THE DEVELOPMENT OF A LEARNING MODULE FOR YOUTH CARE COUNSELLORS WORKING WITH INCARCERATED YOUTH

by

© Roslyn Spurvey

A practicum report submitted to the

School of Graduate Studies

in partial fulfillment of the requirements for the degree of

Master of Nursing

School of Nursing

Memorial University of Newfoundland

April, 2016

St. John's Newfoundland and Labrador

ABSTRACT

Background: A shift toward a rehabilitative model of care has prompted the Newfoundland and Labrador Youth Centre to institute a policy restricting seclusion and restraint as a means of behavioural management. This policy has been received with skepticism by youth counsellors who use these methods to contain disruptive behaviours. Insufficient training in mental health has precipitated feelings of inadequacy as they feel ill-equipped to do their jobs. ***Purpose:*** The purpose of my practicum is to develop a mental health learning module for youth counsellors to reduce seclusion and restraint in youth corrections. ***Methods:*** A literature search illustrated what is known on the topic of seclusion and restraint in youth corrections. Consultation with stakeholders revealed staff attitudes regarding the policy and its operational impact. An environmental scan revealed the availability of other resources intended to address disruptive behaviours. ***Conclusion:*** The learning module is focused on mental illnesses to increase youth counsellors' competency in managing disruptive behaviours while minimizing the use of seclusion and restraint.

ACKNOWLEDGEMENTS

I would like to thank my colleagues at the Newfoundland and Labrador Youth Centre, for their time and invaluable input into this practicum project**.**

To Dr. Khraim, my most sincere appreciation for your guidance, understanding, and support over the last two semesters. You have motivated me to focus on my potential and fostered in me a belief that I could actually achieve my goal.

To my partner Brian, for everything you have done, thank you. It was your encouragement and belief in me that incited me to participate in the Master of Nursing Program. Your unwavering support has carried me through many challenges; from walking the streets of New York City in search of a computer repair store to recover my lost literature review to proof reading all my work and offering words of wisdom, “thank you" does not nearly suffice. I could not have done this without you.

To my Mom, and my sons, Justin, Jake, and Jordan thank you for seeing me through this journey. To Jordan, who pleaded with me several years ago, "please Mom, no more courses,” thank you for your patience and understanding.

To my virtual classmate, Karen Leyte, whom I've never met, my heartfelt thanks for keeping me focused on today. We did it!

Table of Contents

Introduction

Coercive means of behavioural control are commonplace in correctional settings and take the form of restraining devices which limit bodily movements or isolation whereby the individual is removed from the general population and placed in seclusion (Ulla, Maritta, & Riittakerttu, 2012). Institutions marred by aggression and violent behaviours have in their arsenal these restrictive methods only to be employed in the case of imminent danger to self or others. Intended to mitigate self-injurious or assaultive behaviours these tactics have inappropriately spilled over into the areas of punitive disciplinary control, potentially negating their intended safety parameters and offer little in the way of therapeutics. Studies have shown that such procedures are not only dangerous to the client but may have adverse effects on staff as well (Fisher, 1994). Practices such as these have come under considerable scrutiny due to the actual and perceived potential of further deteriorating mental health or death (Mohr, Petti, & Mohr, 2003).

The Newfoundland and Labrador Youth Centre (NLYC) is the only secure custody facility for young offenders in the province. It has the capacity to house 60 youth between the ages of 12 and 18 who are serving remand or secure custody dispositions for criminal offences. Like many other correctional facilities, the use of seclusion and restraint as methods to contain aggressive and disruptive behaviours has been standard practice at the NLYC. As a nurse practitioner with youth corrections, I have witnessed

firsthand the employment of these strategies and every incident instills in me a foreboding sense of hopelessness and inadequacy as troubled youth succumb to control of mechanical vices and seclusion. The cumulative effects of these methods on the young person's mental health are well documented in the literature and blatantly obvious to any care provider familiar with the individual.

Recent research illustrating the perilous consequences of intrusive means of behavioural control has prompted management of NLYC to institute a new policy on seclusion and restraint as they move toward a more rehabilitative model of care. This initiative however, has been met with considerable resistance from youth care counsellors who for years have relied upon the "security" afforded by seclusion and restraint as effective measures of behavioural control. A lack of mental health training and therapeutic counselling skills has precipitated feelings of inadequacy among these front line workers who are tasked with mitigating aggressive and disruptive behaviours in mentally ill youth. A timely buy-in is contingent on a proven plan, one that placates and appeases all parties.

A learning module that highlights the most common mental illnesses in our prison population coupled with therapeutic communication techniques and other practical management strategies has been developed to increase staff competency in managing disruptive behaviours, and subsequent seclusion and restraint. The objectives of the practicum include:

- to assess staff awareness and acceptance of alternate strategies to reduce the utilization of seclusion and restraint
- to assess factors that may impact the development of the learning module
- to identify current teaching resources available at NLYC for their utility in behavioural management
- to develop a learning module that will teach youth care counsellors about mental illness and in so doing to teach them ways to reduce the use of seclusion and restraint.
- to demonstrate advanced nursing competencies contingent with the Canadian Nurses Association (2008).

Methods

The practicum was informed by a thorough literature review and based on consultation with key stakeholders at the NLYC. An environmental scan of available resources influenced the content of the learning module.

A literature review illustrated the dangers of seclusion and restraint in correctional settings and supported the need for my proposed practicum project to develop a learning module that will teach strategies to reduce seclusion and restraint at NLYC. It identified the prevalence of seclusion and restraint used in residential facilities to contain disruptive behaviours and illustrated the need for least restraint protocols. The literature review also enlightened me in my quest for the most appropriate teaching methodologies for adult learners. It identified Knowles' Adult Learning Theory and Robert Gagne's Five Stage

Framework for Instructional Design as guiding philosophies on which to base my learning module.

The consultation process offered multiple perspectives of both seclusion and restraint and of the new policy at NLYC elicited at reducing these measures. Management, clinical staff and correctional workers discussed their roles in seclusion and restraint and voiced their opinions of the new policy. It appeared that there was a divide among these perspectives, with those in favour of the new policy being the furthest removed from direct frontline care.

An environmental scan completed concurrently with the consultation process revealed the availability of alternative resources that albeit intended to foster positive behaviours are ineffective in containing aggressive and disruptive behaviours in mentally ill youth.

Summary of the Literature

A search of the terms “youth corrections” “adolescents”, “juvenile delinquents” and “justice” on Memorial University's CINAHL, PubMed, PsycINFO and Cochrane Library databases resulted in a plethora of information. With over 13000 results, the search was further refined to include “restraint” and “seclusion” and was delimited to include articles written in English and that were original literature. To capture historical data and to gain a greater perspective of the movement to less intrusive measures articles from 1990 to the present were reviewed. The resultant parameters resulted in 75 returns.

The integrated literature review (Appendix A) is a summary of what has been researched pertinent to my topic of interest and has generated themes such as (1) trends of seclusion and restraint in the juvenile justice system, (2) predictive factors for and potential consequences of the use of these restrictive measures, (3) programs augmenting alternatives to seclusion and restraint that other facilities have used and, (4) the role of policy, theory and conceptual frameworks in implementing learning programs. The amenability of selected research to critical appraisal is contingent on criteria of the Public Health Agency of Canada Critical Appraisal Toolkit and is summarized in literature summary tables (Appendix A.1).

Aggressive behaviours abound in correctional settings and most especially among those with mental health issues. In fact, 75% of young offenders have at least one identifiable mental illness (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). Equally as common are methods used to contain behaviours that are threatening to the self or others or disruptive to the operations or security of the institution. Historically, attempts to manage and control such behaviours involved the use of intrusive means such as seclusion and restraint (Ulla, Maritta, & Riittakerttu, 2012). Current literature has condemned the use of these invasive strategies citing overuse and even abuse by custodians authorized in their use (Mohr, Mahon, & Noone, 1998). In fact, correctional facilities in the United States and Canada have reported a 40% and 75% increase in the use of seclusion practices over a five and one year period respectively (Browne, Cambier, & Agha, 2011; Office of the Provincial Advocate for Children and Youth of Ontario,

2015) . Disciplinary reasons were cited as the most frequent reason for seclusion. Restraint use was staggering as well.

The literature highlighted trends in the use of seclusion and restraint and uncovered commonalities among youth profiles that dictated its use. It was reported that these measures were more often used with young females, of African American descent and with a mental health diagnosis (dosReis et al., 2010). U.S. statistics pertinent to restraint-related deaths are unnerving at 142 deaths over a ten-year period. These deaths were more common in young males with a history of mental illness (Weiss, 1998). Like seclusion, restraint use was most commonly used for noncompliance with staff demands.

Other consequences were found to be associated with the use of seclusion and restraint as well. Notwithstanding the potential for staff injury and physical injury to the child, other consequences are equally detrimental. The psychological aftermath of seclusion and restraint has largely been ignored in the youth demographic due to their covert nature but are of late beginning to be a focus of clinicians in the field. The use of seclusion and restraint has been reported to result in feelings of fear and abandonment, humiliation, confusion, and retraumatization of those who were physically or sexually abused (LeBel et al., 2004). These sequelae may be more precarious in the mentally ill child.

The grim realization of the devastating effects of seclusion and restraint use paints an ugly and ironic portrait of the safety system within the institutions designed to protect our troubled youth. Consistent with these findings, correctional facilities are now

endeavouring to move toward a least restrictive approach that emphasizes rehabilitation in lieu of discipline. Stringent criteria for the use of seclusion and restraint have become the norm. Educational programs and changes in philosophy and culture are spearheading efforts to curtail the use of these intrusive means of behavioural control. Policy changes too are simple but effective ways to reduce the use of seclusion and restraint in residential institutions and are the first steps in realizing a restraint-free environment. Policy change coupled with new care approaches have contributed to dramatic decreases in the use of seclusion and restraint (Donovan, Siegel, Zera, Plant, & Martin, 2003). Pursuant to these findings, many authors contended that seclusion and restraint use by staff was "associated more with culture, tradition and policy than with medical or safety requirements" (Ulla, Maritta, & Riittakerttu, 2012, p. 1401). This finding in and of itself has paved the way toward a least restraint environment and lends itself as an exemplar for other institutions whose vision is a least restrictive environment.

To that end, and congruent with the literature, I have developed a learning module that aligns with the recent policy change at the Newfoundland and Labrador Youth Centre. The material in this module will allow adequate understanding and subsequent management of mental illnesses and serves as the quintessential restraint and seclusion reduction initiative. The learning module was based on the principles of Knowles' Adult Learning Theory and is congruent with the strategies endorsed by Robert Gagne's Instructional Design Framework. The premise of Knowles Adult Learning Theory is the recognition of the adult learner as autonomous, self-directed, and motivated to learn (Mitchell & Courtney, 2005). The theory identifies several elements essential to learning,

all of which are applicable to my target audience and their identified learning needs: (1) need to know, (2) a responsibility for one's own learning, (3) experience as a tool for learning, (4) applicability of the information to one's life situation, and (5) problem-centered learning with real-life problems (Mitchell & Courtney, 2005).

Robert Gagne's Five Stage Framework for instructional design informed the construction and development of the learning module. This conceptual framework postulated requisites of educational materials that incite behavioural change. Simply stated, and congruent with the five stage framework, the learning module was designed to (1) gain attention, (2) present stimulus material, (3) provide learner guidance, (4) elicit performance and provide feedback, and (5) enhance retention and transfer.

Summary of Consultations / Environmental Scan

The consultation process occurred at the Newfoundland and Labrador Youth Centre. The Administrator, Manager of Resident programs, Managers of Services and Operations, Clinical Therapist, Social Worker, Nurse Practitioner (NP), as well as Youth Care Counsellors were interviewed. The complete consultation report is included in Appendix B.

The administrator of the NLYC is the ultimate authority on policy and programming. He is responsible for all operations and accountable to the Department of Justice. The manager of resident programs is in charge of programming and funding and serves as the gatekeeper to statistics on incidents and happenings at the youth centre. She is instrumental to the implementation of the new policy on secure isolation and is

interested to see what alternatives will foreseeably work relative to a new care philosophy at the youth centre. The on-duty manager of services and operations supervises the daily operations of the facility and acts as the immediate supervisor of the youth care counsellors. They must be notified if a youth is put in seclusion or if restraining devices have been employed. Mental health providers (a social worker, a nurse practitioner, and a clinical therapist) were consulted for their expertise on how best to deliver the learning module relative to the identified learning needs of the front line workers and how their knowledge may contribute to this effort. Their input will be used to guide the development of the module. Youth care counsellors are the direct care providers of the youth at the correctional facility. They are uniquely positioned to detect changes in the mental health and wellbeing of the youth imposed by the seclusion or restraint. It is the youth care staff that ultimately decides if these restrictive devices will be used and the duration for which they will be implemented. The correctional staff are the employees at the crux of the conflict at the NLYC whereby they feel alienated by senior staff who have taken away their means to control and protect inmates. It is these staff that must cope with and find alternative ways of behavioural control. They were asked directly about their learning needs and how best to fulfill them.

This group was chosen because they are representative of the disciplines that care for the youth. This demographic offered diverse and comprehensive perspectives of contributing factors and adverse effects of the practice of seclusion and restraint of young offenders. They were contacted via email and invited to participate. Participation was strictly voluntarily.

Interviews were held in the participants' respective offices. Youth Care Counsellors were interviewed in the board room of the administrative office. A semi-structured interview (Appendix B.1) using open-ended questions elicited uninhibited responses and often times guided the next question. Closed-ended questions were used to begin the interview and provided demographical data. Questions were determined by the professional designation of the participant. With verbal consents from the participants all interviews were audio-taped and verbatim handwritten notes were used to supplement the process. Each interview lasted approximately 30 minutes and each subsequent interview, 15 minutes. Data was collected until all necessary information was obtained. Contingent with the Health Research Ethics Authority Screening Tool (Appendix B.2), it was determined that ethics approval was not required.

An environmental scan conducted simultaneously with the consultation process uncovered the availability of a Dialectal Behavioural Therapy. This weekly program is offered to youth residing at the centre, teaching them emotional regulation and distress tolerance. Still in the implementation phases, this program is facilitated by the clinical therapist and is intended to be reinforced by youth care counsellors. A Behavioural Evaluation System is also ongoing at the NLYC and is aimed at reinforcing positive behaviour. This initiative is a points reward system whereby points are rewarded or deducted for positive and negative behaviour respectively and are exchanged for small prizes or unit privileges.

Support related to adopting the new policy of least seclusion and restraint and the availability of alternate resources varied across the disciplines. The results of the

consultation infer that the policy change is least supported by those more directly involved in youth care than for management who are remotely involved, and there exists a divide among these disciplines as to the utility of the policy. Indubitably policy change coupled with dialectal behavioural therapy exposure has resulted in less seclusion imposed on imprisoned youth at NLYC, however issues abound beyond the statistics. As the chain of command descends it appears more issues and concerns surface with the practicality of these resources. Management seemed in favor of the new policy as it resulted in fewer incidents of seclusion and restraint. Clinical staff seemed indifferent toward the policy as it did not significantly impact their job. Correctional staff unanimously agree that these approaches, albeit appropriate as proactive strategies to prevent disruptive behaviours, offer little in the way of teaching the specifics of various mental illnesses are therefore inadequate to curtail violent and aggressive behaviours that mandate seclusion or restraint.

Summary of the Resource

The learning module entitled "Unlocking the Door to Mental Illness: A Learning Module for Youth Care Counsellors" (Appendix C) was informed by the literature review, guided by consultations with key stakeholders and an environmental scan, and based on theory and a conceptual framework. Rimer and Glantz (2005) posited that the use of theory serves as "a foundation for program planning and development (and) is consistent with the current emphasis on using evidence based interventions in public health, behavioural medicine and medicine" (as cited in McKenzie, Nieger, & Thackery, 2013). Advanced practice nurses have in their arsenal theoretical bases and guiding

frameworks from which to plan, develop, and implement health related programs. Knowles' Adult Learning Theory (Mitchell & Courtney, 2005), and the Instructional Design Framework (Kinzie, 2005) are two such paradigms, that when aligned collaboratively offer unparalleled guidance in the development of the learning module.

The elements that Knowles identifies as essential to learning were paramount in the development of the learning module: (1) Need to know; based on research findings that " …as many as 75% of young offenders have at least 1 identifiable mental illness" (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002), it is quite conceivable that youth care counsellors will be expected to work with this demographic during their careers. This module offers basic information on the most common mental illnesses at the NLYC. The knowledge gained from this learning module will enhance their ability to interact therapeutically with mentally ill or aggressive youth and result in more favourable outcomes when they behave disruptively. (2) Responsibility for one's own learning; the self-directed orientation of the learning module recognizes the delicate work - life balance of the youth care counsellor and allows for flexibility of the learning process. (3) The role of experience as a tool for learning; the content of the module builds on the YCC's existing knowledge of mental illness. The scenarios presented are representative of what may be a typical day in youth corrections. (4) Motivation to learn; the overall goal of the module - reducing seclusion and restraint shall result in favourable unit operations, improved professional relationships with the youth, and will ultimately enhance work satisfaction. These propensities shall act as a significant impetus for learning. (5) The content of the module is applicable to the learner's life situation. The prevalence of mental

illness in youth corrections coupled with the learning needs of youth care counsellors identified in the consultations supports the need for mental health education (6) Contingent on this premise then, the content is focused on problem-centered learning with real-life problems. Examples of scenarios with appropriate therapeutic communication techniques are offered to diffuse potentially disruptive behaviours.

Robert Gagne's Five Stage Framework for Instructional Design guided the construction of the module. The strategies endorsed within this framework are theory driven, complimentary to each other and are well suited to engage the audience and encourage learning. (1) The learning module gains attention through the use of an explicit picture of iron bars bound by a lock and heavy chains on the opening cover of the module. This illustration depicts confinement and references the essence of mental illness within the prison population. (2) Present stimulus material; the scenarios presented are interesting, thought provoking and realistic depictions of life in a correctional setting. The learner may be stimulated to continue on with the module to learn how to respond to these typical situations. (3) Provide learner guidance; the module begins with an introductory preface that explains the rationale for the module and offers a general explanation of how to use it. (4) Elicit performance and provide feedback; a multiple choice self-test question section is appropriately positioned at the conclusion of the module to assess what has been learned. The correct responses are provided to enable the reader to gauge their performance. (5) Enhance retention and transfer; the identification of correct responses may enhance reader retention of the material and subsequent transfer of the skills into practice.

Comprised of seven units, the module focuses on the basics of various mental illnesses so that youth care counsellors are better equipped to intervene in disruptive and hostile situations. Links to other online resources as well as contacts of frequently used resources are provided in the module's appendix (Appendix C.1).

The features of the learning module are attractive to the adult learner and conducive to learning. Each unit follows a routine presentation, beginning with a general definition of the specific mental health disorder, followed by its clinical presentation and concluding with the proposed management plan of each disorder. This repetition allows the learner to anticipate upcoming material. Some units present clinical vignettes that enhance the readers' understanding of the condition. The visual presentation of the learning module contributes to its appeal. Typed text interspersed with colourful abstract pictures, textboxes, and tables enable appropriate use of white space so as not to overwhelm or bore the reader. Some questions in the testing section are designed with bold print to allow the reader to focus on the key aspects of learning.

Advanced Nursing Practice Competencies

Completion of this practicum was contingent on the integration and execution of several advanced nursing competencies. Advanced practice nurses have in their repertoire advanced nursing competencies (Canadian Nurses Association, 2008) as a contingency from which to practice, lead, research, collaborate, and consult as they delve into best practice guidelines. Competencies are defined as "…specific knowledge, skills, judgement and personal attributes required for a registered nurse to practice safely and

ethically in a designated role and setting" (CAN, 2005). Advanced practice nurses possess and exhibit an intricate marriage of these attributes in a variety of practice domains. The parameters of each competency however are not mutually exclusive, and as demonstrated throughout the completion of my practicum project, specific nursing acts and abilities may encompass several competencies.

Direct clinical practice is one such competency. It is the art of using experience and skill gleaned through a specialized area of nursing to provide holistic and comprehensive patient care (Canadian Nurses Association, 2008). As a direct care provider and primary health care nurse practitioner, I have the opportunity, knowledge, and skill to assess, diagnose, and treat incarcerated youth as consumers of care and holistic beings. Course requisites of N6660 have afforded me the opportunity to use my experience and skill gleaned through a specialized area of nursing to provide comprehensive and holistic care (Canadian Nurses Association, 2008). My certification in psychiatric nursing has allowed me to apply my clinical knowledge of mental health to the promotion of health and wellness. Specific to this practicum, I have relied on my knowledge of isolation and restraint and the effects of these intrusive means on a young persons' psychological wellbeing in order to develop effective intervention strategies that foster positive outcomes.

As leaders, advanced practice nurses are champions for healthcare delivery. They set the stage for affecting institutional change, restructuring and optimizing healthcare delivery so patients receive the best care possible. The knowledge gained via the literature review juxtaposed with the findings of the consultation process relative to restraint and

seclusion illustrated the learning needs of youth care counsellors and has incited me to seek new and innovative practice domains that will encourage and evoke a shift in momentum from the punitive prison mentality to that of a therapeutic, rehabilitative approach that prepares the youth for reintegration into society. Advocating for these learning needs vis-à-vis developing an educational resource enables me to create a culture congruent with the vison of the organization. As a nurse practitioner and sole healthcare provider with youth corrections, I naturally assume a leadership role - to be an "agent of change, consistently seeking effective new ways to practice, to improve the delivery of care, to shape (my) organization, to benefit the public and to influence health policy" (Canadian Nurses Association, 2008, p. 24). I suspect that my role will be paramount to the acceptance of the new policy change as it will be supplemented with a viable action plan contingent on the practicum.

The ability to evaluate current practice modalities and interpret evidenced-based findings central to professional advancement is a hallmark of the research competency. Generating, synthesizing and using research to enhance nursing practice, patient care, and operations is a formidable skillset of the advanced practice nurse (CNA, 2008). This practicum course vis-à-vis the literature review, consultation process and environmental scan has allowed me to evaluate the current practice of seclusion and restraint and the utility of dialectal behavioural therapy and the behavioural evaluation system in mitigating these coercive measures and contingent with the research, to disseminate findings and incorporate them into practice as novel approaches to care are explored and proposed.

The competencies of consultation and collaboration are integral to the overall process of building partnerships and professional relationships that together influence healthy public policy and foster meaningful positive change. I have liaised with colleagues, other institutions, and those with expertise in other fields to gather and synthesize information that will invariably dictate cultural change within the correctional setting vis-à-vis behavioural control. Nurses are valuable members of the correctional team. Their expertise transcends unit culture and influences organizational policy and operations. Their knowledge supplements that which is known and practiced by youth care staff as the two disciplines merge for a common good- to provide optimal care to our vulnerable youth populations. Correctional nurses invite the opinions and concerns of their youth care counterparts. It is this collaboration that empowers correctional workers to make evidence based decisions that positively inform their practice.

Next Steps

Now that the learning module has been developed, it shall be presented to the administrative team at the NLYC for approval. It is hoped that this resource will be implemented into the facility's repertoire of educational resources. Conceivably the module's content could be incorporated into the interview process to assess the applicant's knowledge of mental illness and ascertain their approach to disruptive behaviours. It will be recommended too that the module be completed during the orientation of new hires to ensure that they are starting off with a professional approach untainted by the prevailing prison mentality. I envision that the module be adapted by the Department of Justice Information Technology Department for intranet delivery to allow for accessibility to all

youth care counsellors during regular working hours. A hard copy of the module could be kept in the facility's library for easy reference and available on all living units as well.

Ideally, this learning module, if implemented at NLYC, will be followed by an evaluation. To be deemed an effective and efficient teaching tool it must be ascertained that learning has occurred relative to alternate strategies to reduce seclusion and restraint. It is expected that evaluators will determine the extent to which learning has occurred by identifying demonstrable changes in youth behaviour, staff management of aggressive behaviours and staff attitude regarding behavioural management. A thorough investigation into operational practices and statistics of seclusion and restraint shall reveal if learning has been incorporated into practice.

Conclusion

The potential dangers associated with seclusion and restraint has incited justice officials to investigate and endorse alternative therapeutic means of behavioural control. A review of the literature and an inclusive consultation process coupled with an environmental scan has supported the notion of least restrictive means as the standard of practice for containing disruptive behaviours. Change initiatives implemented at the worksite were determined to be ineffective in meeting the learning needs of youth care counsellors who will be instrumental in initiating the desired change. A learning module that addresses the identified deficiencies is proposed to teach correctional staff about mental illness in order to equip them with the appropriate resources they need to affect change.

The correctional staff play a pivotal role in the supervision, discipline and rehabilitation of incarcerated youth. Resources, guidelines or directives that increase the knowledge of aggressive and disruptive behaviours are well suited to mitigate the use of isolation and restraint in secure custody facilities.

References

Browne, A., Cambier, A., & Agha, S. (2011). Prisons within prisons: The use of segregation in the United States. *Federal Sentencing Reporter, 24*(1), 46-49. doi: 10.1525/fsr.2011.24.1.46

Canadian Nurses Association (2008). Advanced nursing practice: A national framework. Ottawa: Author. Retrieved from http://www.nurseone.ca/docs?NurseOne?CNAPrimaryCAreToolkit?ANP_NationalFramework_e.pdf

Donovan, A., Siegel, L. Zera, G., Plant, R., & Martin, A. (2003). Child and adolescent psychiatry: Se-clusion and restraint reform: An initiative by a child and adolescent psychiatric unit. Psychiatric Services,54, 958-959. doi: 10.1176/appi.ps.54.7.958

Fisher, W.A. (1994). Restraint and seclusion: a review of the literature. American Journal of Psychiatry, 151(11), 1584-1591. doi: 10.1093/hrp/8.5.261

Kinzie, M. (2005). Instructional design strategies for health behaviour change. Patient Education and Counselling, 56, 3-15. PMID: 15590217

LeBel, J., Stromberg, N., Duckworth, K., Kerzner, J., Goldstein, R., Weeks, M.,…Sutters M. (2004). Child and adolescent inpatient restraint reduction: A state initiative to promote strength-based care. *Journal American Academy of Child and Adolescent Psychiatry, 43*(1),37-45. doi: 10.1097/01.chi.0000096368.43887.f7

McKenzie, J. F., Neiger, B. L., & Thackeray, R. (2013). Planning, implementing & evaluating health promotion programs: A primer. (6th ed.). USA: Pearson Education

Mitchell. M., & Courtney, M. (2005). Improving transfers from the intensive care unit: The development, implementation and evaluation of a brochure based on Knowles' Adult Learning Theory. International Journal of Nursing Practice, 11, 257-268. doi:10.1111/j.1440-172x.2005.00533.x

Mohr, W.K., Mahon, M.M., & Noone, M.J. (1998). A restraint on restraints: The need to reconsider the use of restrictive interventions. *Archives of Psychiatric Nursing, 12*(2), 95-106. doi: 10.1016/S0883-9417(98)80059-9

Mohr, W.K., Petti, T.A., & Mohr, B.D. (2003). Adverse effects associated with physical restraint. Canadian Journal of Psychiatry, 48(5), 330-337.

Ontario. Provincial Advocate for Children and Youth. (2015). *It's a matter of time: Systemic review of secure isolation in Ontario youth justice facilities.* Retrieved from https://www.provincialadvocate.on.ca/documents/en/SIU_Report_2015_En.pdf

Teplin, L. A., Abram, K. M., McClelland, G. M., Dulcan, M. K., & Mericle, A. A. (2002). Psychiatric disorders in youth in juvenile detention. Archives of General Psychiatry, 59(12), 1133-1143. doi: 10.1001/archpsyc.59.12.1133

Ulla, S., Maritta, V., Riittakerttu, K.U. (2012). The use of coercive measures in adolescent psychiatric inpatient treatment: A nation-wide register survey. Social Psychiatry and Psychiatric Epidemiology, 47, 1401-1408. doi: 10.1007/s00127-011-0456-7

Weiss, E. (1998, October 11). Deadly restraint: A nationwide pattern of death. *The Hartford Courant.* Retrieved from http://www.charlydmiller.com/LIB05/1998hartfordcourant11.html

APPENDIX A

Integrated Literature Review: The Need for Alternatives to Seclusion and Restraint in Youth Corrections

Abstract

The literature overwhelmingly suggests that isolation and restraint in juvenile justice systems has demonstrable negative consequences on the health of youth subjected to these means of control. Efforts to curtail its use have been haphazard and fragmented with no definitive direction from management or justice officials. The vast majority of these workers lack formal vocational training and knowledge of therapeutic counselling techniques. Front line correctional staff require support through education for the management of disruptive and harmful behaviours exclusive of these intrusive and coercive means. A review of the literature suggests that there are no best practice guidelines to facilitate the management of disruptive behaviors in incarcerated youth and there are no indoctrinated educational requirements of staff that care for them. These gaps set the stage for a conundrum that begs the question of whether both elements are needed to become a restraint and seclusion free facility. Would the development of best practice protocols in and of itself be sufficient to reduce the use of seclusion and restraint in corrections? Would setting the minimal entry to practice requirements to include a psychological background be warranted? Relative to these identified deficiencies, I suspect that addressing both, albeit not probable, is ideal. Information from this literature review will seek to address knowledge gaps in the therapeutic management of aggressive and disruptive imprisoned youth and will inform the practice of front line staff that care for this population.

The Need for Alternatives to Seclusion and Restraint in Youth Corrections

Aggressive behaviours are commonplace in correctional settings and equally as common are methods to mitigate and manage behaviours that are threatening to the self or others or disruptive to the operations or security of the institution. Historically, attempts to manage and control such behaviours involved the use of intrusive means such as seclusion and physical restraint (Ulla, Maritta, & Riittakerttu, 2012). The United States General Accounting Office (1999) defined restraint as "…any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body" (as cited in Nunno, Holden, & Tollar, 2006, p. 1334). Its use applies to the application of handcuffs, shackles, sitting on, lying across, chocking or placing weight on another person in an effort to limit maneuverability. Proponents of the use of restrictive means of behavioural control contend that restraints and seclusion practices protect the therapeutic milieu of the environment when the safety of staff and patients may be compromised (Duke, Scott, & Dean, 2014). Others assert that the restraining practice encourages aggressive children to act out intense emotional feelings and serve as a means to develop effective coping skills and gain self-control (Sourander, Aurela & Piha, 1996).

The restraining practice has come under considerable scrutiny in recent years however due to the actual and perceived potential of further deteriorating mental health, injury or death (Mohr, Petti, & Mohr, 2003). Studies have shown that such practices are not only dangerous to the patient but may have adverse effects on staff as well (Fisher,

1994). Likewise, the practice of seclusion, defined in the literature as the physical isolation of an individual from the general population as a means of curtailing aggressive behaviour and preventing self-harm and harm to others (Mitchelle & Varley, 1990) is under the microscope for similar reasons. Pursuant to this knowledge is a trend toward negating the effects of restrictive measures vis-à-vis decreasing or eliminating their use.

Background

The Newfoundland and Labrador Youth Centre is the only secure custody facility for young offenders in the province and has the potential to house up to 60 youth between the ages of 12 and 18 years for the commission of criminal offences. Correctional staff at this facility bears the professional designation of "Youth Care Counsellor" and provide direct supervision of the youth on a daily basis on their living units. Whilst the preferred educational requirement for employment is at the post-secondary level with a background in social sciences, the majority of correctional staff lack any formal post-secondary training. Until recently the Newfoundland and Labrador Youth Centre has relied on the use of seclusion and to a lesser degree restraint as a means of mitigating aggressive or disruptive or even disrespectful behaviours. My work as nurse practitioner in the correctional setting has exposed me to the deleterious effects of seclusion and restraint on youth and most especially on those with mental health instabilities. The longstanding effects of seclusion and restraint on the mental health and well-being of youth are well documented in the literature and resonate with justice officials as lessons learned on the heels of the recent Ashley Smith Report (Office of the Ombudsman and Child and Youth Advocate, 2008). Management at the youth correctional centre, cognizant of the potential

catastrophic effects of these coercive strategies is endeavouring to implement less invasive and more therapeutic means of behavioural control. Efforts to initiate these practice changes however have been challenging. A lack of appropriate training has contributed to feelings of inadequacy among front line correctional staff that prefer the security of seclusion and restraining devices in managing aggressive behaviours.

Topic of Interest

To align with recent policy changes, I propose to develop a learning module for the Newfoundland and Labrador Youth Centre correctional staff aimed at strategies to reduce the use of seclusion and restraint practices. A search of the terms "youth corrections" "adolescents", "juvenile delinquents" and "justice" on Memorial University's CINAHL, PubMed, PsycINFO and Cochrane Library databases resulted in a plethora of information. With over 13000 results, the search was further refined to include"restraint" and "seclusion" and was delimited to include articles written in English and were original literature. To capture historical data and to gain a greater perspective of the movement to less intrusive measures articles from 1990 to the present were reviewed. The resultant parameters resulted in 75 returns. The amenability of the research to critical appraisal will be contingent on criteria of the Public Health Agency of Canada Critical Appraisal Toolkit and summarized in literature summary tables (Appendix). The integrated literature review that follows is a summary of what has been researched pertinent to my topic of interest and has generated themes such as (1) trends of seclusion and restraint in the juvenile justice system, (2) predictive factors for and potential consequences of the use of these restrictive measures, (3) programs augmenting alternatives to seclusion and restraint that other facilities have used and (4) the role of policy, theory and conceptual

frameworks in implementing learning programs. Pursuant to these findings the applicability of select learning modalities will be discussed as will the implications for nursing practice.

Literature Review

Trends and Contributing Factors

Specific to seclusion practices but nonspecific to youth, the literature reviewed on American prisons revealed a 40% increase in its use during a five year time period from 2000 to 2005 (Browne, Cambier, & Agha, 2011). The authors contended that it was most commonly used for disciplinary reasons. Ontario statistics involving 21 of its youth correctional facilities yielded a similar trend. Data on seclusion practices from 2013 to 2014 demonstrated a 75% increase in its use. The influence of the prison population on the number of confinement cases was not determined (Office of the Provincial Advocate for Children and Youth of Ontario, 2015).

The statistics on the use of restraint are not population specific. Duff, Gray, and Bristow (1996) reported that this form of physical intervention was used 8 times per year on an average ward in the United Kingdom. In 2002 there was a mean annual incidence of 230 of seclusion and restraint in the U.K. (Wynn, 2002). A 2005 study of the use of restraints in the United Kingdom revealed a mean frequency of 3.13 incidences per month in acute inpatient psychiatric units (Wright et al., 2005). Whittingtonn et al. (2006) reported 261 incidences of restraint among 5 wards (112 beds) over a 3 year period in a psychiatric trust in Liverpool, England.

Several studies investigated client profiles to determine commonalities among the youth being restrained or secluded. Knowledge as to which youth demographic is most

amenable to disruptive behaviour and subsequent restraint allows for early intervention and proactive interventions with this population subset. In their study of seclusion and restraint practices among youth in residential treatment centres in Maryland, dosReis et al., (2010) found that these practices were most prevalent among young females (mean age = 13.2 years), of African American descent with a history of depression, anxiety or mood disorder. These clients were shown to have longer dispositional sentences (mean = 515 days) and previous admissions. Results were similar in a study of coercive measures employed in youth psychiatric settings in Findland. Ulla et al., (2012) reported that females were more likely to be secluded or restrained than males. Younger clients and those with a history of schizophrenia, mood disorder and conduct disorder were more susceptible to these coercive measures as well. Other investigators have found that seclusion and restraint were more likely to be employed during incidents of physical aggression, were recently admitted, and when the aggression occurred in a private space such as one's bedroom (Duke et al., 2014).

Trends have also been examined in restraint-related deaths that have occurred in youth residential treatment facilities. Between 1988 and 1998 there were 142 restraint-related deaths in U.S. psychiatric institutions (Weiss, 1998). It was found that restraint-related deaths were more prevalent in males aged 14.2 years, diagnosed with either a behavioural, emotional, psychiatric, or developmental condition and admitted to a psychiatric institution. (Nunno et al., 2006). The investigators found too that the majority of deaths were related to asphyxia secondary to physical restraint that was applied while the youth was in a prone position. Noncompliance with staff requests was the reason most cited for the restraint use among the youth.

Potential Consequences

The employment of seclusion and restraint in psychiatric settings have been associated with fatalities (US Department of Health and Human Services, 1992), staff injury (Fisher, 1994), and counterproductive treatment outcomes (Richmond, Trujillo, Schmelzer, Phillips, & Davis, 1996). LeBel et al. (2004), cited feelings of fear, abandonment, humiliation, and confusion associated with coercive measures as well as re-traumatization for those who were sexually or physically abused. The authors argued too that its use does not positively affect self-control in those who exhibit aggressive behaviour. To effectively augment safe and therapeutic behavioural control, clinicians must understand the risks associated with physical restraint and be cognizant of the demographics that dictate its use. Delaney (2001) posited that restraint is a potentially deadly practice that offers no therapeutic value.

A review of the literature illustrated the gripping reality of the consequences of restraints in adolescent residential care. Children especially are more likely to suffer physical injury and incur death from the restraint process than adults (U.S. General Accounting Office, 1999). Death is thought to be related to the type and amount of force used during the restraining process, the anatomical size of and the body position of the person being restrained (Nunno et al., 2006; Mohr et al., 2003). According to Zusman (1997), improperly applied restraints, client response to the restraining process and restraint failure have been implicated as contributing factors to fatalities as well (as cited in Mohr et al., 2003). Physiologically, restraint- related death is attributable to (1)

asphyxia, whereby respiratory movements are restricted by the weight of a restraining body or device to the chest or the airway is compromised from compression of the neck (Nunno et al., 2006); (2) aspiration, whereby the restrained person is rendered immobile and cannot protect his or her airway from a potential accumulation of secretions (Mann et al., 1986); (3) chest trauma that may potentiate lethal cardiac arrhythmias (Boglioli, Taff, & Harleman, 1998); (4) catecholamine rush, such as that occurring during the excitement and hyperarousal of the restraining process leaves the heart vulnerable to disrrhythmias (Kirby, Pinto, Hottinger, Johnson, & Lown, 1991), and, (5) thrombosis, whereby prolonged immobilization imposed by restraints may potentially lead to pulmonary emboli (McCall, Mann, Shelp, & Caroff, 1995).

The psychological aftermath of seclusion and restraining practices albeit not immediate, is equally disturbing. The literature overwhelmingly supports the notion that the use of coercive means in correctional institutions are punitive, counter intuitive and potentially hazardous (Fox, 2004; Mitchell & Varley, 1990). Accounts from institutionalized youth were the focus of a 1998 study by Mohr, Mahon, and Noone and illustrated for hospital officials and other clinicians the hardships suffered at the hands of care providers whom they felt were abusing their power as caretakers. Common themes emerged among the participants: vicarious trauma, staff alienation, and direct trauma as a result of "inappropriate use by staff of power and control" (Mohr et al., 1998. P. 95). There were client reports of feeling "invaded" and comparisons were made that paralleled the restraint experience to rape. Those tasked with responding to maladaptive and disruptive behaviours are often the ones least trained to do so resulting in overuse and

often times abuse of restraint and seclusion procedures - a dynamic with the propensity to set in motion a cycle of trauma (Mohr et al., 1998). Other qualitative studies involving adult psychiatric clients cited themes of hopelessness, helplessness and lack of empathy from care providers (Chien, Chan, Lam, & Kam, 2004). The grim realization of the devastating effects of restraints paints an ugly and ironic portrait of the safety system within the institutions designed to protect our troubled youth. The findings should incite an immediate and critical review of institutional protocol related to restraint use and alternatives sought.

The effect of the restraining process on staff has largely been ignored in the literature and that specific to the restraint and seclusion of youth is lacking significantly. The emotional sequelae bestowed upon staff tasked with applying mechanical restraints to individuals range from feelings of fear, guilt, sadness, and inadequacy (Bethel & Beail, 2013; Bonner et al., 2002) and as well carries the potential for physical injury, post-traumatic stress disorder, in addition to a vast array of other mental health consequences (Johnson, 2010). The use of coercive measures as a job requirement was found to result in decreased staff morale, absenteeism and difficulties with staff recruitment (Johnson, 2010; Lee et al, 2003) and most staff expressed a desire to use alternative means of behavioural control (Bethel & Beail, 2013). Staff expressed concerns for the safety of their colleagues who were involved in the restraining process (Sequeira & Halstead, 2004) as well as a concern that the practice may be inappropriately and over used (Lee et al., 2003). The findings, albeit pertinent to working with an adult population may still be of value to practitioners and administrators who work in institutions that endorse the use

of restraints. One should not be quick to dismiss the potential parallels of this study to staff who work with children and adolescents, especially those with developmental conditions. Leaders would be well advised to acknowledge the concerns of their staff vis-à-vis feelings of inadequacy and ensure sufficient training and resources are available.

Programs to Mitigate Aggressive and Disruptive Behaviours

The literature review resulted in a dearth of information specific to programs aimed at reducing the use of seclusion and restraint in those who exhibit aggressive and disruptive behaviours. Many authors cited primary prevention while others were proponents of secondary preventative means as management techniques used to mitigate undesired behaviours and subsequently seclusion and restraint. As vast as the literature was, there appeared to be variations and inconsistencies among different institutions that cared for the same youth demographic. Without standardized clinical practice guidelines, correctional staff are left without adequate direction as to what to use and when.

Fundamentally, education is paramount in affecting change (Forster, Cavness and Phellps, 1999). Their study found that educating staff, making them more accountable, and involving them in decisions that impacted patient care realized significant decreases in both the rates of restraint and the duration of seclusion. Traditionally, educational programs focused solely on the management of aggressive behaviours and tended to be targeted toward physical intervention and breakaway skills without little consideration given to primary preventative strategies (Beech & Leather, 2006; Oud, 2006).
Primary prevention approaches such as therapeutic de-escalation techniques, anger management programs, and strengths-based problem solving are effective in decreasing violence and aggression (Lebel et al., 2004). Their study realized the benefits of a

"strengths-based" model of care which emphasized and encouraged the young person's ability to problem solve and self-soothe. Similarly in their 2007 study, Dean, Duke, George, and Scott found that behaviour modification programs that reinforced positive behaviours negated the need for seclusion and restraint on adolescent inpatient psychiatric units.

Experts contend that the move to least restrictive means involves a shift in care philosophy from that of control to one of concern for "individualized patient needs" (Sullivan-Marx, Strumph, Evans, Baumgarten, & Maislin, 1999). Reorienting organizational philosophies augment the process of least restrictive means and are paving the way toward a rehabilitative model of care (Delaney 2006; Huckshorn, 2004). Reduction of these intrusive measures is also contingent on a change of prison culture. A paradigm that challenges the traditionally held beliefs, assumptions and practices leads to changes in attitude of staff that are tasked with these authoritative practices (Alty, 1997).

Organizational restructuring invites new models of care, revisions of incidents that precipitated seclusion or restraint, initiation of behaviour plans, enhancement of communication among staff and between staff and youth (Johnson, 2010). Collectively, and notwithstanding the value of education, these initiatives "...focus on changing processes within the structure of the unit rather than simply delivering content to the staff" (Johnson, 2010, p. 186). Similarly Duxbury and Paterson (2005) found that providing clients with information about their condition, their medication and side-effects, ward routines and policies were proactive initiatives that decreased violence and aggression which ultimately led to a reduction in the use of seclusion and restraint. Other measures which promoted teamwork, effective communication, professionalism,

relationship-based care and organizational support were effective at changing unit culture and creating a new vision of care (Johnson & Delaney, 2007). Further, these initiatives "...move beyond the focus of de-escalation techniques toward a comprehensive focus on prevention within the context of changing unit dynamics" (Johnson, 2010, p. 195).

Restraint reduction initiatives have proven to be effective when endorsed and supported by management. Staff member support as well, is paramount to the success of endeavours where cultural change is needed. This is what Holstead, Lamond, Dalton, Horne and Crick (2010) found in their study of the effectiveness of a restraint reduction strategy in a youth residential facility. Staff involvement was an overarching concept in the success of this initiative. Institutional culture, albeit cemented in what we know and believe to be true is amenable to change if there is convincing evidence to support this change (Azeem, Aujla, Rammerth, Binsfeld, and Jones, 2011). Sharing an organization's goals with its employees as was the case in this study aids in "selling" new philosophies and models of care.

Role of Policy

Policy changes regarding seclusion and restraint use are simple yet effective ways to reduce its use in psychiatric units (Currier & Farley-Toombs, 2002; Morrison, 1998). In fact, Jensen et al. (1998) posited that policy change is the first step in realizing a restraint-free environment. Institutions that implemented new restraint policies concurrently with behavioural programs or new care approaches realized dramatic reductions in the use of seclusion and restraint (Donovan, Siegel, Zera, Plant, & Martin, 2003). The study by Ulla et al. (2012) illustrated, among other things, the staggering use of restrictive interventions as a means to control behaviours in an adolescent psychiatric setting in Finland and the

impact of policy change on these rates. They found that as the number of admissions increased so too did the rates of seclusion or restraint during a portion of the study period (1996-2001) until such time that legislative changes in 2002 curtailed its use and the rates subsequently declined. The authors contended that this signified that restraint and seclusion use by staff was "associated more with culture, tradition and policy than with medical or safety requirements" (Ulla et al., 2012, p. 1401). Under the new law, hospitals were required to abide by stricter conditions for restraint, acceptable only to prevent violence or imminent violence and were required to report to the authorities all instances of seclusion and restraint. The patient's legal representative was required to be notified as well.

U.S guidelines advocate for least restrictive means of control and condone its use only in circumstances of imminent danger (American Academy of Pediatrics, 1997). A recent report from Ontario's Provincial Advocate for Children and Youth (2015) highlighted the dangers of solitary confinement on youth and recommends consistent standards for its use in youth justice facilities in the province. To align with recent recommendations of Correctional Services Canada, and to negate the potential adverse effects associated with restrictive and intrusive control measures, the Newfoundland and Labrador Youth Centre has recently implemented new policy that limits the amount of time that a young offender may spend in secure isolation.

As with Ontario secure custody institutions this new policy of secure isolation is an intervention of last resort to be instituted only when other less intrusive means have failed and when the young person's behaviour is such that they are a danger to themselves or others. Youth care staff are not permitted to isolate young offenders longer than an

aggregate of 8 hours in a 24-hour period or 24 hours in a week. All isolation procedures are to be approved by management, who are obligated to notify parents or guardians if 3 hours or more of isolation time has been warranted. Once isolated from the general prison population the young person is routinely observed every 20 minutes or more frequently as dictated by their behaviour. Release is at the discretion of correctional staff and only when it can be demonstrated that the disruptive behaviour has abated. Once released from isolation the offender is encouraged to complete a "Thinking Log" - a written account of feelings and behaviours that precipitated the isolation procedure. This document is discussed between the young person and the youth care staff or other mental health provider and alternate coping skills are identified. A monthly summary of the instances of seclusion practices is submitted to the Department of Justice.

Guiding Philosophies

Effective programs are contingent on thorough planning, that which is mediated through an appropriate guiding philosophy or theoretical base. Rimer and Glanz (2005) posited that the use of theory serves as "a foundation for program planning and development (and) is consistent with the current emphasis on using evidence based interventions in public health, behavioural medicine and medicine" (as cited in McKenzie, Nieger, & Thackery, 2013). Advanced practice nurses have in their arsenal theoretical bases and guiding frameworks from which to plan, develop and implement health related programs. Knowles' Adult Learning Theory and the Instructional Design Framework are two such paradigms that when aligned collaboratively offer unparalleled guidance in program development.

Theory

The theoretical principles inherent in Knowles' Adult Learning Theory align with my objective to educate correctional staff. The underlying premise of this theory is the recognition of the adult learner as autonomous, self-directed, and motivated to learn (Mitchell & Courtney, 2005). Knowles, Holton, and Swanson (2005) supported the notion that "the use of Adult Learning Theory in education enables the development of competencies, knowledge, and abilities, supporting personnel to do the work required and to accomplish the goals of the organization in a way that is meaningful to the learners" (as cited in Inoue, Del Fabbro, & Mitchell, 2012, p. 125). This theory identifies several elements essential to learning: (1) a need to know, (2) a responsibility for one's own learning, (3) experience as a tool for learning, (4) applicability of the information to one's life situation and (5) problem-centred learning with real-life problems (Mitchell & Courtney, 2005) which will be illustrated.

(1) Need to know; a review of the literature revealed that a knowledge gap exits regarding best-practice guidelines in the treatment of aggressive behaviours among incarcerated youth. The research suggests that educational programs aimed at strategies to reduce seclusion and restraint is paramount in the juvenile justice system.

(2) Responsibility for one's own learning; correctional workers, albeit not bound by professional standards have a moral obligation to advance their competencies in counselling troubled youth. The onus is on them to ensure that they avail of the most current and accessible resources. The self-directed orientation of the module recognizes the delicate work-life balance of the correctional shift worker and allows for flexibility and control of the learning process. The workers' commitment to learning and interest in

professional empowerment will be determined during the consultation process.

(3) The role of experience as a tool for learning; correctional staff have voiced feelings of inadequacy in counselling youth during times of emotional upheaval or aggression. The learning module will offer typical unit scenarios as case studies and highlight positive staff responses to maladaptive youth behaviours. Inappropriate responses to behaviours will be identified in the implementation phase of the learning module as staff responses are evaluated and used as teaching opportunities for effective behavioural management. Presentations such as these will be used to build on the workers' existing knowledge and enhance their confidence in this practice area.

(4) Motivation to learn; the promotion of the learning model will be based on the emphasis that completion of the learning module will enhance therapeutic communication, unit operations, and ultimately enhance work satisfaction. Workers will be reminded that the client profile in the youth justice system is often one with complex mental health needs to which the learning module will be targeted. Stressing the inevitability of having to work with mentally ill youth within the justice system will motivate correctional staff to learn proper management skills to deal with disruptive and harmful behaviours.

(5) Applicability of the information to one's life situation; it was determined in the literature review that an overwhelming percentage of incarcerated adolescents suffer from compromised mental health (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). It is hopeful that the correctional staff will gain invaluable information from the learning module and embrace all that it has to offer in enhancing job performance and satisfaction. This may be assessed at a later date during the evaluation phase of the practicum.

(6) Problem-centered learning with real-life problems; again, stressing the prevalence of incarcerated mentally ill youth denotes the high probability of the need to mitigate aggressive and threatening behaviours and the subsequent need to learn appropriate and therapeutic measures of behavioural control. Educating the workers about the potential consequences of restraint and seclusion will encourage them to seek alternate ways to deal with disruptive behaviours exclusive of these invasive methods.

Conceptual Framework

To guide the development of the learning module I chose Robert Gagne's *Five Stage Framework* for instructional design, an adaptation from his original *Nine Events of Instruction* (Kinzie, 2005). The strategies endorsed within the framework are theory driven and well suited to incite behavioural change. Five stages are suggested as an outline for designing educational materials: (1) gain attention; to appeal to the sensibilities of correctional staff considerable attention will be given to the risks and consequences of seclusion and restraint practices of incarcerated youth, illustrating the grave dangers of asphyxiation and death. Expert opinion of the effects of intrusive control measures on one's mental health will be offered. (2) present stimulus material; the learning module will expand on staff's prior knowledge of consequences of intrusive methods of control and illustrate how alternative measures of control will achieve desired outcomes. (3) provide learner guidance; the learning module will provide online links to effective counselling techniques. Alternate strategies to intrusive means will be discussed as proven interventions for behavioural control. (4) elicit performance and provide feedback; one component of the learning model will be role playing to illustrate effective communication techniques. Most appropriate responses will be tested via multiple choice

testing. (5) enhance retention and transfer; in an effort to incorporate new methodologies, all staff will be encouraged to routinely practice the skills taught. Staff will support one another in this endeavour.

Role of Self-Learning Module

Contingent with the principles of Knowles Theory of Adult Learning the selection of a self-directed learning module was chosen as the mode of delivery for teaching strategies to reduce seclusion and restraint at the Newfoundland and Labrador Youth Centre. This design provides flexibility to staff, accommodates busy work schedules, and compensates for lack of employer-sponsored training. Further, the self-directed mode of learning captures all learners and ensures a consistent teaching technique (Lehr et al, 2013). Correctional staff, as the targeted audience, are shift workers who have busy lives outside the workplace and subsequently require flexibility in the delivery of educational services. Self-directed learning modules consider “the learners' needs to be central to the design and delivery of instruction” (Pillay, 2002) and as the following studies demonstrate, are appropriate to meet the learning needs of adult learners.

Lehr et al. (2005) studied the effectiveness of an electronic learning module with healthcare providers on the use of an asthma severity assessment tool and found it was adequate to meet identified learning needs, was appreciated by the participants and increased their performance of the assessment tool. Similarly, the 2014 study by Phillips, Heneka, Hickman, Lam, & Shaw used a pretest-post-test quasi-experimental design to demonstrate the effectiveness of online learning module on palliative care nurses' pain assessment competencies and on patient reported pain ratings. This mode of teaching demonstrated an increase in the participants’ assessment knowledge and confidence

levels. These studies, albeit directed at health services and providers lend themselves to the support of self-directed learning modules in a general sense. Self-directed learning strategies are effective methods to inform the practices of service providers (Murad, Coto-Yglesias, Varkey, Prokop & Murad, 2010) and the results of these studies may be generalizable to other settings that are considering the effectiveness of teaching methods for adult learners.

The literature, albeit supportive of the use of self-directed learning, does not promote it to the exclusion of other methods. The superiority of one teaching design was not debated. Rather, the research posits to the "adequacy" of self-directed learning, maintaining that it is comparable to traditional lecture-based methods of instructional delivery (Davis, Crabb, Rogers, Zamora, & Khan, 2008). In fact, the available data suggests that it is best not to place emphasis on one instructional design but to embrace the learning potential offered by different teaching methods (Singh & Kharb, 2013). With this mindset and satisfied with the juxtaposition of the design "adequacy" with the added convenience of flexibility I will move forward with the self-directed learning method of teaching correctional staff. If during the consultation process it is determined that staff prefer an alternate method of instruction or if the evaluation process I will endeavour to supplement the self-directed learning module with that identified as the preferred teaching method by staff.

Ideally, this learning module, if implemented at NLYC, will be followed by an evaluation. To be deemed an effective and efficient teaching tool it must be ascertained that learning has occurred relative to alternate strategies to reduce seclusion and restraint. It is expected that evaluators will determine the extent to which learning has occurred by

identifying demonstrable changes in youth behaviour, staff management of aggressive behaviours and staff attitude regarding behavioural management. A thorough investigation into operational practices and statistics of seclusion and restraint shall reveal if learning has been incorporated into practice. Conceivably nurses may be involved in determining improvements in youth behaviour, practice and operations.

Implications for Practice

The correctional staff play a pivotal role in the supervision, discipline and rehabilitation of incarcerated youth. Resources, guidelines or directives that increase the knowledge of aggressive and disruptive behaviours, and their precipitating factors are well suited to mitigate the use of isolation and restraint in secure custody facilities. Correctional teams augmented by a nursing presence offer a multidisciplinary and holistic perspective, that which fosters therapeutic relationships and optimizes the supervision, discipline and rehabilitation offered by other disciplines. Correctional nurses are uniquely positioned within the justice system to challenge the status quo and cultivate and put into practice new knowledge as it becomes available through research.

Advanced practice nurses have in their repertoire advanced nursing competencies (Canadian Nurses Association, 2008) as a contingency from which to research, collaborate and consult as they delve into best practice guidelines in restraint and seclusion use in young offenders. As direct care providers, advanced practice nurses offer a unique lens from which to assess, diagnose, and treat incarcerated youth as consumers of care and holistic beings. Nurses are valuable members of the correctional team. Their expertise transcends unit culture and influences organizational policy and operations. Their knowledge supplements that which is known and practised by youth care staff as

the two disciplines merge for a common good- to provide optimal care to our vulnerable youth populations. Correctional nurses invite the opinions and concerns of their youth care counterparts and through appropriate collaboration empower them to make evidenced based decisions that positively inform their practice.

As leaders, nurses are champions for health. They set the stage for institutional change, restructuring and optimizing health care delivery so patients receive the best care possible. The knowledge gained via the literature review relative to restraint and seclusion incites me to seek new and innovative practice domains that will encourage and evoke a shift in momentum from the punitive prison mentality to that of a therapeutic rehabilitative approach that prepares the youth for reintegration into society.

Discussion

A deluge of knowledge emanates from these collective data. Much of what has been referenced pertains to psychiatric hospitals, adult patients, and restraint practices. The research states that aggressive and violent behaviours are intrinsically linked to seclusion and restraining practices (Stubbs et al., 2009) and to study one to the exclusion of the other would be a formidable injustice in the plight to offset the effects of seclusion and restraint on the incarcerated youth (Johnson, 2010). Combining what is known about these restrictive means in these settings with research on seclusion in children, clinicians can tease out what may be relevant in the field of corrections. Knowledge gained through experiential learning, albeit unsupported in the literature, plays an invaluable role in informing practice.

Much of what has been reviewed in the literature, albeit dated, is significant as it explores the historical context of seclusion and restraint in the penal system and provides

the reader with a greater appreciation of the problem. This preliminary understanding underscores the progression of the treatment of young offenders within the justice system from a punitive to a rehabilitative approach. All the research, from the dated to the most recent, illustrates the need for change within corrections vis-à-vis seclusion and restraint as methods to contain aggressive and disruptive behaviour. Differences in approach to this change however can be detected as the literature evolves. Historically, experts advocated for least restrictive means of behavioural control in an effort to mitigate the physical dangers associated with its use. More recently, greater emphasis has been placed on the psychological effects of these coercive means on incarcerated youth and the importance of preventative strategies were realized and promoted. Changes in care philosophy espoused by a change in prison culture sets the stage for a new treatment milieu as we move forward in youth corrections. The direction of the literature lends support for my proposed practicum as I hope to further delve into strategies that will change the mindset of correctional workers from a punitive perspective of care to one of rehabilitation and reintegration.

Conclusion

Given the potential dangers associated with restraints, correctional officials and other care providers are investigating alternative therapeutic means of behavioural management strategies to mitigate the need for restraining and seclusion processes. A review of the literature serves to inform administrators and clinicians of the dangers associated with seclusion and restraint and supports the notion of least restrictive means as the standard of practice for containing aggressive behaviour. An enlightening experience, this literature review has provided me with the knowledge and practical tools

I need to incite a cultural change at my work-site. Equipped with a theoretical base and conceptual framework I am well positioned to take on this challenge and start the process of influencing clinical practice under the guise of evidence-informed decision making.

References

Alty, A. (1997). Nurses' learning experience and expressed opinions regarding seclusion practice within one NHS trust. *Journal of Advanced Nursing, 25,*786-793. doi: 10.1046/j.1365-2648.1997.1997025786.x

American Academy of Pediatrics. (1997). The use of physical restraint interventions for children and adolescents in the acute care setting. *Pediatrics, 99,* 786-793. doi: 10,1542/peds.99.3.497

Azeem, M.W., Aujla, A., Rammerth, M., Binsfeld, G, & Jones, R.B. (2011). Effectiveness of six core strategies based on trauma informed care in reducing seclusions and restraints at a child and ad olescent psychiatric hospital. *Journal of Child and Adolescent Psychiatric Nursing, 24*, 11-15. doi: 10.1111/j.1744-6171.2010.00262.x

Beech, B., & Leather, P. (2006). Workplace violence in the health care sector: A review of staff training and integration of training evaluation models. *Aggression and Violent Behavior, 11,* 27-43. doi: 10.1016/j.avb.2005.05.004

Bethel, N., & Beail, N. (2013). The use of mechanical restraint with people who engage in severe self-injurious behaviour: impact on support staff. *Advances in Mental Health and Intellectual Disabilities, 7*(5), 312-318. doi: 10.1108/AMHID-06-2013-0042

Boglioli, L. R., Taff, M. L., & Harleman, G. (1998). Child homicide caused by commotio cordis. *Pediatric Cardiology, 19,* 436-438. doi: 10.1007/s002469900347

Bonner, G., Lowe, T., Rawcliffe, D., & Wellman, N. (2002). Trauma for all: A pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK. *Journal of Psychiatric and Mental Health Nursing, 9.* 465-473.doi:10.1046/j.1365-2850.2002.00504.x

Browne, A., Cambier, A., & Agha, S. (2011). Prisons within prisons: The use of segregation in the United States. *Federal Sentencing Reporter, 24*(1), 46-49. doi: 10.1525/fsr.2011.24.1.46

Canadian Nurses Association (2008). *Advanced nursing practice: A national framework.* Ottawa: Author. Retrieved from http://www.nurseone.ca/docs?NurseOne?CNAPrimaryCAreToolkit?ANP_NationalFramework_e.pdf

Chien, W. T., Chan, C.W.H., Lam, L.W., & Kam, C.W. (2005). Psychiatric inpatients' perceptions of positive and negative aspects of physical restraint. *Patient Counselling, 59,* 80-86. doi: 10.1016/j.pec.2004.10.003

Currier, G. W., & Farley-Toombs, C. (2002). Use of restraint before and after implementation of the new HCFA rules. *Psychiatric Services, 53*(2). 138. doi: orgqe2aproxy.mun.ca/10.1176/appi.ps.53.2.138

Davis, J., Crabb, S., Rogers, E., Zamora, J., & Khan, K. (2008). Computer-based teaching is as good as face to face lecture-based teaching of evidencmedicine: A randomized controlled trial. *Medical Teaching, 30,* 302-307. doi: 10.1080/01421590701784349

Dean, A.J., Duke, S. G., George, M., & Scott, J. (2007). Behavioural management leads to reduction in aggression in a child and adolescent psychiatric inpatient unit. *Journal of American Academy of Child and Adolescent Psychiatry, 46*(6), 711-720. doi: 10.1097/chi.0b013e3180465a1a

Delaney, K. (2001). Developing a restraint-reduction program for child/adolescent inpatient treatment. *Journal of Child and Adolescent Psychiatric Nursing, 14*(3). 128-140.

Donovan, A., Siegel, L. Zera, G., Plant, R., & Martin, A. (2003). Child and adolescent psychiatry: Seclusion and restraint reform: An initiative by a child and adolescent psychiatric unit. *Psychiatric Services,54,* 958-959. doi: 10.1176/appi.ps.54.7.958

dosReis, S., Culloch, J.R., Colantuoni, E., Barnett, S.R., Pruitt, D., Zachik, A., & Riddle, M.A. (2010). Early identification of seclusion and restraint patterns during adolescents' course of residential treatment. *Residential treatment for children & youth, 27*, 160-174. doi: 10.1080/0886571x.2010.500145

Duff, L., Gray, R., & Bristow, F. (1996). The use of control and restraint in acute psychiatric units. *Psychiatric Care, 3,* 230-234.

Duke, S.G., Scott, J., & Dean, A.J. (2014). Use of restrictive interventions in a child and adolescent inpatient unit – predictors of use and effect on patient outcomes. *Australasian Psychiatry, 22*(4), 360-365. doi: 10.1177/1039856214532298

Duxbury, J., & Paterson, B. (2005). The use of physical restraint in mental health nursing:

An examination of principles, practice and implications for training. *The Journal for Adult Protection, 7*(4)*,* 13-24. doi: 10.1108/14668203200500021

Fisher, W.A. (1994). Restraint and seclusion: a review of the literature. *American Journal of Psychiatry, 151*(11), 1584-1591. doi: 10.1093/hrp/8.5.261

Forster, P.L., Cavness, C., & Phelps, M.A. (1999). Staff training decreases use of seclusion and restraint in an acute psychiatric hospital. *Archives of Psychiatric Nursing, 13*(5), 269-271**.** doi: 10.1016/S0883-9417(99)80037-5

Fox, L. E. (2004). The impact of restraint on sexually abused children and youth. *Residential Group Care Quarterly*, *4*(3), 1-6.

Holstead, J., Lamond, D., Dalton, J., Horne, A., & Crick, R. (2010). Restraint reduction in children's residential facilities: Implementation at Damar Services. *Residential Treatment for Children & Youth, 27*, 1-13. doi: 10.1080/08865710903507961

Huckshorn, K. A. (2004). Reducing seclusion and restraint use in mental health settings: Core strategies for prevention. *Journal of Psychological Nursing and Mental Health, 42*(9), 22-33. PMID: 15493493

Inoue, M., Del Fabbro, L., & Mitchell, M. (2012). Assessing the educational needs of mental health nurses working in an adolescent inpatient psychiatric ward in Japan. *Journal of Child and Adolescent Psychiatric Nursing, 25,* 125-129. doi: 10.1111/j.1744-6171.2012.00335.x

Jensen, B., Hess-Zak, A., Johnson, S. K., Otto, D. C., Tebbe, L., Russell, C. L., & Walker,

A. S. (1998). Restraint reduction: A new philosophy for a new millennium. *Jour nal of Nursing Administration, 28,* (7/8), 32-38.

Johnson, M. E. (2010). Violence and restraint reduction efforts on inpatient psychiatric units. *Issues in Mental Health Nursing, 31,* 181-197. doi: 10.3109/01612840903276704

Johnson, M. E., & Delaney, K. R. (2007). Keeping the unit safe: The anatomy of escalation. *Journal of the American Psychiatric Nurses Association, 13,* 42-52. doi: 10.1177/1078390307301736

Kinzie, M. (2005). Instructional design strategies for health behaviour change. *Patient Education and Counselling, 56*, 3-15. PMID: 15590217

Kirby D. A., Pinto, J. M., Hottinger, S., Johnson, D. A., & Lown, B. (1991). Behavioral arousal enhances inducibility and rate of ventricular tachycardia. *The American Journal of Physiology, 261*(6), 1734-1739. PMID: 1661087

LeBel, J., Stromberg, N., Duckworth, K., Kerzner, J., Goldstein, R., Weeks, M.,…Sutters M. (2004). Child and adolescent inpatient restraint reduction: A state initiative to promote strength-based care. *Journal American Academy of Child and Adolescent Psychiatry, 43*(1),37-45. doi: 10.1097/01.chi.0000096368.43887.f7

Lee, S., Gray, R., Gournay, K., Wright, S., Parr, A., & Sayer, J. (2003). Views of nursing staff on the use of physical restraint. *Journal of Psychiatric and Mental Health Nursing, 10*(4), 425-430.doi: 10.1046/j.1365-2850.2003.00625.x

Lehr, A., McKinney, M., Gouin, S., Blais, J., Pusic, M., & Duchrame, F. (2013).

Development and pretesting of an electronic learning module to train health care professionals on the use of the pediatric respiratory assessment measure to assess acute asthma severity. *Canadian Respiratory Journal, 20*, 435-441. PMID: 3917818

Mann S.C., Caroff, S. N., Bleier H. R., Weiz, W. K. R., Kling, M. A., & Hayashida, M. (1986). Lethal Catonia. *The American Journal of Psychiatry, 143*(11), 1374-1381. PMID: 3777225

McCall, W. V., Mann, S.C., Shelp, F. E., & Caroff S.N. (1995). Fatal pulmonary embolism in the catatonic syndrome: two case reports and a literature. *The Journal of Clinical Psychiatry, 25,* 21-25. PMID: 7836335

McKenzie, J. F., Neiger, B. L., & Thackeray, R. (2013). *Planning, implementing & evaluating health promotion programs: A primer*. (6th ed.). USA: Pearson Education

Mitchell. M., & Courtney, M. (2005). Improving transfers from the intensive care unit: The development, implementation and evaluation of a brochure based on Knowles' Adult Learning Theory. *International Journal of Nursing Practice, 11,* 257-268. doi:10.1111/j.1440-172x.2005.00533.x

Mitchell, J. & Varley, C. (1990). Isolation and restraint in juvenile correctional facilities. *Journal of American Academy of Child and Adolescent Psychiatry, 29*(2), 251-255. doi: 10.1097/00004583-199003000-00014

Mohr, W.K., Mahon, M.M., & Noone, M.J. (1998). A restraint on restraints: The need to reconsider the use of restrictive interventions. *Archives of Psychiatric Nursing,*

12(2), 95-106. doi: 10.1016/S0883-9417(98)80059-9

Mohr, W.K., Petti, T.A., & Mohr, B.D. (2003). Adverse effects associated with physical restraint. *Canadian Journal of Psychiatry, 48*(5), 330-337.

Morrison, E. F. (1998). The culture of caregiving and aggression in psychiatric settings. *Archives of Psychiatric Nursing*, *12*(1), 21-31. doi: 10.1016/S0883-9417(98)80005-8

Murad, M. H., Coto-Yglesias, F., Varkey, P., Prokop, L. J., Murad, A. L. (2010). The effectiveness of self-directed learning in health professions education: A systematic review. *Medical Education, 44*, 1057-1068. doi: 10.1111/j.1365-2923.2010.03750.x

Office of the Ombudsman and Child and Youth Advocate. (2008, June). *Ashley Smith report.* New Brunswick: Author. Retrieved from https://www.gbn.ca/0073/PDF/AshleySmith-e.pdf

Nunno, M.A., Holden, M.J., & Tollar, A. (2006). Learning from tragedy: A survey of child and adolescent restraint fatalities. *Child Abuse & Neglect, 30*, 1333-1342. doi: 10.1016/j.chiabu.2006.02.015

Ontario. Provincial Advocate for Children and Youth. (2015). *It's a matter of time: Systemic review of secure isolation in Ontario youth justice facilities.* Retrieved from https://www.provincialadvocate.on.ca/documents/en/SIU_Report_2015_En.pdf

Oud, N. (2006). Aggression management training programs: contents, implementation and organization. In D. Richter & R. Whittington (Eds.), *Violence in mental health settings* (pp. 194-210). New York: Springer

Phillips, J., Heneka, N., Hickman, L., Lam, L., & Shaw, T. (2014). Impact of a novel online learning module on specialist palliative care nurses' pain assessment competencies and patients' reports of pain: results from a quasi-experimental pilot study. *Palliative Medicine, 28*, 521-529. doi: 10.1177/0269216314527780

Pillay, H. (2002). Understanding learner-centeredness: Does it consider the diverse needs of individuals? *Studies in Continuing Education, 24*(1), doi: 10.1080/01588037022013048

Richmond, I., Trujillo, D., Schmelzer, J., Phillips, S., & Davis D. (1996). Least restrictive alternatives: Do they really work? *Journal of Nursing Care Quality, 11*(1), 29-37.

Sequeira, H., & Halstead, S. (2004). Psychological effects on nursing staff of administering physical restraint in secure psychiatric hospital: "When I go home, it's then that I think about it." *The Journal of Forensic Practice, 6,* 3-15. doi: 10.1108/14636646200400002

Singh, V., & Kharb, P. (2013). A paradigm shift from teaching to learning gross anatomy: Meta-analysis of implications for instructional methods. *Journal of the Anatomical Society of India, 62,* 84-89

Sourander, A., Ellila, H., Valimaki, M., & Piha, J. (2002). Use of holding restraints, seclusion and time-out in child and adolescent psychiatric in-patient treatment. *European Child & Adolescent Psychiatry, 11,* 162-167. doi: 10.1007/s00787-002-

0274-2

Stubbs, B., Leadbetter, D., Paterson, B.,Yorston, G., Knight, C., & Davis, S. (2009). Physical intervention: A review of the literature on its use, staff and patient views, and the impact of training. *Journal of Psychiatric and Mental Health Nursing, 16*, 99-105. doi: 10.1111/j.1365-2850.2008.01335.x

Sullivan-Marx, E. M., Strumph, N. E., Evans, L. K., Baumgarten, M., & Maislin, G. (1999). Initiation of physical restraint in nursing home residents following restraint reduction efforts. *Research in Nursing and Health, 22,*369-379. doi: 10.1002/(SICI)1098-240x(199910)

Teplin, L. A., Abram, K. M., McClelland, G. M., Dulcan, M. K., & Mericle, A. A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry, 59*(12), 1133-1143. doi: 10.1001/archpsyc.59.12.1133

Ulla, S., Maritta, V., Riittakerttu, K.U. (2012). The use of coercive measures in adolescent psychiatric inpatient treatment: A nation-wide register survey. *Social Psychiatry and Psychiatric Epidemiology, 47*, 1401-1408. doi: 10.1007/s00127-011-0456-7

U.S. Department of Health and Human Services, Public Health Service, Food and Drug Administration. (1992). *Potential hazards with restraint devices.* Rockville, MD: Department of Health and Human Services.

Weiss, E. (1998, October 11). Deadly restraint: A nationwide pattern of death. *The Hartford Courant.* Retrieved from http://www.charlydmiller.com/LIB05/1998hartfordcourant11.html

Whittington, R., Lancaster, G. A., Meehan, C., Lane, S., & Riley, D. (2006). Physical restraint of patients in acute mental health care settings: Patient, staff, and environmental factors associated with the use of a horizontal restraint position. *The Journal of Forensic Psychiatry & Psychology, 17*(2), 253-265. doi: 10.1080/14789940600645753

Wright, S., Sayer, J., Par, A. M., Gray, R., Southern, D., & Gournay, K. (2005). Breakaway and physical restraint techniques in acute psychiatric nursing: Results from a national survey of training and practice. *The Journal of Forensic Psychiatry & Psychology, 16,* 380-398. doi: 10.1080/1478994041233127075

Wynn, R. (2002). Medicate, restrain or seclude? Strategies for dealing with violent and threatening behaviour in a Norwegian university psychiatric hospital. *Scandinavian Journal of Caring Sciences, 16,* 287-291. doi: 10.1046/j.1471-6712.2002.00082.

Appendix A.1

Literature Summary Tables

Title / Author Year/ Purpose	Sample	Design	Outcomes Measured	Results	Conclusion / Rating
Early identification of seclusion and restraint patterns during adolescents' course of residential treatment. dosReis, S., McCulloch, J.R., Colantuoni, E., Barnett, S.R., Pruitt, D., Zachik, A., & Riddle, M.A. (2010). To determine when following an	156 admissions to 2 residential care facilities in Maryland between 2000 and 2005.	Naturalistic investigation. Retrospective study. Demographic data was collected from medical charts and cross referenced with incidence of restraint or seclusion to determine which patient demographic was at highest risk of these procedures.	Age, gender, race, length of stay, mental health diagnoses, prior hospitalization and use of psychotropic medication as factors related to being restrained or secluded.	Restraints or seclusion was more frequently used with younger females of African-American descent with a history of depression, anxiety or mood disorder who were sentenced to longer dispositions. Restrictive measures were also used more frequently after school or evening hours.	Limits: A retrospective design runs the risk of missing data as records were not kept with research in mind. Inclusion criteria (those with at least 12 months disposition) may represent the more aggressive youth which may attribute to an increased restraint and /or seclusion practice. The long

admission a youth is most at risk of seclusion or restraint.					period of time to complete the study may skew the results as well. <u>Strength:</u> Large study sample and length of study enhances validity of study. Medium quality.

Title / Author Year / Purpose	Sample	Design	Outcomes Measured	Results	Conclusion / Rating
Learning from tragedy: A survey of child and adolescent restraint fatalities. Nunno, M.A., Holden, M.J., & Tollar, A. (2006). To examine restraint related deaths in US residential care settings from 1993 to 2003.	45 child / adolescent restraint related deaths in 160 agencies in the US between 1993 and 2003.	Descriptive study. Data was tabulated from an internet search that yielded reports of restraint related institutional deaths. Circumstance of the fatality and characteristics of the youth were entered in a electronic database and analysed.	Trends among the fatalities: Age Reason for placement Facility Type Immediate cause of death Sex Restraint type Position of youth Rationale for restraint	Restraint related deaths were most common in: 14.2 year olds Diagnosed with behavioural, emotional, psychiatric or developmental condition. Psychiatric facility Asphyxia Male Physical restraint Prone position Noncompliance	<u>Limits:</u> No report on the frequency of restraint usage, the ratio of male to females in care, or the overall child population in care. No comparison of death by position. Only media –reported deaths included. Many unknown factors related to risk assessment and actual statistics. Medium quality.

Title/ Author Year/ Purpose	Sample	Design	Outcome	Results	Conclusion / Rating
Isolation and restraint in juvenile correctiona l facilities. Mitchell, J., & Varley, C. (1990). Examined the practice of restraint and isolation in order to recommen d safer alternative practices for behavioura l control.	Sample lacks clarity. Correction al settings across US and District of Columbia were either visited or telephone d. No definite number of institution s was provided. The number of inmates involved was not disclosed.	Descriptive Design. A cross-sectional study that examines the practice of seclusion and or restraint in youth corrections at one point in time. Recommendati ons are made accordingly.	The practice of isolation and restraint used by various institutio ns and the effects of same on youth.	A wide range of seclusion and restraint practices are used in juvenile custody with no standardization within or between institutions. The authors, expert mental health clinicians make recommendati ons to standardization of the appropriate use of restraints.	<u>Limits:</u> Validity is questionable as results are based on a limited number of facilities. Results therefore may not be generalizable to the broader correctional community. A scientific study may enhance the validity of the study. <u>Strengths:</u> Many recommendati ons are standard practice at my worksite.Some minor threats to validity, therefore medium quality.

Title/ Author Year/ Purpose	Sample	Design	Outcomes Measured	Results	Conclusion / Rating
A restraint on restraints: The need to reconsider the use of least restrictive interventions. Mohr, W.K., Mahon, M.M., & Noone, M.J. (1998). To describe attributes of troubled children and illustrate for caretakers why restraint is not the best option.	19 former patients hospitalized in psychiatric hospitals owned by the same cooperation between 1985 and 1991.	Exploratory-descriptive study using qualitative methods. A multiple case study design using semi-structured interviews and archived data consisting of medical records and questionnaires. Results were analyzed using N.U.D.I.S.T for qualitative data analysis.	Experiences of former patients who were admitted as children to psychiatric institutions.	Common themes emerged: Feeling misunderstood, alienated, and traumatized.	<u>Limits:</u> Recollections of former patients may be questionable. Time factors or feelings of anger at the time of the incidents may skew the accuracy of the reports. Archived medical records may be negatively charged because they are problem oriented. Small sample Validity therefore may be

					questioned. <u>Strengths:</u> Ethics approval obtained. Follow up interviews obtained. A variety of analysis techniques allows for thorough analysis, contributes to rigor & consistency Overall high quality.

Title / Author Year/ Purpose	Sample	Design	Outcomes Measured	Results	Conclusion / Rating
The use of mechanical restraint with people who engage in severe self-injurious behaviour: impact on support staff. Bethel, N., & Beail, N. (2013). To gain an understanding of the experiences of staff who apply restraints to those exhibiting self-injurious behaviour.	9 support staff who worked directly with intellectually challenged clients who engage in self-injurious behaviours.	A qualitative design. The study used a series of semi-structured interviews coding for themes until saturation was achieved. Data was analyzed using emergent coding.	The perceptions and experiences of support staff required to use mechanical restraints to prevent intellectually challenged clients from harming themselves.	All 9 support staff reported negative experiences related to the practice of applying restraints to patients. They reported feeling sad, guilty, fearful, and anxious.	Limits: Such a small sample limits the generalizability to other practice settings and with other groups. Medium quality.

Title/Author / Year/ Purpose	Sample	Design	Outcomes Measured	Results	Conclusion/ Rating
Staff training decreases use of seclusion and restraint in an acute psychiatric hospital. Forster, P.L., Cavness, C., & Phelps, M.A. (1999) To examine the effect of a quality improvement program on the rates of seclusion and restraint during a 12 month period before and after the implementation of the initiative.	One 83-bed psychiatric hospital in California. This hospital has an admission rate of 2000 patients per year.	A descriptive / ecologic design. The study analyzes the rates of seclusion and restraint before and after implementation of a quality improvement program. The participants are not manipulated in any way. This study demonstrates a relationship between the intervention and safer behavioural management.	Rates of seclusion and restraint in the hospital 12 months previous to and after the implementation of recommendations of a multidisciplinary quality improvement working group to reduce the use of physical constraint and seclusion.	The annual rate of restraint decreased 13.8% - from 2379 episodes per 2560 admissions in 1995 to 2380 episodes per 3010 admissions in 1996.The duration of seclusion also decreased 54.6% - from 13.9 hours per episode in 1995 to 6.3 hours per episode the following year.	<u>Limit:</u> Study confined to one hospital and descriptive design may threaten rigor and limit generalizability of findings. <u>Strengths:</u> study results are replicated in previous studies and reproduced across various psychiatric settings: acute, chronic, pediatric and adult clients and in teaching and community based institutions. Cause and effect are well established with no alternative variables accountable for the effect. Quality is medium.

Title / Author Year/ Purpose	Sample	Design	Outcome Measured	Results	Conclusion / Rating
Child and adolescent inpatient restraint reduction: A state initiative to promote strength-based care. Lebel, J., Stromberg, N., Duckworth, K., Kerzner, J., Goldstein, R., Weeks, M.,…Sudders, M. (2004). To reduce the use of seclusion and restraints by introducing a strengths-based model of care in a child and adolescent mental health	25 child/adolescent acute psychiatric units in Massachusetts.	Descriptive ecological design. Compares the rates of restrictive interventions before and after a different approach to care.	The total episodes of seclusion and/or restraint per 1000 patient days from Nov. 1999 to Aug. 2002.	The use of restraint and seclusion was significantly reduced on child and adolescent inpatient units after the introduction of a strengths-based model of care.	Limits: A variety of strengths-based models of care were used among the different state facilities. Results therefore are not linked to a single model. Generalizability may therefore be limited. Study was for 22 months post-intervention. This short interval may not be adequate to make accurate conclusions. Validity may be somewhat limited. Strength: study did not involve the effect of

inpatient unit.					policy change therefore findings based solely on the effect of care models utilized which was the intent of the study. Quality is high.

Title/ Author/ Year/ Purpose	Sample	Design	Outcomes Measured	Results	Conclusion / Rating
Behavioral management leads to reduction in aggression in a child and adolescent psychiatric inpatient unit. Dean, A.J., Duke, S.G, George, M., & Scott, J. (2007). To evaluate the impact of a behavioural management program on the frequency of aggression in children and adolescents in a mental health inpatient	10 bed child and adolescent mental health inpatient unit. 151 admissions took place on this unit during the study period from September 2003 to August 2004	A descriptive naturalistic study examining the rates of seclusion and restrain before and after the initiation of a behavioural management program.	Number of: Aggressive episodes Injuries Seclusions Restraints PRN medications Security services used Staffing factors	In the 6 months following the behavioural management program there were significant reductions in the aggressive incidents, injuries to patients and staff as well as the number of times security services were required. Number of retrains and seclusions were reduced and there was as slight decrease in the use of PRN medications used to treat aggression.	<u>Limits:</u> No standardized assessments were used. Findings were based on a retrospective review of clinical records. The study was based on findings in 1 institution over a short time frame leaving one to question whether the same results would be generalized to other settings and for longer periods of time. <u>Strengths:</u> Results of

unit.					this study were replicated in previous studies, enhancing its rigor. Medium quality.

Title / Author Year / Purpose	Sample	Design	Outcomes Measured	Results	Conclusion / Rating
Restraint reduction in children's residential facilities: Implementation at Damar services. Holstead, J., Lamond,D., Dalton, J., Horne, A., &Crick, R. (2010). To determine the effectiveness of a restraint reduction strategy in large residential setting for children.	A private non-profit residential facility for children in Indianapolis that services 125 youth.	Descriptive design. A retrospective study that compared the circumstances surrounding restraint before and after a restraint reduction plan.	Numbers of restraints, number of patient and staff injuries, and amount of time staff spent with restraints in 2004 before implementation of the program and again in 2008 after the program was initiated.	A significant decrease in the number of restraints, amount of staff time spent with restraints and the number of patient injuries secondary to restraint use.	<u>Limit:</u> The long period of time it took to complete the study (5 years) may lead one to question the results of the study. Was it that the changes were a direct result of the intervention or could it be that they evolved naturally over time – maybe by staff turnover and accompanying change in attitudes. <u>Strengths:</u> Results replicated in other studies. Results generalizable to other

					settings. High quality.

APPENDIX B

PRACTICUM: REPORT FOR CONSULTATION WITH COLLEAGUES

1. Brief overview of the project

Seclusion and restraint are commonplace in correctional institutions as methods to contain aggressive, disruptive or disrespectful behaviours (Allen, 2000). These abrasive methods have been shown to be potentially dangerous and nontherapeutic and as such have been called into question by justice officials who advocate for less invasive and more therapeutic means of behavioural control (Mohr, Petti, & Mohr, 2003). The move to set a 'best practice' model has prompted management at the Newfoundland and Labrador Youth Centre (NLYC) to revise policy on seclusion and restraint as they move toward a more rehabilitative model of care. Significant policy changes and stringent criteria for such restrictive means of control have considerably limited the autonomy of frontline correctional staff, who previous to the policy change have been instrumental in determining the parameters of seclusion and restraint. Further, the lack of formal training in therapeutic communication or psychological counselling has precipitated feelings of inadequacy as they feel ill-equipped to do their jobs.

The move from a punitive approach to one of therapeutics and rehabilitation behests a primary prevention plan whereby youth are empowered to problem-solve and self-soothe (LeBel et al., 2004), and positive behaviours are reinforced (Dean, Duke, George & Scott, 2007). This trajectory augmented with staff input and involvement in care

policies, enhanced communication between frontline staff and management as well as an unyielding accountability fosters a change in care philosophy which ultimately leads to a reduction in violence and aggression, hence seclusion and restraint (Holstead, Lamond, Dalton, Horne, & Crick, 2010; Johnson & Delaney, 2007; Duxbury & Paterson, 2005).

Misalignment of the new rehabilitative vision of management of the Newfoundland and Labrador Youth Centre with the concerns of correctional staff has incited me to develop a learning module for the youth care counsellors of NLYC about strategies aimed at decreasing the use of seclusion and restrain with young offenders. It is hopeful that the shift from a punitive to a rehabilitative model of care will enhance coping skills, foster therapeutic relationships and improve overall mental health so that upon release incarcerated youth can lead meaningful and productive lives.

2. Objectives for the consultation

The objectives for the consultation were:

1. To guide the development of the learning module pursuant to the learning needs identified with frontline staff, management and clinical staff.
2. To identify learning resources available to correctional staff and aid in the construction of the proposed learning module.
3. To seek feedback related to strategies on the implementation of learning.

3. Participants and Methods

The consultation process occurred at the Newfoundland and Labrador Youth Centre. The Administrator, Manager of Resident programs, Managers of Services and Operations, Clinical Therapist, Social Worker, Nurse Practitioner (NP), as well as Youth Care Counsellors were interviewed.

The administrator of the NLYC is the ultimate authority on policy and programming. He is responsible for all operations and accountable to the Department of Justice.

The manager of resident programs is in charge of programming and funding as well as the gatekeeper to statistics on incidents and happenings at the youth centre. She is instrumental to the implementation of the new policy on secure isolation and is interested to see what alternatives will foreseeably work relative to a new care philosophy at the youth centre.

The on-duty manager of services and operations supervises the daily operations of the facility and acts as the immediate supervisor of the youth care counsellors. They must be notified if a youth is put in seclusion or if restraining devices have been employed.

Mental health providers (social worker, NP, clinical therapist) were consulted for their expertise on how best to deliver the learning module relative to the identified learning needs of the front line workers and how their knowledge may contribute to this effort. Their input will be used to guide the development of the module.

Youth care counsellors are the direct care providers of the youth at the correctional facility. They are uniquely positioned to detect changes in the mental health

and wellbeing of the youth imposed by the seclusion or restraint. It is the youth care staff that ultimately decides if these restrictive devices will be used and the duration for which they will be implemented. The correctional staff are the employees at the crux of the conflict at the NLYC whereby they feel alienated by senior staff who have taken away their means to control and protect inmates. It is these staff that must cope with and find alternative ways of behavioural control. They were asked directly about their learning needs and how best to fulfill them.

This group was chosen because they are representative of the disciplines that care for the youth. This demographic offered diverse and comprehensive perspectives of contributing factors and adverse effects of the practice of seclusion and restraint of young offenders. They were contacted via email and invited to participate. Participation was strictly voluntarily.

Interviews were held in the participants' respective offices. Youth Care Counsellors were interviewed in the board room of the administrative office. A semi-structured interview (Appendix B.1) using open-ended questions elicited uninhibited responses and often times guided the next question. Closed-ended questions were used to begin the interview and provided demographical data. Questions were determined by the professional designation of the participant. With verbal consents from the participants all interviews were audio-taped and verbatim handwritten notes were used to supplement the process.

Each interview lasted approximately 30 minutes and each subsequent interview 15 minutes. Data was collected until all necessary information was obtained.

5. Data Management and Analysis

Data analysis occurred concurrently with data collection. Data was manually categorized into themes via file cards. This method was appropriate as there were only a few dichotomous themes pertaining to seclusion and restraint in youth corrections. For example, there were management issues (accountability, potential adverse effects of seclusion and restraint), clinical issues (deteriorating mental health), and concerns of frontline staff (lack of safety net, loss of autonomy, safety issues).

Content analysis was used to identify prevailing themes. Data was broken down into smaller, more manageable units, coded and named according to its respective content. Contingent with Krippendorff (as cited in Polit & Beck, 2012), categorical units defined its membership such as management, clinical, and front-line staff and their corresponding concerns. Thematic units consisted of the themes within these categories, for example the safety and accountability concerns of management, the health focus of clinical staff, and issues associated with autonomy of correctional staff.

The process of reading, rereading, and categorizing the data facilitated data analysis as, over time it became clearer what the data meant and it was easier to draw conclusions. Interpretations were validated with the participants.

6. Ethical Considerations

Permission to facilitate the interview process with staff was granted from the Manager of Resident Programs via email. The participants were briefed on the interview process and reminded that they were free to withdraw from the process at any time.

Contrary to my original plan to obtain written consents to participate in the interview it was determined that verbal consents would suffice and so were obtained from all those who participated. The audiotaped interviews and hand-written field notes remained in my possession, in a locked filing cabinet in the nursing office accessible only by master key which is governed by the facility manager and administrator. Confidentiality was maintained by assigning numerical codes to the participant. These codes are inaccessible to all managers and staff. Further, the final publication will be devoid of any identifiers. Audiotapes were erased immediately after use and subsequently shredded. Handwritten field notes were shredded immediately after use as well. Contingent with the Health Research Ethics Authority Screening Tool (Appendix B.2), it was determined that ethics approval was not required.

7. Results

Support related to adopting the new policy of least seclusion and restraint varied across the disciplines. Management seemed in favor of the new policy as it resulted in fewer incidents of seclusion and restraint. Clinical staff seemed indifferent toward the policy as it did not significantly impact their job. Youth care workers had a negative attitude toward the policy as they felt worked within its parameters and directly experienced the impact of the change. For the purposes of this report I shall categorize the results into Management, Clinical, and Frontline staff issues. The themes are further defined within these categories to include the subject matter addressed during the consultation process.

Management Issues

Five managers were interviewed – the administrator, manager of resident programs, and 3 managers of services and operations (MOSO). We discussed their role in the seclusion and restraint process, their opinion of the current policy, the impact of the policy on operations and the challenges associated with policy implementation.

Role in Seclusion and Restraint

None of the managers had any direct involvement in seclusion or restraint of the residents. The administrator is to be notified of any restraint process and approve any extended amount of seclusion (beyond 3 hours). The manager of resident programs is notified of all incidents of secure isolation and like that with the administrator, becomes involved only if the recommended amount of time in isolation exceeds that stipulated in policy. The managers of services and operations are notified by youth care staff when secure isolation is initiated and they in turn inform the manager of resident programs. They routinely communicate with the correctional staff to ensure both the safety of staff and incarcerated youth.

Opinion of New Policy

All managers feel the new policy is a step in the right direction. The administrator labelled it as a "fair" policy that holds youth accountable for their actions. The manager of resident programs says the new policy has placed restrictions on the use of secure isolation and has created a shift in the way disruptive behaviours are managed. One MOSO feels that more frontline staff discretion is warranted in the use of secure isolation.

Impact of Policy on Operations

The administrator contended that the policy has resulted in decreased seclusion

imposed upon the youth and simultaneously resulted in more counselling and programming. The manager of resident programs posited that there is a more stringent review of incidents that provoke seclusion and restraint and youth care staff are relying more on other skills such as counselling and defusing rather than resorting to these coercive measures. From the perspective of the MOSOs there is no significant change in operations and this new policy has created tension in the workplace between management and staff. They contend as well that the policy has yet to be accepted by youth care staff.

Challenges with Policy Implementation

Management unanimously agreed that staff support was the biggest challenge to policy implementation. Most of the correctional staff have been employed in the justice system for a number of years and are accustomed to using seclusion and restraint as means to control undesired behaviours. Front line correctional workers believe in the power of punitive measures to contain disruptive behaviours. Management contended that it was extremely challenging to change the thought processes of correctional staff that were "old school" as they didn't see anything wrong with their approach to behavioural management. It was reported by management that youth care staff were angry with them for instituting this new policy.

Clinical Issues

The clinical team at the NLYC consists of the NP, social worker, clinical therapist, psychologist, and psychiatrist. The psychologist provides services once weekly while the psychiatrist visits monthly. Due to the transient nature of their affiliation with the youth centre they were not interviewed. The NP, social worker and clinical therapist were interviewed regarding their role in policy, the benefits and challenges of the new

policy, impact on clinical practice, and their role in policy implementation.

Role in Seclusion and Restraint

The NP and social worker, albeit aware that a new policy was implemented regarding seclusion and restraint, were unaware of its particulars. Both the NP and the social worker were unsure of the time limits imposed upon seclusion. The social worker researched the specifics of policy during our interview. Neither of the clinical team members is directly involved in the seclusion or restraint process. The NP is called to assess the physical and mental status of the young person following restraint or seclusion, and the social worker does not become involved unless the amount of seclusion imposed exceeds policy in which case she discusses the situation with the correctional staff and the manager of services and operations. She would also be called upon to interview the youth in extreme cases of isolation as well. The clinical therapist is "very aware" of the new policy on secure isolation but is not involved unless there is disagreement among youth care staff and clinical team members on the amount of secure isolation to be imposed.

Benefits of New Policy

The nurse practitioner was of the opinion that time spent in seclusion does not have any therapeutic value and instead exacerbates the young persons' anger. The social worker agrees that short periods in "time out" as is aligned with current policy are just as effective as extended periods that were administered prior to the policy change. The clinical therapist is familiar with research that supports the notion that prolonged periods of secure isolation adversely affect ones mental health. With this new policy in place all clinical team members see decreased amounts of seclusion imposed on the youth as desirable.

Challenges of New Policy

The new policy did not present any challenges from a clinical perspective. Inconsistency among the correctional workers in the use of seclusion to contain negative behaviours was a predominant finding with the NP and social worker. They reported that the same infraction may incur different forms of disciplinary action by youth care staff consequently resulting in mixed messages for the youth involved. Confusion exists too regarding the authority to impose seclusion and restraint at all as some staff feel that they are not permitted to resort to this form of behavioural control. The clinical therapist contended that correctional staff are unsure about how to manage severe aggressive behaviours. The old policy provided them with more flexibility as to the duration of seclusion imposed for different behaviours, with more severe and aggressive behaviours resulting in longer periods of isolation. The new policy appears as a "one size fits all" approach with no differentiation between the offensive behaviours. She would like to see more creativity regarding the management of such cases.

Impact on Clinical Practice

The NP reported no obvious changes in her clinical practice and no discernable differences in the mental status of the youth incurring seclusion periods. The social worker contended that she is less involved in formal mediation which would require her to be physically present with the youth to attend to his or her emotional needs and to attempt to resolve any issues that contributed to the troubled behaviour. She said that since the policy implementation correctional staff usually have incidents resolved before they escalate to a level requiring her intervention. The clinical therapist reported that she is more involved in unit issues and she is currently implementing a Dialectical

Behavioural Therapy (DBT) program to facilitate the policy implementation. This weekly program teaches the youth skills in emotional regulation, distress tolerance, mindfulness and self-management. It is expected by the clinical team and management that correctional workers reinforce these skills with the youth on a daily basis.

Role in Policy Implementation

Clinical team members have identified resources available to youth care counsellors to help them mitigate negative behaviours and improve relationships with imprisoned youth. Some staff have received training in several competencies throughout the years to enable them to interact therapeutically with troubled youth and the clinical team is available to help with the facilitation and adoption of these practice regimes. The NP realizes the importance of educating correctional staff regarding mental health issues in youth and incorporating research about seclusion and restraint into practice. The social worker emphasized the value of team work and effective role modeling in policy acceptance. The clinical therapist as DBT coordinator sees her role as pivotal in improving the therapeutic milieu on the living units.

Frontline Staff Issues

The four staff members interviewed had an average of 23.25 years of experience in their current positions. One worker holds a degree in psychology, while another has completed "some" psychology courses. The remaining 2 correctional workers have completed courses in corrections. All but one reported that their educational background adequately prepared them for their position. We discussed the benefits and challenges of seclusion and restraint, their opinion of the new policy that limits the amount of seclusion to be used with disruptive behaviours, the tools they currently use in lieu of seclusion or

restraint and the challenges associated with the use of these alternate methods. Lastly, we talked about their needs in managing negative behaviours.

Benefits of Seclusion and Restraint

All correctional staff perceived some benefit in seclusion. They proposed that seclusion provided the youth with an opportunity to reflect on the situation that led to this punitive measure, it mitigated the offensive behaviour and offered them a "cool down" period, and afforded them some privacy which would facilitate therapeutic conversation with staff. Seclusion or restraint was seen as necessary to avoid self-harm and harm to others in situations of violence and aggression. Seclusion was also perceived as a punitive consequence to undesired behaviours with the potential to teach the youth right from wrong.

Challenges with Seclusion and Restraint

The cited challenges associated with the use of seclusion and restraint were many and varied. Staff acknowledged that deciding what circumstances warranted seclusion or restraint and for what duration was sometimes challenging. They said that often times youth did not understand the rationale for the use of these coercive measures. Correctional staff feared injury to staff and inmates as a result of the restraint process and subsequent legal fallout should the result be injury or death. They felt more staff was needed when a youth was placed in seclusion as their jobs required them to be more diligent with supervisory duties. One staff member reported that using these restrictive means in youth with mental health issues was inappropriate and other forms of therapeutic intervention is needed.

Opinion of New Policy

There were mixed reviews of the new policy among correctional staff. Three of the four correctional staff expressed frustration with the new policy insisting that it "ties their hands" in dealing with youth who display disruptive or inappropriate behavior. They feel that they have no recourse but to discipline all levels of disruptive behaviours equally or not at all. They feel as if the new policy has limited their autonomy and feel that they should be afforded more discretion in the use of seclusion and restraint. One staff member reported that the new policy is inappropriate in cases of violent behaviour and it is insufficient in changing undesired behaviours in general. Two workers claimed that the policy change has not made any difference in the way they do their jobs.

From a positive perspective, one worker said that the new policy has changed the way she views her job. She said she now sees herself as more of a counsellor as opposed to a guard. It was reported too that the new policy has increased awareness of the "old way of doing things" and begs the question if seclusion and restraint, as it was once used, was achieving desired results. Workers attribute less show of force to the new policy. The workers stated their preference is not to be involved in physical altercations with the youth and it is hoped that skills taught in the learning module may be geared toward de-escalation of aggressive and volatile situations.

Tools Used / Available Resources to mitigate Disruptive Behaviours and associated Challenges

All the correctional staff interviewed reported a progressive discipline approach to behavior management. This entails an initial verbal warning of inappropriate behavior as staff attempt to reason with the young person to stop the behavior. Counselling techniques contingent with DBT are utilized. If this approach fails the youth may be

placed in "cool down" – a brief period of seclusion until the behaviour is brought under control. If this approach is unsuccessful the young person is placed in secure isolation for a time to be determined by the youth care counsellor. The Behaviour Evaluation System (BES) - a points reward system whereby points are rewarded and deducted for positive and negative behaviours respectively and exchanged for certain unit privileges or small prizes is used to influence positive behaviours as well. Other than these aforementioned "tools" there are no resources currently available that address the needs of youth care staff to manage aggressive behaviours in a therapeutic and non-punitive manner.

Staff unanimously agree that these approaches, albeit appropriate as proactive strategies to prevent disruptive behaviours are insufficient to curtail violent and aggressive behaviours in progress when the only recourse is seclusion or restraint. They contended that reasoning with mentally ill youth challenges their patience and many times it is simply easier to put youth in isolation than to reason with them. All youth care staff unanimously contended that they feel deficient in their counselling skills and would welcome any form of education that advances their knowledge and skill in therapeutic communication.

Identified Needs to manage Disruptive Behaviours

Correctional staff overwhelmingly agreed that they need more education on mental illnesses and how to interact with mentally ill youth who behave aggressively. They identified a need for more proactive strategies to prevent disruptive behaviours. One correctional worker cited a need for more training in the proper application of physical restraints while another staff saw a need for an open forum for staff to discuss unit issues in a safe and nonjudgmental environment. All staff desired more flexibility in the new

policy with more discretion afforded to them in the use of seclusion and restraint.

Regarding teaching strategies, correctional staff contended that they prefer not to be lectured to but to witness or view some simulated scenarios of managing aggressive behaviours and therapeutic communication techniques that would be appropriate for the correctional setting. While on-line presentations are the preferred method of delivery, interactive seminars are valued as well.

8. Discussion and Conclusion

The results of the consultation will guide the development and refinement of the learning module. They will inform the content of the learning module and guide teaching methodologies utilized. The results of the consultation infer that the policy change has less significance for those more directly involved in youth care than for management who are remotely involved and there exists a divide among these disciplines as to the utility of the policy. Indubitably policy change coupled with DBT exposure has resulted in less seclusion imposed on imprisoned youth at NLYC, however issues abound beyond the statistics. As the chain of command descends it appears more issues and concerns surface with the practicality of these resources. However glorified on paper, statistical data offer little in the way of translating meaning where it matters. What does decreased frequencies and durations of seclusion look like on the living units where staff are stressed and frustrated, feeling inadequate to manage aggressive behaviours, and apprehensive and unsure about utilizing restrictive means of behavioural control? Is this, or should this be a consideration for management?

A balance between the objectives of management with that of front line staff

appeases all parties and lends itself to a harmonious work environment where all disciplines are respected - an ideal that manifests into competency, safety and security. Despite the initiatives put in place to decrease seclusion and restraint, correctional staff are experiencing difficulty with proactive and reactive strategies to disruptive behaviours and need other tools in their arsenal to increase their knowledge about mental illnesses and provide them with practical and therapeutic communication strategies to prevent and mitigate aggressive and disruptive behaviours. To that end, the proposed learning module will offer educational modules on various mental illnesses that allow correctional staff to test their knowledge about how best to communicate with youth who display disruptive behaviours in such a way as to avoid the use of seclusion and restraint. I envision an on-line learning module that offers vignettes of therapeutic conversations or interactions and a testing component that allows learners to choose the most appropriate response to comments made by the actors.

Further, correctional workers need to be able to communicate with management about what they see as deficiencies in operational guidelines which inform their practice and how these deficiencies impact their work. To augment support for and acceptance of the policy of least restraint, I will encourage team work among the disciplines and advocate for communication forums that promote input from frontline staff. A culmination of these ideals shall espouse the essence of my proposed learning module.

9. References

Allen, J. J. (2000). Seclusion and restraint of children: A literature review. *Journal of Child and Adolescent Psychiatric Nursing, 13*(4), 159-167

Dean, A.J., Duke, S. G., George, M., & Scott, J. (2007). Behavioural management leads to reduction in aggression in a child and adolescent psychiatric inpatient unit. *Journal of American Academy of Child and Adolescent Psychiatry, 46*(6), 711-720. doi: 10.1097/chi.0b013e3180465a1a

Duxbury, J., & Paterson, B. (2005). The use of physical restraint in mental health nursing: An examination of principles, practice and implications for training. *The Journal for Adult Protection, 7*(4)*,* 13-24. doi: 10.1108/14668203200500021

Holstead, J., Lamond, D., Dalton, J., Horne, A., & Crick, R. (2010). Restraint reduction in children's residential facilities: Implementation at Damar Services. *Residential Treatment for Children & Youth, 27*, 1-13. doi: 10.1080/08865710903507961

Johnson, M. E., & Delaney, K. R. (2007). Keeping the unit safe: The anatomy of escalation. *Journal of the American Psychiatric Nurses Association, 13,* 42-52. doi: 10.1177/1078390307301736

LeBel, J., Stromberg, N., Duckworth, K., Kerzner, J., Goldstein, R., Weeks, M.,…Sutters M. (2004). Child and adolescent inpatient restraint reduction: A state initiative to promote strength-based care. *Journal American Academy of Child and Adolescent Psychiatry, 43*(1),37-45. doi: 10.1097/01.chi.0000096368.43887.f7

Mohr, W.K., Petti, T.A., & Mohr, B.D. (2003). Adverse effects associated with physical restraint. *Canadian Journal of Psychiatry, 48*(5), 330-337

Polit, D. F., Beck, C. T. (2012). *Nursing research: Generating and assessing evidence for nursing practice (9th ed.).* New York: Lippincott Williams & Wilkins.

Appendix B.1
Interview Questions

Management Questionnaire:

1. **What is your role at NLYC?**
2. **How long have you held this position?**
3. **What is your educational background?**
4. **What is your opinion on the current policy on the use of seclusion and restraint?**
5. **How long has this policy been in effect?**
6. **What was the policy previous to this?**
7. **What was the impetus for this policy?**
8. **What is your role in the use of seclusion and restraint?**
9. **Is there flexibility in the policy on seclusion and restraint?**
10. **How has the policy/policy change been reflected in operations?**
11. **What challenges, if any, have been associated with the policy change?**
12. **How have these challenges been mitigated?**

Clinical Staff Questionnaire:

1. **What is your role at the NLYC?**
2. **How long have you assumed this position?**
3. **What is your educational background?**
4. **What is your awareness of the seclusion/restraint policy?**
5. **What is your role in this policy?**
6. **What do you see as the benefits and challenges of the new policy?**
7. **Has the new policy resulted in changes to your clinical practice?**
8. **What differences, if any, have you noticed in the mood or behaviour of young offenders since the policy change?**
9. **What do you see as alternatives to the use of seclusion and restraint?**
10. **Are these alternatives currently in practice? Why or why not?**
11. **How can your expertise help with the adoption of the new policy for youth care staff?**

Youth Care Staff Questionnaire:

1. **What is your role at the NLYC?**
2. **How long have you been in this position?**
3. **What is your educational background?**
4. **Do you feel your background adequately prepares you for this position?**
5. **Does your position require you to use seclusion and restraint with young offenders?**
6. **What are your views on the use of seclusion and restraint? (Challenges, benefits)**

7. **What is your awareness on the seclusion/restraint policy?**
8. **What is your opinion on the new policy on seclusion/restraint?**
9. **What difference has this policy made to your job? On operations?**
10. **What tools do you currently rely on to mitigate aggressive behaviours?**
11. **What challenges do you see with using these alternatives to seclusion/restraint?**
12. **What do you feel you need to enhance your ability to manage disruptive bahaviours?**

Appendix B.2
Health Research Ethics Authority Screening Tool

	Question	Yes	No
1.	Is the project funded by, or being submitted to, a research funding agency for a research grant or award that requires research ethics review	❒	❒☒
2.	Are there any local policies which require this project to undergo review by a Research Ethics Board?	❒	❒☒
	IF YES to either of the above, the project should be submitted to a Research Ethics Board. **IF NO** to both questions, continue to complete the checklist.	❒	❒
3.	Is the primary purpose of the project to contribute to the growing body of knowledge regarding health and/or health systems that are generally accessible through academic literature?	☒❒	❒
4.	Is the project designed to answer a specific research question or to test an explicit hypothesis?	❒	☒❒
5.	Does the project involve a comparison of multiple sites, control sites, and/or control groups?	❒	☒❒
6.	Is the project design and methodology adequate to support generalizations that go beyond the particular population the sample is being drawn from?	❒	☒❒
7.	Does the project impose any additional burdens on participants beyond what would be expected through a typically expected course of care or role expectations?	❒	☒❒
LINE A: SUBTOTAL Questions 3 through 7 = (Count the # of Yes responses)		1	
8.	Are many of the participants in the project also likely to be among those who might potentially benefit from the result of the project as it proceeds?	☒❒	❒
9.	Is the project intended to define a best practice within your organization or practice?	☒❒	❒
10.	Would the project still be done at your site, even if there were no opportunity to publish the results or if the results might not be applicable anywhere else?	☒❒	❒
11.	Does the statement of purpose of the project refer explicitly to the features of a particular program, Organization, or region, rather than using more general terminology such as rural vs. urban populations?	☒❒	❒
12.	Is the current project part of a continuous process of gathering or monitoring data within an organization?	x	
LINE B: SUBTOTAL Questions 8 through 12 = (Count the # of Yes responses)		5	

	SUMMARY **See Interpretation Below**		

Interpretation:

- If the sum of Line A is greater than Line B, the most probable purpose is **research**. The project should be submitted to an REB.
- If the sum of Line B is greater than Line A, the most probable purpose is **quality/evaluation**. Proceed with locally relevant process for ethics review (may not necessarily involve an REB).
- If the sums are equal, seek a second opinion to further explore whether the project should be classified as Research or as Quality and Evaluation.

These guidelines are used at Memorial University of Newfoundland and were adapted from ALBERTA RESEARCH ETHICS COMMUNITY CONSENSUS INITIATIVE (ARECCI). Further information can be found at: http://www.hrea.ca/Ethics-Review-Required.aspx.

APPENDIX C

Learning Module

Unlocking the Door to Mental Illness: A Learning Module for Youth Care Counsellors

Table of Contents

List of Tables

Introduction

Why should youth care counsellors complete this self-directed learning module on mental illness among incarcerated youth?

Seclusion and restraint are commonplace in correctional institutions as methods to manage aggressive and disruptive behaviours (Allen, 2000). These methods however have been shown to be nontherapeutic and potentially dangerous and are being shunned in favour of more therapeutic means of behavioural control (Mohr, Petti, & Mohr, 2003). Studies have shown that the move to least restrictive means involves a shift from the perspective of control to one of concern for the individual youth (Sullivan-Marx, Strumph, Evans, Baumgarten, & Maislin, 1999). Educational programs aimed at primary prevention and therapeutic communication are effective means of changing unit culture and fostering a rehabilitative model of care (Delaney 2006; Huckshorn, 2004).

Teplin et al., (2002) contended that as many as 75% of young offenders have at least one identifiable mental illness. Studies have shown that a lack of mental health training for front line correctional staff contributes to the use of seclusion and restraint as the mainstay of behavioural management of imprisoned youth who behave aggressively (Sorenson, 2010; Mood Disorders Society of Canada, 2009). The Mood Disorders Society of Canada (2009) reports a complete lack of mental health training for front line correctional staff. It is important that as direct care providers, you have sufficient understanding of the various mental illnesses common to our youth population. Understanding the causes of disruptive behaviours will enhance your ability to manage

them without resorting to seclusion and restraint. This module will provide you with an educational opportunity which will build on your existing knowledge of mentally ill incarcerated youth.

What is the purpose of the module?

This module will act as a resource while you provide care to incarcerated youth. It has been developed to enhance your knowledge of mental illness. The module provides an overview of common mental illnesses and effective communication skills. The knowledge gained from completion of this learning module will enrich your rapport with our youth and result in better outcomes when they behave disruptively.

The module is organized into seven units. More specifically:

Unit 1 provides a general overview of what it means to be mentally healthy versus mentally ill.

Unit 2 - 4 addresses some common mental health issues. These units present signs and symptoms of anxiety, depression, psychosis, and bipolar disorder respectively. General management techniques are identified. Some units contain clinical vignettes that will enhance your understanding of the specific disorder.

Unit 5 focuses on therapeutic communication skills that will enable you to build a trusting relationship with your clients. The ultimate goal of these skills is that they will enable you to diffuse potentially disruptive situations when they arise, minimizing the need for seclusion or restraint.

Unit 6 identifies practical strategies you may use to diffuse violence and aggression.

Unit 7 tests your knowledge of basic mental health issues. Answers are provided at the end of the testing section.

What is the best way to use this module?

This self-directed learning module was developed with your learning needs in mind. It presents current information in basic form. You may complete this module at your own pace and convenience. It is recommended that you complete the sections of the module in the sequence presented. You may test your knowledge by completing the questions at the end of the learning module. Contacts of frequently used resources are provided as well as links to other resources (Appendix C.1) should you require additional information.

Unit 1: Understanding Mental Illness – An Overview

Unit one provides a basic overview of mental health and mental illness and identifies risk factors and protective factors that contribute to mental illness. This knowledge will help in understanding your clientele and how his or her background may impact their mental well-being.

Mental health is broadly defined as "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community." (World Health Organization, September, 2010). Mental health is achieved when there is a "…balance between the mental, emotional, physical and spiritual health…" of an individual (Mood Disorders Society of Canada, 2009).

Mental illness as defined by the Mood Disorder Society of Canada (2009) is "a serious disturbance in thoughts, feelings, and perceptions that is serious enough to affect day-to-day functioning." Persons with mental illness usually display deficits in social adjustment, intellectual functioning, reasoning, thinking, memory and orientation. Mentally ill persons may exhibit poor impulse control, unrealistic self-appraisal, impaired judgement and inappropriate emotional responses. Delusions or other disorders of perception may exist as well (Health Canada, 2000). These alterations in behaviour may be more specifically defined depending on the nature of the mental illness.

It should be noted that certain life events and circumstances may adversely affect one's mental health. These are referred to as risk factors and are predictive of an increased likelihood or longer duration of a mental illness. Other circumstances called

protective factors, as the name suggests, decrease the risk for developing mental illness or better prepare one to deal with the effects of mental illness.

Table 1

Mental Illness Risk Factors

Mental Illness Risk Factors

Social isolation

Poor social support

Lack of housing, education

Uneducated

Substance abuse

Exposure to violence or trauma

Family history of mental illness

Unemployment

Medical illness

Stress related to life events

Racial injustice / Discrimination

Health Canada, 2000

Table 2

Protective Factors

Protective Factors

Ability to deal with stress

Positive parent-child relationship

Social support

Positive self-esteem

Problem-solving skills

Physical exercise

Sense of security

Sense of mastery and control

Literate, educated

Conflict resolution skills

Social and emotional growth

Good parenting and attachment

Adaptability and autonomy

Health Canada, 2000

Special Considerations

The mental health assessment of adolescents can be challenging. Caregivers need to be mindful of several characteristics pertinent to children and frame their interactions accordingly:

- Youth think in concrete terms. Youth care staff should gauge their communications with this in mind. Using fewer open-ended questions and simple phrasing will enable a more adequate assessment. Examples of this may be found in the Communication module.

- Developmental stage does not always coincide with chronological age. All children develop at different rates and stages. Do not assume that all 16 year olds have the same ability to understand and communicate. For various reasons, a 16 year old adolescent may have the mental ability of an 8 year old. This child needs to be communicated with at the level of an 8 year old.

- The influence of culture on one's mental health is significant. Behaviours that are considered normal or acceptable in some cultures may be unacceptable in others.

Psychiatric disorders are less easily diagnosed in children than they are in adults.

Austin & Boyd, 2008

The most common psychiatric condition among children and youth is anxiety.

Mood Disorders Society of Canada, 2009

Anxiety affects 6.5% of the Canadian youth population (Mood Disorders Society of Canada, 2009). Persons with anxiety experience uncomfortable feelings of apprehension or dread to things or events within one's body or in the external environment.

Anxiety is not always a negative experience. Occasionally anxiety motivates the individual to act or do better such as preparing for tests. Other times it results in "paralyzing fear that causes inaction" (Austin & Boyd, 2008). A perceived threat causes anxiety levels to rise resulting in physical and emotional changes in an individual (see Table 1). All symptoms of anxiety are experienced in all people under certain circumstances. Anxiety may be considered a mental illness when it is too intense for the situation and interferes with the person's ability to work or maintain relationships (Austin & Boyd, 2008). Generalized anxiety disorder exists when the individual worries too much over a period of at least six months. The worry is not usually

due to any particular situation, but rather a number of circumstances in one's life (Austin & Boyd, 2008).

Table 3

Symptoms of Anxiety

Physical	Emotional
Racing heart	Edgy
Increased blood pressure	Uneasy
Fainting	Impatient
Decreased heart rate	Nervous
Decreased blood pressure	Tense
Rapid breathing	Apprehensive
Shortness of breath	Frightened
Lump in throat	Alarmed
Choking sensation	Confused
Gasping	Unable to control thinking
Pressure of chest	Difficulty concentrating
Increased reflexes	Fear of losing control
Tremors	Altered environmental perceptions
Difficulty sleeping	Fear of physical injury / death
Pacing Fidgeting	Frightening visual images
Unsteadiness	Avoidance
Face flushed or pale	
Sweating	
Hot and cold spells	
Itching	
Loss of appetite	
Abdominal pain	
Diarrhea	
Dilated pupils	
Impaired coordination	

Persons with generalized anxiety disorder often have physical complaints (aches, pains, abdominal upset) and mood symptoms (depression)

Management of Anxiety

- Avoid caffeine – caffeine increases anxiety symptoms
- Adequate sleep – avoid anything that interferes with the sleep cycle (alcohol, dealing with sensitive issues before bedtime, eating late). Engage in activities that promote sleep (warm bath, relaxation, reading, routine bedtime).
- Referral to health provider
- Encourage positive self-talk – talk about the individual's positive attributes
- Stress management

Depression

Depression is defined as intense feelings of sadness and worthlessness that can impair one's ability to enjoy life (Mood Disorders Society of Canada, 2009). Symptoms include:

- Disturbed sleep
- Depressed mood
- Appetite / Weight changes (increased or decreased)
- Difficulty concentrating
- Decreased energy

- Feelings of guilt or worthiness
- Loss of pleasure in activities
- Suicidal thoughts

Age with the highest rate of depressive symptoms: Under 20 years of age

Mood Disorders Society of Canada, 2009

In addition to these symptoms, other behavioural findings may be observed:

- Panic attacks
- Difficulty with relationships
- Substance abuse
- Increased pain and physical illness
- Irritability, tearfulness
- Obsessive thoughts
- Excessive worry over physical health

The age of onset for depression is adolescence. This age group is more likely to experience symptoms of anxiety (physical complaints) and their mood may be irritable as opposed to sad. Suicide becomes a very real threat. Pay close attention to severely depressed clients who, all of a sudden feel

Suicide accounts for 24% of all deaths among Canadians aged 15-24
Mood Disorders Society of Canada

better and more energized. It may be that they have made the decision to commit suicide and are at peace with it. Do not misinterpret this as a sign of clinical improvement (Austin & Boyd, 2008).

Management of Depression

- Referral to healthcare provider for suicide assessment and possible antidepressants
- Referral to psychologist for possible psychotherapy
- Establish normal sleep patterns
- Healthy nutrition
- Activity and exercise
- Assist with medications if prescribed
- Establish supportive relationship
- Provide encouragement regarding progress
- Be available
- Help with realistic goal setting
- Ensure safety Therapeutic communication
- Be honest
- Maintain professional boundaries

Establishing a therapeutic relationship with a person with depression requires an empathetic, quiet approach. Too much enthusiasm can block communication.

The most severe mental illness is Schizophrenia (Austin & Boyd, 2008). This complex form of psychosis represents bizarre changes in thoughts and behaviours. A person with schizophrenia may experience delusions and hallucinations. They also may exhibit emotional inhibition.

Delusions are fixed beliefs that are false and make no sense to anyone but the person with schizophrenia. They take several forms:

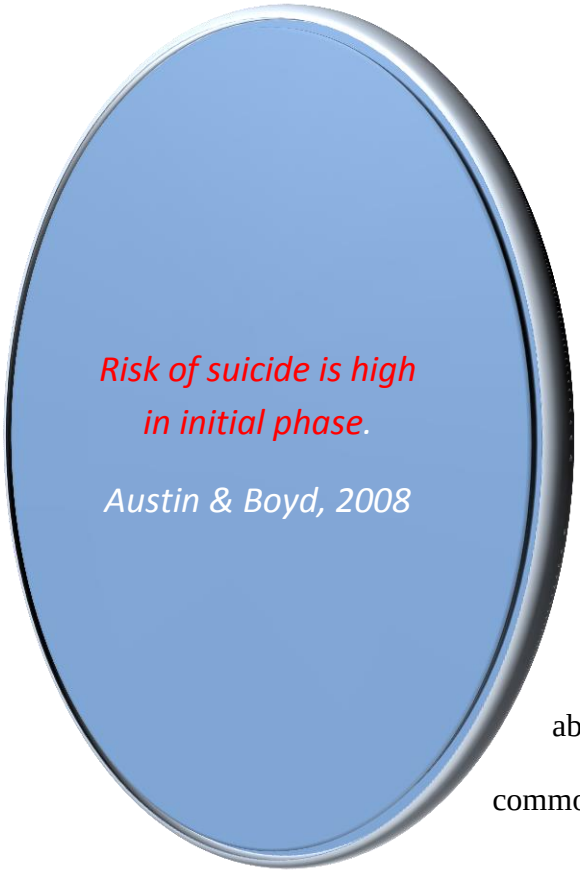
- The belief that one has exceptional powers, wealth, skill or importance
- The belief that one is being watched or plotted against
- The belief that one is dead or something dreadful is going to happen
- The belief that there is something medically wrong

Hallucinations are distortions in perception. They involve seeing, hearing or smelling things that aren't there. These experiences can be very frightening for the person.

Emotional inhibition exists when the person shows little or no emotion to personal loss. A child with schizophrenia laughs, cries and shows anger less often. Emotionally they are flat. They find it hard to make decisions because they do not know how they feel about something. Persons with schizophrenia do not enjoy pleasurable activities. They have difficulty with conversation and have limited speech. These feelings may interfere with their everyday needs such as bathing, dressing and eating. They often withdraw from social situations and suffer from feelings of isolation (Austin & Boyd, 2008).

Other bizarre behaviours include:

- Rage and hostility - especially if feeling threatened
- Agitation – can't sit still
- Abnormal movements
- Imitating movements and gestures of others
- Holding posture in odd positions for extended time



Course of Disease

The course of schizophrenia is not the same for everybody. Usually the personality changes are difficult to notice at first but then later become more noticeable. As the disorder advances the person is less able to care for themselves. Substance use is common.

After treatment is begun the symptoms become less severe but may still persist. There is no known cure. Life stresses may cause flare-ups. Treatment with medication is life-long.

One patient's parents report their son staying up all night having incoherent conversations with himself.

A patient believes he had been visited by aliens who want to unite their world with the earth and reassured him that he would be leader of his country.

Management of Schizophrenia

- Referral to healthcare provider
- Portray accepting, nonjudgmental approach
- Use calm approach
- Use short time-limited interactions
- Be consistent with interactions
- Follow through on promises
- Be respectful of the person and their personal space
- Be patient
- Provide reassurance

- Do not challenge hallucinations or delusions – remember that to the patient these are real.
- Acknowledge person's fear
- Provide opportunity for seclusion if hallucinating
- Determine content of hallucinations and delusions
- Identify the meaning of hallucinations and delusions for the patient
- Be genuine and empathetic
- Reorient to the here and now
- Ensure safety – suicide watch may be necessary
- Provide quiet, non-stimulating environment during acute phase
- Ensure adequate nutrition
- Provide opportunities for activity and exercise
- Ensure medication compliance (if ordered)
- Encourage socialization with peers (when stable)
- Assist with self-care as necessary
- Point out person's positive attributes
- Assist in developing positive coping mechanisms

- Ensure minimal stimulation in classroom
- Encourage family contact through visits and telephone

These symptoms cause great distress and interfere with social functioning and relationships

Bipolar disorder is a mood disorder characterized by cycles of feeling really happy and invincible followed by periods of depression (Mood Disorders Society of Canada, 2009). The high period lasts at least one week and is usually accompanied by:

- Distractibility
- Engaging in questionable activities (excessive shopping, sexual indiscretion)
- Inflated self-esteem
- Racing thoughts

- Increased activity or agitation
- Decreased need for sleep
- Talkativeness

Health Canada, 2000

The person with bipolar disorder usually behaves normally between mood cycles.

Management of Bipolar Disorder

In the acute or "high" phase the person with bipolar disorder may resist any kind of interference because they like how they feel and they don't see the need for any type of intervention.

- Referral to health care provider
- Be respectful of client's feelings.
- Avoid reacting to client's behaviours.
- Avoid confrontations
- Be firm and consistent.
- Respond calmly
- Protect from harm
- Use distraction technigues when hyperactive

- No Caffeine
- Ensure compliance with medications if ordered.
- Decrease stimuli to ensure adequate sleep
- High energy foods
- Adequate fluids
- Assist with self care when needed
- Limit stress

Clinical Vignette

Peter S. is a 17 year old male who has recently began getting in trouble with the law. He began drinking alcohol when he was in his early teens. His mother abandoned him when he was a young child and he never knew his father. He was raised by his aunt in a small isolated community. His maternal grandfather and his sister committed suicide within the past few years.

Last year Peter sold his aunt's jewellery and moved to the city where he was stopped by the police driving a stolen car at a dangerously

excessive speed. In police custody, Peter was witnessed pacing the floor of his cell all night long and talking non-stop to the prison guard through his cell door. The next day Peter could not sit still long enough to eat his meals and again began to talk excessively to cellmates. He became enraged when a guard told him to stop annoying everyone. Peter was transported to the local health centre where he is being investigated for bipolar disorder.

Therapeutic communication is essential to developing a trusting relationship with those affected by mental illness and is fundamental to mental health intervention (Austin & Boyd, 2008). This unit identifies the importance of self-awareness in the therapeutic relationship and discusses communication skills that promote a healthy rapport. The role of boundaries will be discussed in relation to the therapeutic relationship as well.

Self-awareness is the ability to understand one's own beliefs, attitudes and feelings and how they affect other people. (Austin & Boyd, 2008). As caregivers, you must not let your personal feelings influence how you treat others. All youth, regardless of who they are or what crime they have committed are to be treated with respect. It may be extremely challenging to put your personal feelings aside and at times it may be impossible. In such cases your manager may assign you to a different unit. The important thing is that you acknowledge your feelings.

Being hostile toward sex offenders is an example of letting your personal feelings interfere with care.

Self-disclosure, or sharing personal information about yourself to clients is usually not a good idea. The cornerstone of a therapeutic communication is that it focuses on the client (Austin & Boyd, 2008). In the event a

request for personal information is made you should always redirect the conversation to focus on the client.

Table 4

Self-Disclosure in the Therapeutic Relationship

Situation	Inappropriate Response	Appropriate Response
Client asks worker if she had fun over the weekend.	"It was great. I went out dancing with my friends."	"The weekend was fine. How was your's?"
Client asks worker where he lives.	"I live on 123 Street, Anytown."	"I'm not from around here."

Communication is verbal and nonverbal. Both are equally important in developing a therapeutic relationship. There are numerous verbal communication skills that are used to keep the client talking. Each one has a specific purpose and will be discussed separately. Overall they aid in establishing a trusting relationship between the caregiver and client.

Table 5

Therapeutic Communication Techniques

Technique	Definition	Example	Rationale
Acceptance	Being non-judgemental and interested	Ct: *I am the worst person.* YCC: *I'd like to hear more about that. It's okay to talk about it.*	Develops trust and empathy
Confrontation	Giving the client a different perspective	Ct: *"My parents hate me. They never call"* YCC: "*They came to visit last week*."	Redefines the client's reality. Use cautiously
Doubt	Expressing doubt or disagreement	Ct: "*Everybody wishes I was dead*" YCC: "*Your parents seem to care very much for you"*	Directs client toward other explanations. Use cautiously and only when confident of the details.
Interpretation	Putting into words what the client has said	Ct: "*I couldn't sleep because staff was looking at me all night"* YCC: "*That made you feel uncomfortable*"	Helps client identify feelings
Observation	Telling the client what you are witnessing	YCC: "*You look tired. Didn't you sleep well last night*?"	Effective when client's behaviour is obvious or unusual
Open-ended statements	Introducing an idea and letting the client expand on it	YCC: *"How does that make you feel?"*	Enables client to explore feelings
Reflections	Redirecting back to the client what he or she has said	Ct: *Should I call home?"* YCC: "*Should you call home?"*	Promotes non-judgemental approach
Restatement	Repeating the main idea.	Ct: "*I miss my family"* *YCC: "You feel alone"*	Clarifies what client has said
Validation	Clarifying your understanding	YCC: *"Let me see if I understand this right"*	Used to help understand what was said

Adapted from Austin & Boyd, 2008.

Table 6

Techniques that Block Communication

Technique	Definition	Example	Problem
Advice	Telling client what to do	Ct: *"I can't take this medication. It makes me sick."* YCC: "*Just take it and try not to think about it"*	Solving problems for client encourages dependency
Agreement	Agreeing with client's point of view	Ct: "*Drugs are just wrong."* YCC: *"I agree"*	Discourages client from considering another point of view
Challenges	Disputing with client's beliefs	Ct: "*I'm a rock star*" YCC: "*If you're a rock star what are you doing here?"*	Belittling to client. Discourages client from talking
Reassurance	Telling client everything will be alright	Ct: *"I'm such a loser*." YCC: "*You're a good person."*	May not be truthful. Discourages client from exploring feelings further
Disapproval	Judging client's behaviour	Ct: "*I stole my aunt's jewelry*." YCC: "How could you steal from your own family?"	Belittles client

Adapted from Austin & Boyd, 2008.

Nonverbal communication is a true reflection of one's feelings and attitudes toward another person. It is demonstrated through body language, gestures and facial expression (Austin & Boyd, 2008). Nonverbal cues should coincide with what is communicated verbally but often times this is not the case. When verbal and nonverbal communications do not match, the listener will believe the nonverbal message.

The youth care counsellor must ensure that his or her nonverbal and verbal messages match.

....A client tells you that he is okay with his parents breaking their promise that they would visit but looks like he has been crying....

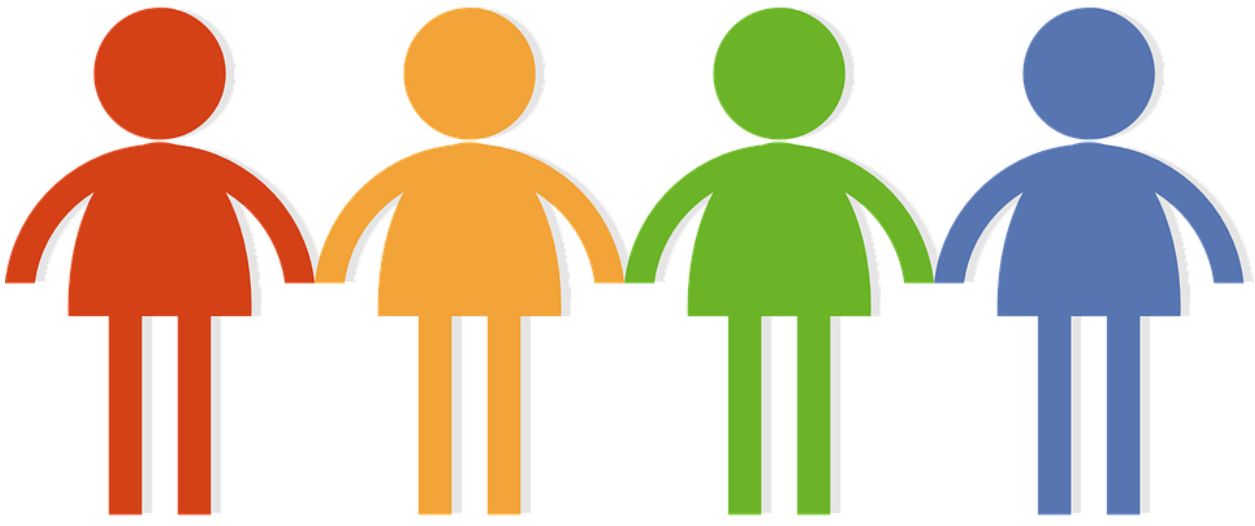
It is important to note however that nonverbal communication is greatly influenced by culture. In many Canadian Aboriginal cultures it is considered disrespectful to look someone in the eye.

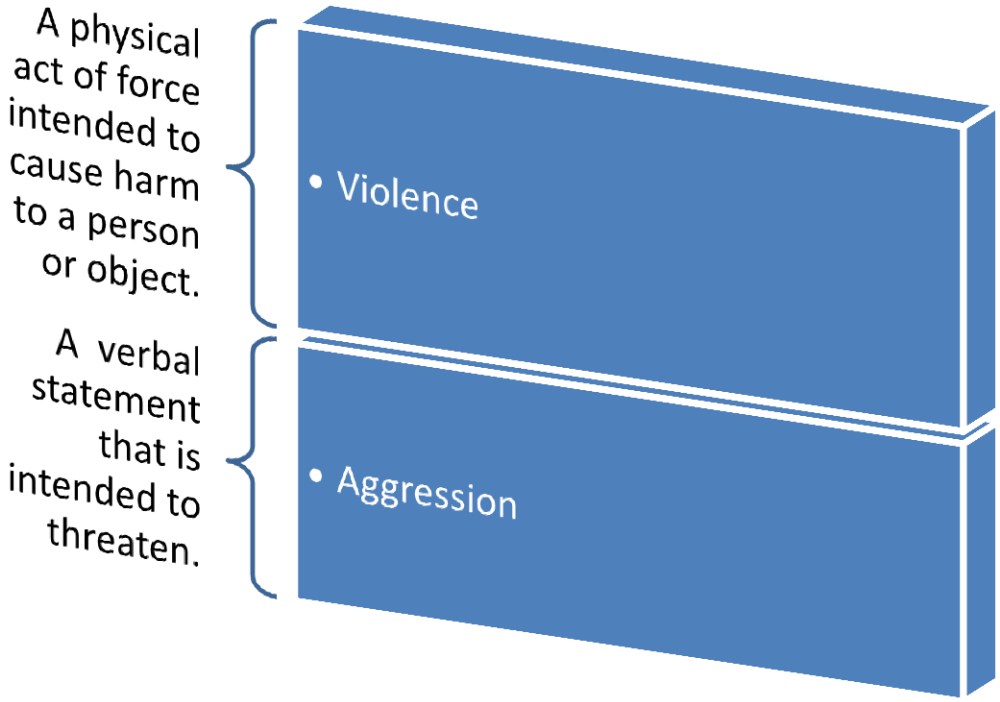
Boundaries are extremely important in any therapeutic relationship. Professional boundaries define the limits of relationships with clients and often determine what acceptable behaviour is within the relationship. The following are some indicators that the relationship may be moving outside professional boundaries:

- Gift Giving
- Spending more time than usual with the client

- Seriously defending the client's behaviour at team meetings
- Feeling that you are the only person who understands how the client feels
- Keeping secrets pertaining to the client
- Sharing your personal information with the client
- Frequently thinking about the client outside of work hours.

Austin & Boyd, 2008.





Austin & Boyd, 2008

Being able to predict violence and aggression helps caregivers to prepare for these uncomfortable and potentially dangerous situations. Some predictors of violence and aggression include:

- Previous episodes of violence or rage
- Escalating irritability
- Brain injury
- Substance use or abuse
- Use of certain medications (anti-seizure medications) Austin & Boyd, 2008

Physical and behavioural cues to anger are important to be aware of:

- Clenched fist, firm jaw
- Changes to the eyes: eyebrows lower and closer together
- Lips pressed together to form a thin line
- Flushing
- Goose bumps
- Twitching
- Sweating
- Increased muscle tone

Safety of clients and staff should be maintained at all times. Although most individuals with a mental illness do not behave aggressively, caregivers should always be prepared to respond to violent situations, while being mindful that minimizing personal risk is a priority. There are several basic actions that you can take to ensure your safety in potentially volatile situations:

- Use nonthreatening body language
- Respect client's personal space
- Position self so that there is access to the door in the event of need for escape
- Leave door open while client is in same office
- Always know whereabouts of colleagues
- Refrain from wearing clothing or accessories that could be used to cause harm (dangling earrings, scarves).

Austin & Boyd, 2008

Preventative measures decrease the possibility of violence and aggression:

- Taking a thorough client history may identify history of violence
- Ensure consistent limit setting
- Encourage the client to speak calmly and constructively with those whom they are angry instead of to a third party

- Schedule regular but brief "cool down" periods to provide for privacy
- Involve the client in contracting an outline of expected behaviours and consequences. Goal setting may be discussed as well
- Adequate nutrition
- No caffeine (caffeine is a stimulant)
- Reduce feelings of isolation
- Provide choices. Frequently clients have little control over their daily routine. Providing them with opportunities for decision making (which pants to wear, what to eat), may decrease feelings of helplessness and increase self-esteem and sense of control.
- Highlight the client's positive characteristics
- Anticipate client's needs. Aggressive outbursts are often provoked by hunger, thirst, or need to urinate. Regular meal times and bathroom routines may lessen the possibility of aggression in those with cognitive impairment.

Morrison et al, 2003; Austin & Boyd, 2000

Other preventative strategies focus on teaching the client specific skills they can use to manage their anger:

- Thought stopping is a technique used to “turn off” angry feelings. This process invites the youth to identify anxiety-provoking thoughts and encourages them to focus on other feelings instead. The client may say “stop” aloud or sub-consciously and think about other pleasing thoughts.

- Assigning tasks such as observing how others manage anger and to evaluate the effectiveness of same with care provider.

- Bibliotherapy is a simple technique whereby the client reads educational information about anger management and discusses with care provider which strategies he or she may use when angry.

- Interrupting patterns involves disrupting negative thoughts to prevent the escalation of anger and allows the client to regain composure (counting to 10, leaving the area, do something different).

Austin & Boyd, 2008

Often times, therapeutic communication is adequate in diffusing potentially violent and aggressive situations. The conversation serves to help the client identify the purpose of his or her anger and to find solutions to it.

- The caregiver must always treat the client with respect

- Approach client calmly

- Use non-threatening body language

- Assume non-judgmental attitude
- Avoid violation of clients boundaries
- Establish trust and rapport. Help client identify source of anger
- Prevent physical harm to self and others
- Encourage self-soothing measures (deep breathing, self- talk)
- Reassure client that staff will ensure safety
- Seclusion for brief period if other measures have failed
- Mechanical restraints only as last resort to ensure safety

Clinical Vignette

Tommy is a 16 year old male, who was admitted to the youth centre on assault charges. He is being held for court. The nurse practitioner completes a routine assessment on Tommy and he reports a long standing history of drug abuse. He tells the nurse that he doesn't know how to cope with prison if he is convicted. He appears nervous and agitated. He is pacing the floor and pounding one fist into his other hand. He asks the nurse if he may have some Ativan to help him settle. The nurse advises him of the adverse effects of Ativan and

encourages him to use alternative coping mechanisms instead. Tommy leaves the nursing office quite upset and shouts profanities at the nurse as he leaves. He is escorted back to his unit by youth care staff that have been chaperoning his nursing visit.

Below is an example of how effective communication skills help to diffuse this potentially volatile situation.

Ineffective Approach	Effective Approach
YCC: ***Tommy I understand that being in here scares you.*** **Tommy:** ***How can you possibly understand? Have you ever been held prisoner?*** **YCC:** ***I do understand Tommy. Now you must calm down or you'll lose your privileges.*** **Tommy:** ***(voice gets louder) I don't care about privileges. Privileges are not gonna help me cope with this place. Can you talk to the nurse for me?*** **YCC:** ***No Tommy, I can't. She already refused to give you the medication.*** **Tommy:** ***Thanks for nothing!***	**YCC:** ***Tommy I understand that you're frustrated. What exactly did the nurse say to you?*** **Tommy:** ***She said that I couldn't have the medication. No explanation really, just that I should find other ways to cope with being in here. She said it would get easier.*** **YCC:** ***Some people might feel like they weren't being taken seriously. Is this how you feel?*** **Tommy:** ***Yeah…story of my life!*** **YCC:** ***Sounds like experiences like this make you feel powerless?*** **Tommy:** ***I don't have any power. Sometimes when I have no power I get angry. At least then I get people's attention.*** **YCC:** ***Well in the situation with the nurse, what would help you feel that you had some power?*** **Tommy:** ***Well if she would only take me seriously instead of saying it will get easier. She doesn't know me.*** **YCC:** ***Yes that's true. You could help her get to know you so she could get a clear picture of your history. Would you like that?*** **Tommy:** ***Yes, that would make me feel like someone is on my side.***

Unfortunately and despite our best efforts these interventions will not be successful with all clients. This is not the fault of any particular individual. It simply means that the intervention did not fit with the particular situation at that point in time.

In the event of uncontrolled anger and rage immediate action is required:

Call for help

Remove other clients from the area

Give client choice as to which intervention he or she would prefer (cool down, counsellor, lose privileges)

If noncompliant escort to private room.

Seclusion or restraint as last resort

Unit 7: Testing Your Knowledge

Now that you have completed this module, you may want to test your knowledge about mental illness. Answers are provided at the end of the testing section.

1. Label the following as being either a **protective factor** or **risk factor** for mental illness:

- Problem-solving skills
- Social Isolation
- Exposure to violence or trauma
- Regular physical exercise
- Sense of security

2. An Aboriginal male does not make eye contact when you are having a conversation with him. The **most likely** explanation for this is:

   (a). He does not like you

   (b). He does not hear you

   (c). This behaviour is a cultural finding

   (d). He has low self-esteem

3. Mental health disorders look the same in adults and adolescents: True or False?

4. The most common psychiatric disorder in adolescents is:

   (a). Schizophrenia

(b). Depression

(c). Bipolar Disorder

(d). Anxiety

5. Sam believes the radio host is talking directly to him. This is an example of:

(a). Self-talk

(b). Hallucination

(c). Delusion

(d). Illusion

6. Match the following symptoms to the most probable disorder:

- Racing heart, pacing, fidgeting, pressure on chest.
- Difficulty sleeping, loss of pleasure, irritability, obsessive thoughts.
- Feeling really good, increased energy, decreased need for sleep, followed by bout of depression.

(a). Depression

(b). Bipolar Disorder

(c). Anxiety

7. Chris, a 17 year old male has been battling depression since his admission 2 weeks ago. He has been lying around the unit refusing to participate in any of the unit activities or socialize with his peers. One morning Chris is seen laughing and talking with the other boys on the unit. He gives away his watch that his mother had given him for his birthday. You should consider:

(a). He is getting better

(b). He is thinking about suicide

(c). His peers have threatened him

(d). He is hearing voices

8. Marsha is hearing voices that are telling her to hurt herself. This is an example of:

(a). Thought Blocking

(b). Delusion

(c). Hallucination

(d). Illusion

9. The best approach to someone who is hearing voices is:

(a). Tell the client the voices are not real

(b). Find out what the voices mean for the client

(c). Agree with the client

(d). Seek an adjustment in the client's medication

10. You are caring for a teenaged girl charged with drug trafficking. Your nephew recently died from an accidental drug overdose at a party where drugs were obtained from a seller in the community. You are having difficulty containing your feelings. What should be your course of action?

(a). Discuss your situation with your manager and ask to be switched to a different unit.

(b). Try to supress your feelings and fake acceptance of the young girl.

(c). Treat the girl harshly

(d). Ignore your feelings

11. Jessie shouts at you and calls you a mean name when you tell him it's time to go to bed. The **most appropriate** response would be:

(a). "I really don't care what you think of me."

(b). "Let's talk about ways to manage your anger."

(c). "I know it's upsetting for you to go to bed at this time. Let's talk about that for a while."

(d). "Just go to your room Jessie."

12. Joshua was recently admitted to the facility. He is charged with car theft. He has bipolar disorder and you learn that he has recently decided to stop taking his medications because he was feeling so good. You are working night shift and you notice that Joshua is still awake well past midnight. He is pacing the floor in his room and he is singing quite loud. You worry that he will wake the other clients. What is your **top** priority at this time?

(a). Tell him to go to bed.

(b). Protect him from self-harm

(c). Keep him from waking the other clients

(d). Threaten to take away his unit privileges

13. Randy, who has depression, tells you that he didn't sleep well last night. Your **most appropriate** response would be:

(a). "Neither did I. The rain kept me awake."

(b). "Oh, that's too bad. Perhaps you will get a nap today."

(c). "Perhaps you shouldn't eat before you go to bed."

(d). "What do you usually do when you can't sleep?"

14. Katrina frequently complains of headaches. She has been investigated by her family doctor and all tests were negative. She approaches you one night and tells you she has a headache again. What should you do?

(a). Ask her to describe her headache

(b). Refer her for medical attention

(c). Give her the acetaminophen you have in your purse.

(d). Tell her to stop looking for attention.

15. Angie has schizophrenia. You are trying to have a conversation with her but she appears distracted. She is looking behind you. This is **most likely** due to:

(a). Lack of respect for you.

(b). Characteristics of her disorder

(c). Angie's low self-esteem

(d). Angie's inability to concentrate

16. Effective relaxation techniques consist of:

(a) Cup of coffee

(b). Loud music

(c). Slow deep breathing

(d). Quiet private room

(e). All of the above

(f). a,c, & d

(g). c &d only

17. You promise Mary that you will watch a movie with her after dinner. There is an unexpected admission and you will not have the opportunity to watch a movie today. Your **best** approach would be:

(a). Tell Mary you will watch a movie with her some other time.

(b). Tell Mary that you don't have the time to watch a movie with her.

(c). Tell Mary to make a list of the movies that she would like to see and tomorrow you'll pick one out and watch it together.

(d). Ask your co-worker to watch a movie with Mary.

18. You are assigned to do a suicide assessment on a potentially violent new admission. You feel uneasy about being alone in a small room with him. What can you do to ensure your safety?

(a). Leave the door open

(b). Sit behind the desk that's positioned in the corner of the room

(c). Refrain from wearing long scarves and long earrings

(d). Sit closest to the door

(e). Leave the window open

(f). All of the above

(g). a, b, & c

(h) a, c, & d

19. Peter was just admitted to the facility. He is charged with attempted murder of his mother. He is tearful during the admission process and he attempts to speak to you about what he has done. The **most therapeutic** response would be:

(a). “I can’t believe you tried to kill your mother.”

(b). “Are you on drugs?”

(c). “You seem upset.”

(d). “What did your mother do to you?’

20. John verbally assaults you. The most appropriate course of action would be:

(a). Demand that he apologize.

(b). Point your finger at him and tell him his behaviour is not acceptable

(c). Put him in seclusion

(d). Tell him his behaviour is not acceptable and assist him in anger management techniques.

Answer Key

1. P, R, R, P, P

2. C

3. False

4. D

5. C

6. C, A, B

7. B

8. C

9. B

10. A

11. C

12. B

13. D

14. B

15. B

16. G

17. C

18. H

19. C

20. D

REFERENCES

Allen, J. J. (2000). Seclusion and restraint of children: A literature review. *Journal of Child and Adolescent Psychiatric Nursing, 13*(4), 159-167

Austin, W., & Boyd, M. A. (2008). *Psychiatric nursing for Canadian practice.* Philadelphia, PA: Lippincott Williams & Wilkins

Mohr, W.K., Petti, T.A., & Mohr, B.D. (2003). Adverse effects associated with physical restraint. *Canadian Journal of Psychiatry, 48*(5), 330-337

Health Canada (2000). *First Nations and Inuit Health Branch Clinical Practice Guidelines for Nurses in Primary Care.* Government of Canada. Retrieved from http://www.hc-sc.gc.ca/fniah-spnia/services/nurs-infirm/clini/index-eng.php.

Huckshorn, K. A. (2004). Reducing seclusion and restraint use in mental health settings: Core strategies for prevention. *Journal of Psychological Nursing and Mental Health, 42*(9), 22-33. PMID: 15493493

Mood Disorders Society of Canada. (2009). *Quick facts: Mental illness & addiction in Canada.* 3rd ed. p.4. Available at: http://www.mooddisorderscanada. ca/documents/Quick%20Facts%203rd%20 Edition%20Eng%20Nov%2012%2009.pdf

Morrison, E. F., & Carney Love, C. (2003). An evaluation of four programs for the management of aggression in psychiatric settings. *Archives in Psychiatric Nursing, 17*(4), 146-155. doi: 10.1016/j.apnu.2004.09.008

Sorenson, K. (2010). *Mental health and drug and alcohol addiction in the federal correctional system. Report of the Standing Committee on Public Safety and National Security*. Ottawa, Ontario: Government of Canada. Retrieved from http://www.parl.gc.ca/content/hoc/Committee/403/SECU/Reports/RP4864852/securp04/securp04-e.pdf

Sullivan-Marx, E. M., Strumph, N. E., Evans, L. K., Baumgarten, M., & Maislin, G. (1999). Initiation of physical restraint in nursing home residents following restraint reduction efforts. *Research in Nursing and Health, 22,*369-379. doi: 10.1002/(SICI)1098-240x(199910)

Teplin, L. A., Abram, K. M., McClelland, G. M., Dulcan, M. K., & Mericle, A. A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry, 59*(12), 1133-1143. doi: 10.1001/archpsyc.59.12.1133

Appendix C.1

Other Resources

Contacts

Canadian Mental Health Association …….1-877-753-8537

Dr. Wm. H. Newhook Community Health Centre…….....759-2300

Kid's Help Phone…….…….…….1-800-668-6868

Janeway Children's Health and Rehabilitation Centre…....……...1-709-777-6300

Mental Health Crisis Line…….……..….1….-888-737-4668

Poison Control Centre……..……1-709-722-1110

R.C.M.P.....…...759-2600

Smith's Ambulance……759-2691

WEBSITES

A link to the American Academy of Child and Adolescent Psychiatry
www.aacap.org

A link to an internet guide for education and resources
www.mentalhelp.net

A link to the provincial associations websites
www.schizophrenia.ca