistent *Implementation of a corporate intervention *Study only at one site

Author (Year) Title/Journal	Purpose Objective	Study Design	Sample (Setting)	Data Collection/ Methods	Measurement/ Data Analysis	Results/Findings/ Implications	Strengths/Limitations
Azeem, M. W., Aujla, A., Rammerth, M., Binsfield, G., Jones, R. B. (2011) Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and adolescent psychiatric hospital. Journal of Child and Adolescent Psychiatric Nursing Level II	The purpose of the study was to assess if the education of staff and the implementation of six strategies- Leadership vision Use of data for practice change Staff development on principles of trauma informed care Use of seclusion and restraint reduction tools Patient and family involvement in treatment planning Debriefing technique -decreased the use of restraints and seclusion in	Retrospective data collection from medical records of pediatric patients who had been hospitalized on a 26 bed psychiatric unit. Data collected over a 3-year period-July 2004 to March 2007.	All patients between the ages of 6 to 17 hospitalized on psychiatric unit of state hospital from June 2004 to March 2007. (458 patients) No patients during this time frame were excluded. **Independent variable:** the implementation of the six strategies **Dependent variable** The number of seclusion and restraint incidents	Records were reviewed and data collected on each use of seclusion or restraint. Data collected: Age, gender, race, admission date, diagnosis, unit, time of seclusion or restraint, staff involved, injuries to patient or staff **Control:** Data collected prior to intervention **Intervention:** Senior Leadership setting goal to reduce seclusion and restraint episodes Review of statistics on seclusion & restraint Staff education on trauma informed care & de-escalation techniques Patient and family involved in plan Debriefing after seclusion or restraint incident **Dep Variable:** Number of restraints or seclusions	Review of restraint and seclusion data first 6 months of study: 93 episodes of seclusion or restraint on 22 patients Final 6 months of study: 31 episodes of seclusion or restraint on 11 patients	Marked reduction in both the number of seclusion and restraints and the number of patients involved in these incidents. Authors note data in one quarter in 2005 increased, but was explained by one patient requiring numerous restraints over a difficult Christmas/New Years holiday time. Study shows implementation of intervention leads to a decrease in restraint and seclusion incidents Note: study did not put this data into statistical format. Study presented data on a graph to demonstrate downward trend in incidents.	**Strengths:** -Results demonstrate the 6 inventions, which include trauma informed care principles decreased the numbers of restraints and seclusions and the number patients involved. -Identifies the importance of leadership involvement -Units were own control -Results are logical based on interventions **Limitations:** -Only pediatric patients -Only one hospital -Authors note one unit also implemented a CBT program during this time period and difficulties maintaining a steady census -6 components to implement=big project -Lack of statistical interpretation of results-why? Possibly due to census? Was sample size not adequate?

	state hospital setting						
Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
Ashcroft L., Anthony, W. (2008) Eliminating seclusion and restraint in recovery-oriented crisis services. Psychiatric Services Level II	The purpose of this descriptive study was a comparison of the number of seclusion and restraint episodes prior with the number of seclusion and restraint episodes after the implementation of an intensive staff training and organizational change program	Descriptive Retrospective data collection from two crisis centers compared with data collection from same crisis centers after implementation of staff training and organizational change program. Total data collection was over a 58-month period.	All seclusion and restraint episodes during this 58-month period were included in study.	Records were reviewed and data collected on each use of seclusion or restraint monthly by the quality department. Control: Number of seclusion and restraint episodes complied monthly prior to intervention. Intervention: Implementation of staff training and organizational changes identified to support staff training. Dependent variable: Number of seclusion and restraint episodes after intervention.	Purely descriptive comparison of number of seclusion and restraint episodes before and after intervention. No inferential statistics.	Review of results suggests that elimination of seclusion and restraint episodes is a legitimate goal for psychiatric facilities.	Strengths: -Significant length of time for comparison of seclusion and restraint data both prior to and after intervention. -2 crisis centers compiled data. Limitations: -Purely descriptive study -No inferential statistics were used to support outcome. -Population served may not generalize to all psychiatric facilities.
Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
Chandler, G., (2008). From traditional	The purpose of this qualitative study was to provide a	Qualitative Descriptive	8 direct care staff 2 administrative staff Purposely	Individual interviews Participants were asked, "What was your experience in	Verbatim transcripts were analyzed by inductive content analysis. The inductive content	Sharing and educating patients and staff on impact of a history of trauma	Strengths: -Rigorous analysis of qualitative data

inpatient to trauma-informed treatment: Transferring control from staff to patient. Journal of American Psychiatric Nurses Association. Level II	description of experiences from staff that had successfully transitioned from traditional care to trauma-informed care treatment.		recruited from 20-bed inpatient psychiatry unit. 12 years or more experience on this unit as these staff had experienced the transition from the traditional program to the trauma-informed program.	reducing symptoms under the traditional model and the trauma-informed treatment model?" Participants' responses were recorded and transcribed verbatim.	analysis consisted of nine steps and occurred following each interview. Confirmability was used as a measure of scientific rigor. This was determined by auditability, credibility, and fittingness.	on current behaviors of patient is key to creating a safe environment. Providing a safe environment with a collaborative staff-patient relationship may lead to a decrease in restraint and seclusion episodes. The change from traditional to trauma-informed care requires a cultural change from the individual to the top organizational level.	Limitations: -Small sample size -One facility -Lack of inferential statistical analysis
Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
Barton, S.A., Johnson, R., & Price, L.V. (2009). Achieving restraint-free on an inpatient behavioral health unit. Journal of	The purpose of this article is to describe how a psychiatric unit in a private hospital became restraint-free.	Descriptive, longitudinal study of the implementation of the National Executive Training Institute of the National Association of State Mental Health Program	26-bed psychiatric unit of a private, nonprofit community hospital.	Restraint data reviewed and compared for each fiscal year beginning with 2001-2002 through 2007-2008.	Total number of patients restrained per year presented in graph. Year # of restraint 2001-2002=19 2002-2003=5 2003-2004=8 2004-2005=9 NET Training Occurred 2005-2006=4	The application of person-centered and trauma-informed care principles by staff make a restraint-free environment possible.	Strengths: Concrete data that correlates the reduction of use of restraints following NET training. Limitations: -Possibility of other variables such as change in patient population, medication use, or change in personnel

Psychosocial Nursing Level II		Directors.			2006-2007=3 2007-2008=0		creating the reduction in restraints.
Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
Allen, M.H., Carpenter, D., Sheets, J.L., Miccio, S., & Ross, R. (2003). What do consumers say they want and need during a psychiatric emergency? Journal of Psychiatric Practice Level II	The purpose of this study was to better understand consumer experiences and preferences during a psychiatric emergency.	A qualitative study obtaining results from a consumer survey and comments and discussion from 4 consumer workshops held in four different geographic locations in the US. Poughkeepsie, NY; Syracuse, NY; Marshalltown, IA; & Los Angeles, CA. The same 2 individuals moderated workshops in all locations.	n=59 Sample was a convenience sample of individuals willing to participate and contribute to the workshop. Participants must have had at least one emergency psychiatric experience involving medication, seclusion, and or restraint. Participants had to be able to tolerate a daylong experience and be willing to share their emergency services experience both verbally and in writing.	Participants completed a 43 question written survey. During the workshop, participants were asked to write recommendations for improving emergency services. After a review by the individual and a small group of participants, each participant selected the top 3 recommendations.	Survey responses were grouped into 21 categories. Comments made in writing and/or verbally during workshop were also placed into the 21 categories.	Participants generated 571 recommendations for improving psychiatric emergency care. Consumer preferences and recommendation agreed with mental health professionals who had previously completed the survey and workshops.	Strengths: -Study obtains data from psychiatric consumers. -Large sample -Data collected from 4 areas of the country. Limitations: -A sample of convenience with all participants either involved in consumer advocacy and support organizations, or known to and invited by individuals associated with above organizations. -Participants had to tolerate a daylong workshop and be able to discuss their emergency service experiences both verbally and in writing. This may not be representative of the population that utilizes psychiatric emergency services.

Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
Delaney, K.R., (2006) Evidence base for practice: Reduction of restraint and seclusion use during child and adolescent psychiatric inpatient treatment. Worldviews on Evidence-based nursing. Level I	The purpose of this review of current literature is to determine the current state of evidence supporting the restraint reduction efforts with children and adolescents.	Studies were reviewed and critiqued that related to restraint reduction, restraint reduction methods, and aggression management of children and adolescents.	Literature less than 10 years old, written in English or a translation to English available, data based, addressing restraint, seclusion, or aggression management of individuals under the age of 18.	Review of literature. Complied results of literature into categories of multi-method reduction approaches, restraint reduction through skill development, restraint reduction through aggression management, & PRN medication use.		Viewing restraint and seclusion as emergency procedures rather than interventions shifts clinical inquiry to judgment of appropriateness. De-escalation techniques have become central to restraint reduction efforts. However, there are few interventions to address challenging situations with highly aggressive children and adolescents. Multi-method approaches to de-escalating children and adolescents shows promise to achieve the best results. Environment of care is an important aspect of aggression	Strengths: - Review of 109 articles discussing restraint and seclusion of children and/or adolescents. -Summarizes data concisely. Limitations: -No statistical support for recommendations. -Medline, PsycINFO, CINAHL were search engines utilized by one researcher.

						management.	
Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
Donat, D. C. (2003). An analysis of successful efforts to reduce the use of seclusion and restraint at a public psychiatric hospital. Psychiatric Services Level II	The purpose of this study was the evaluation of a variety of intervention s that contributed to reduction in seclusion and restraint episodes in public psychiatric hospital.	Analysis of monthly restraint & seclusion data from 1997 to 2002. Independent variables: change in criteria for administrative review of seclusion and restraint episodes, development of a behavioral consultation team, enhancement of standards for behavioral assessments, improvement in staff/patient ratio.	Adult psychiatric patients in public psychiatric hospital during July 1997 through June of 2002.	Monthly data of number of restraint and/or seclusion episodes divided by the monthly census correlated with independent variables.	Stepwise inclusion method used for multiple regression analysis.	The administrative review of restraint and seclusion was the most important factor in the reduction of seclusion and/or restraint episodes.	Strengths: -Administrative review was the only variable that decreased use of restraint and seclusion. This is an intervention that can be easily implemented in most facilities. Limitations: -Difficult to maintain consistent patient population. -Variables were implemented over periods of several months. -Turnover in direct care staff.
Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
Borckardt, J. J., Grubaugh, A. L., Pelic, C. G., Danielson,	The purpose of this article is a review of	Review of literature that specifically evaluated effort	Review of literature through the use of Medline and			- Assessment of programmatic effort to reduce seclusion and	Strengths: -Review of 50 articles from the literature.

C. K., Hardesty, S J., & Frueh, B. C. (2007) Enhancing patient safety in psychiatric settings. Journal of Psychiatric Practice Level II	available literature to reduce episodes of seclusion and restraint.	to reduce seclusion and restraint on psychiatric units.	Psycinfo.			restraint is lacking. -Lacking from the published literature are randomized controlled studies. Recommend evaluation of change in the following dimensions on number of restraint and seclusion episodes. -Patient perceptions, reaction, and satisfaction. -Process outcomes (medications, PRN medication). -Clinical outcomes-length of stay, clinical improvement. -Staff perceptions -Objective indicators related to staff work experiences -Variables related to cost of care. Recommendation: Changes to physical environment to foster a sense of	Limitations: -Difficult to make the connection between the literature review and the recommendations. The engagement model is not connected to the first part of the article, which is the review of literature with recommendations for more robust studies of variables in restraint and seclusion episodes and their impact on reducing these episodes.

						community and safety for patients. Patient involvement in treatment planning, trauma-informed care philosophy.	
Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
Hammer, J. H., Springer, J., Beck, N. C., Menditto, A., Coleman, J. The relationship between seclusion and restraint use and childhood abuse among psychiatric inpatients. Journal of Interpersonal Violence. Level II	The purpose of this study was to clarify if the presence or absence of childhood sexual or physical abuse differed in the number of episodes of seclusion and/or restraint from patients without this history.	Retrospective, descriptive, quantitative design.	N=622 Data compiled from archival medical records of a 496 bed forensic and long-term care state psychiatric hospital. Participants were hospitalized for over 60 days during the time period between 9/2001 and 9/2006.	Data compiled from archival records. Documentation of presence or absence of both childhood physical and sexual abuse for each participant. Documentation of episodes of seclusion and/or restraint for each participant, and rated as low (never or rarely secluded and/or restrained), moderate (initially high rate of seclusion and /or restraint but use diminished after 6 months), and high (high rates of seclusion throughout entire hospitalization). Presence or absence of abuse was coded on a 5 point scale with 0=no history, 1=abused once, to	Pearson chi-square test compared distribution of proportion of presence or absence of abuse among the 3 classes of seclusion and/or restraint use. Followed up with Pearson chi-square with Bonferroni-adjusted significance levels to compare each group. Differences in chronicity of abuse among the 3 groups assessed with Kruskal-Wallis nonparametric analysis of variance tests. Follow up Mann-Whitney *U* tests with Bonferroni-adjusted significance levels	Inpatients who experienced the highest rates of seclusion and/or restraint over time were significantly more likely to have experienced childhood physical and sexual abuse. These patients also experienced more chronic abuse than those with less frequent use of seclusion and/or restraint.	Strengths: -Large sample over long time period -Rigorous statistical analysis to correlate data with conclusion Limitations: -Population of forensic, long-term state facility may not portray accurate representation of small, private hospital population. -Data compiled from historical records based on history given by patient. No ability to verify information.

				5=abused throughout most of childhood and adolescence.	to compare each group with the other two.		
Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
Barclay-Goddard, R., King, J., Dubouloz, C., & Schwartz, C. E. (2012). Building on transformative learning and response shift theory to investigate health-related quality of life changes over time in individuals with chronic health conditions and disability. The Archives of Physical Medicine and Rehabilitation. Level IV	The purpose of this article was a compare & contrast of transforma-tive learning and response shift with the use of 2 case studies.	Review of literature. Use of clinical scenarios to identify concepts in current practice.	Authors self selected 2 case studies to identify concepts discussed in the literature.	Clinical record and narratives of provider/client interactions.	Discussion and comparisons of Response Shift theoretical model and Transformational Learning theoretical model.	Both theories describe a change in perspective after an experience and/or critical reflection. Response shift appears to focus more on behaviors that require a new response, while transformational experiences focus on the learners interpretation of experiences after critical reflection. Discussion includes qualitative research that as documented perspectives can be altered by critical reflection and logical, rational thought.	Strengths: -Clear and concise description and example of transformational learning theory. Limitations: -Authors identify that these two theories are subject of their research, and this could lead to interpretations that others would challenge.

Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
Dirkx, J. (1998) Transforma-tive learning theory in the practice of adult education: An Overview. PAACE Journal of Lifelong Learning.	The purpose of this article is to provide an understand-ing and summariza-tion of major theoretical perspectives of this concept, and to discuss implications for the educator.	Review of the different concepts of transformative learning, and discuss implications for how the educator can facilitate this process.					Strengths: Excellent summary of different theorists on the topic. Excellent discussion on the role of educators in the transformative learning process. Limitation: Not considered evidence for practice.
Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
Cranton, P. (2002). Teaching for transformation New Directions for Adult and Continuing Education.	The purpose of this chapter published in this journal is to assist educators in facilitating adult learning by use of trans-formative learning.	Review and discussion of the types of knowledge, the concepts of the Transformative Learning theory, and the different facets experience by learners as they progress with learning. Discussion of teaching strategies to facilitate this					Strengths: Excellent, easy to understand description of teaching strategies and the theories that support these strategies. Limitations: Not considered evidence for practice.

		process.					
Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
Dirkx, J. (2006). Engaging emotions in adult learning: A Jungian perspective on emotion and transformative learning. New Directions for Adult and Continuing Education.	The purpose of this chapter published in this journal is to explore how educators may learn to use the concept of emotion and affect in facilitating learning.	Review and discussion of the types of theoretical frameworks borrowed from psychology to facilitate adult learning and foster transformative learning.					Strengths: Excellent discussion on utilizing theories from different disciplines to facilitate or augment educational learning theories. Specific discussion on affect and emotions fostering learning (affective domain), as well as emotional intelligence of learner and educator. Limitations: Not considered evidence for practice.
Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
Dirkx, J. (2000). Transforma-tive learning and the journey of individuation. ERIC Digest #223	The purpose of this article is to discuss the perspective on transforma-tional learning by Boyd.	Discussion on how the affective domain – specifically the emotional and spiritual aspects of an individual learner- is underdeveloped in the education of the adult					Strengths: Enlightening discussion on domain often overlooked by the educator, yet a powerful domain in facilitating adult learning. Brief and concise. Limitations: Not considered evidence for practice.

		learner. A review of Boyd's work on understanding the psychosocial, emotional, and spiritual aspects of adult learning.					
Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
McAllister, M., Tower, M., Walker, R. (2005). Gentle interruptions: Transforma-tive approaches to clinical teaching. Journal of Nursing Education.	The purpose of this article is to address problems faced by clinical educators, explain benefits of transforma-tive learning, and discuss specific strategies for building skills of educator.	Discussion includes issues experienced due to the gap between theory and practice, and describes transformative nursing practice, which values the linking of theory and practice. It encourages students to critique and evaluate their assumptions. Article also identifies strategies the educator may utilize to enact transformative learning.					Strengths: Excellent summary of theory and linkage to practice, and strategies to promote critical thinking in learners. Limitations: Not considered evidence for practice.

Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
Herbst, A. M., Swengros, D. J., & Kinney, G. (2010). How to teach human caring: Nurse educator role in transforma-tional learning in a large healthcare system. Journal for Nurses in Staff Development.	The purpose of this article is to identify and offer ideas to nurse educators on methods to teach caring throughout a large healthcare system by us of principles from tranforma-tional learning.	Discussion on educators promoting learning through use of the affective domain, and the challenges the educators identified. Detailed educational plan given as example for other educators. Interesting discussion on lessons learned. Transforma-tional learning occurred not only for staff, but also for the educators.					Strengths: Enjoyed discussion of the educators moving out of their own comfort zone and need to acknowledge their own personal struggles with concepts. Excellent example of enacting transformational learning in a healthcare setting. Limitations: Not considered evidence for practice.
Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
Horton-Deutsch, S., & Sherwood, G. (2008). Reflections: An educational strategy to develop emotionally	The purpose of this article is to explore educational strategies for nurses that focus on the ability to	Review of literature to support adult education that integrates theoretical learning with experiential learning.	58 articles related to topic reviewed.			Article reviews and summarized theories of learning, gaps between theory and experience, and the role of the educator.	Strengths: Review of 58 articles from the literature. Limitations: Authors do not describe literature search.

competent nurse leaders. Journal of Nursing Management.	lead in midst of constant change.	Defines reflection as key strategy for transforma-tional learning.					
Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
Bolkan, S., & Goodboy, A. K. (2009). Transforma-tional leadership in the classroom: Fostering student learning, student participation, and teacher credibility. Journal of Instructional Psychology Level II	The purpose of this study was to examine the relationships between transforma-tional leadership in the classroom, student learning outcomes, and student participation and student perceptions of instructor credibility.	H1=Student perceptions of their instructors' transforma-tional leadership will be positively associated with student learning outcomes including cognitive learning, affective learning, state motivation, & communication satisfaction. H2=Student perceptions of their instructors' transforma-tional leadership will be positively associated with	N=165 students Undergraduates enrolled in one of 8 introductory or upper level communication courses at mid-size Eastern university. Ages=18 to 30 years.	Participants completed 7 instruments in reference to the instructor-identified class. Confirmatory factor analyses were performed on all scales for purpose od determining validity.	Pearson Product-Moment Correlations completed for H1-3.	Moderate to strong positive relationships between the components of transformation leadership and the various instructional outcomes examined in the study.	Strengths: Statistical support of hypothesis 1-3, demonstrating components of transformational leadership produce strong positive associations with all learning outcomes and teacher credibility. Limitations: Study completed at only one university. Small sample size of instructors.

		student participation in the classroom. H3=Student perceptions of their instructors' Transforma0tio nal leadership will be positively associated with student perceptions of their instructors' credibility including their: Competence, goodwill, & trustworthiness.					
Author (Year) Title/Journal	Purpose Objective	Study Design	Sample Setting	Data Collection Method	Measurement Data Analysis	Results Implications	Strengths Limitations
Springer, P. J., Clark, C. M., Strohfus, P., & Belcheir, M. (2012). Using transforma-tional change to improve organization al culture and climate in school of nursing.	The purpose of this article was the description of a 8-year process to change a school of nursing from a climate of dissatis-factiono and distrust to satisfaction and trust.	Development of a Culture/ Climate Assessment Scale (CCAS) to obtain empirical evidence about the climate of this school of nursing. The CCAS was administered to all members of the School of Nursing in 2-	Voluntary participation. All members of the School of Nursing.	CCAS administered every 2 years from 2005 to2011. Data compiled through 2009 for this study.	Comparison of CCAS scores from 2005 to 2007 demonstrated positive change in every area. Example of one area: 2005=48.9% of staff would recommend the School of Nursing as a workplace. 2007=71% would recommend the School of Nursing as a workplace. This	Transformational change strategies provided a successful framework for the implementation of strategies to improve climate of this organization to one of satisfaction and trust.	Strengths: Empirical evidence demonstrating effect of strategies. Limitations: One university. Long span of study may have allowed other factors to influence the change in climate at this organization.

Journal of Nursing Education. Level II		year intervals from 2005 to 2009. Completion of survey was voluntary. During this time, Kotter's model for change provided the theory for strategies implemented by the School of Nursing to change climate of the school.			rose to 75.5% in 2009. Other results in 2009 indicated that the results maintained or improved.		

The Journey to Trauma-Informed Care: Partnering with Patients to Achieve Safety

The View through Rose Colored Glasses

Joan M. Dahlke, BS, RN,BC
University of North Dakota

Topics

- Introduction
- History and Definition of Trauma-Informed Care
- Seclusion and Restraints
- Prevention and Reduction Strategies
- Case Studies
- Conclusion

Case Studies

Bob is a 22 year old male admitted due to suicidal statements made to police after being a participant in physical altercation with 2 siblings in mother's apartment. Patient has history of gang involvement as a teen and is currently on probation for assault.

Bob is on phone, begins swearing and slams down phone. He then shoves chair into wall and is currently pacing and swearing in lounge.

Standards of Practice

"The psychiatric-mental health nurse provides, structures, and maintains a safe and therapeutic environment in collaboration with patients, families, and other healthcare clinicians."

(American Psychiatric Nurses Association, 2007, p. 39)

The psychiatrist, psychiatric nurse, behavioral health associate, social worker, and program therapists all provide, structures, and maintains a safe and therapeutic environment in collaboration with patients, families, and other healthcare clinicians.

History of Trauma-Informed Care

1998-A series of articles reporting deaths occurring while patients were restrained or in seclusion were published. (Barton, Johnson, & Price, 2009)

2002-National Association of State Mental Health Program Directors (NASMHPD) called for a national action plan to increase regulation and decrease use of seclusion and restraints.

(Barton, Johnson, & Price, 2009)

2003- The Substance Abuse Mental Health Services Administration (SAMHSA) and NASMHPD presented a *A National Call to Action: Eliminating the use of Seclusion and Restraint.*

(SAMHSA, 2010)

" the use of seclusion and restraints (are) disgraceful and a product of treatment failure."

(Curie, 2003, p. 6)

"Seclusion and restraints can become a practice of the past if there is leadership, policy and programmatic change, and a denouncing of the belief that seclusion and restraints are necessary."

(Curie, 2003, p. 7)

2004 Trauma-informed care initiatives became the basis for the implementation of the behavioral healthcare reform.

(Barton, Johnson, & Price, 2009)

Assumption

Seclusion and restraints are utilized for the protection of the patient and/or others around the patient.

An assumption is a belief that is supposed to be factual when in reality it may be a myth.

(Nihart, Huckthorn, & Libel, 2003)

Injuries, death, and psychological trauma of patients and staff can be a result of seclusion and restraint.

(NASMHPD as cited in SAMHSA, 2010)

"In the United States each year, it is estimated that 50 to 150 individuals die as a result of seclusion and practices in mental health inpatient residential facilities"

(Weiss et. al as cited by SAMHSA, 2010)

Staff employed in the mental health setting have injury rates similar to those workers in construction, lumber, and mining industries which are all considered high risk industries for employee safety.

(Weiss et. al as cited by SAMHSA, 2010)

Definition of Trauma-Informed Care

"Trauma-informed care is defined as treatment that incorporates an appreciation for the high prevalence of traumatic experiences in persons who receive mental health services; and a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual." (Jennings as cited in SAMHSA, 2010, p.7)

At least 85% of mental health patients have been exposed to trauma. In trauma-informed care, the patient's behaviors are viewed as attempts to cope with current stressors in the context of the patient's past life experiences.

(Chandler, 2009)

Trauma-informed care is a shift from traditional top-down psychiatric care to care that is based on collaboration with the patient.

(SAMHSA,2010)

The move from the traditional medical model of psychiatry to a patient-centered approach with a milieu that is focused on safety defines the journey to a trauma-informed care model of psychiatry.

(Chandler, 2008)

The collaborative relationships between staff and patients form in trauma-informed care , with staff recognizing that information and education are factors important for patients to take control of their lives. (Chandler, 2008)

Individuals with the history of trauma may have developed problematic behavior patterns in an attempt to cope. They may be unaware of their particular sensory needs or stress response to situations. (Champagne & Stromber, 2004)

In the move to the Trauma-informed care perspective, staff shift their perception of patient behaviors as symptoms of the patient's history, and assist the patient in learning new skills to manage their symptoms. (Chandler, 2008)

The patient who is in crisis may be trying to manage their symptoms using negative or inappropriate behaviors due to their past experiences. Managing the current crisis may require learning and practicing new skills. (Giller, Vermailyea, & Steele, 2006)

The philosophy of trauma-informed care supports a variety of treatment techniques, including CBT and DBT. (Giller, Vermailyea, & Steele, 2006)

CBT

"Cognitive Behavioral Therapy focuses on CHANGE... our goal is to help patients learn to change their irrational negative thoughts and replace them with more rational thoughts thereby making their emotions more manageable."

(Conlin, C. 2012, p.1)

DBT

Dialectic Behavioral Therapy adds validation into the therapeutic interactions. "A validating approach seems more effective when dealing with emotionally reactive patients." (Conlin, C., 2012, p.1)

The patient can learn "I can be both emotionally overwhelmed and behaviorally calm at the same time. DBT balances empathy and warm acceptance (validation) with an unwavering focus on changing problem behavior (problem-solving)."

(Conlin, C., 2012, p.1)

Prevention of Seclusion and Restraint

"Each year, it is estimated that 50 to 150 individuals die as a result of seclusion and restraint practices." (SAMHSA, 2010)

"Seclusion and restraint are dangerous not only to the individuals subjected to these practices, but also for the staff implementing them." (SAMSHSA, 2010)

"The focus must be on ensuring S/R is never used in the first place and that the majority of strategies occur in the primary and secondary prevention stages."

(Champagne & Stromberg, 2004)

Strategies

Primary prevention strategies are those that support the creation of environments, attitudes, and activities that reduce the potential for conflict. (NASMHPD, 1999)

Secondary prevention strategies are those designed for immediate use to help resolve conflict when it does occur (NASMHPD,1999)

Tertiary strategies are those that seek to both minimize the effects of the S/R event, as well as analyze the causal factors so they do not occur again.

(NASMHPD, 1999

Primary Strategies

- Program
- Physical environment
- Staff education
- Focus on milieu
- Focus on relationships

(NASMHPD, 1999)

Secondary Strategies

- Safety Plan
- Modify patient environment
- Conflict resolution
- Medication-both PRN and regularly scheduled

(NASMHPD, 1999)

Safety Plan

An individualized tool developed with the patient before a crisis occurs.

Patient identifies things known to set off problem behaviors.

Patient identifies coping strategies for these behaviors before these strategies are needed.

Assists staff in encouraging patient to practice coping skill in time of crisis and reduce risk and trauma experiences for staff and patient.

(Huckshorn, 2004)

A safety plan should be completed with patient as soon as possible after admission-usually 24-72 hours from admission. The goal is for staff to be aware of triggers of problematic behaviors and to establish coping strategies before the crisis.

(Huckshorn, 2007)

Tertiary Strategies

- Show of support
- Respectful behavior
- Continue de-escalation
- Immediate debriefing for staff involved
- Immediate debriefing with other patients
- Formal debriefing

(NASMHPD, 1999)

Debriefing

An analysis of a critical event to examine what occurred and to facilitate an improved outcome the next time an even occurs. (Huckshorn, 2007)

Debriefing Goals

To prevent future events that require seclusion or restraint; to minimize negative effects of the event; and to make any changes that would prevent the use of seclusion or restraint.

(Huckshorn, 2007)

Immediate Debriefing

Immediate- a review of events right after event.

(Huckhorn, 2007)

Formal Debriefing

- Analyze seclusion and restraint event
- Examine what occurred and what can be improved to prevent another event
- Completed next working day after seclusion and restraint
- Management staff to be included with treatment team and patient
- Address specifics of patient care for this event
- Address organizational problems to prevent future events

(Huckshorn, 2007)

Case Studies

Bob is a 22 year old male admitted due to suicidal statements made to police after being a participant in physical altercation with 2 siblings in mother's apartment. Patient has history of gang involvement as a teen and is currently on probation for assault.

Bob is on phone, begins swearing and slams down phone. He then shoves chair into wall and is currently pacing and swearing in lounge.

Conclusion

The strength of our treatment team is our differences... our style of communication, our physical traits, our relationships with our peers and our patients. Our strength is from our different perceptions, being open to new ideas, to rethinking how and why we do what we do.

These traits can be used to our advantage in de-escalation of patients and implementing trauma-informed care.

"I believe education on trauma informed care is the step to least restrictive environments on the units. Most people have no idea about trauma informed care and once you start to educate on it, it starts to make sense. It can be a long process of change however, and I know in St. Peter, things got worse before they started to get better - but in the end there was improvement in treatment on the units."

(K. DeLuca, MSN, PMHNP, personal communication, July 6, 2012)

"Our differences .... teach us how to use the tools and gifts we got"

(Mraz, 2012)

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