MODULE 5

Strategies to Prevent Seclusion and Restraint

Module 5

Strategies to Prevent Seclusion and Restraint

*"It is rather impressive how creative people can be when restraint
is simply not a part of the treatment culture."*
—John N. Follansbee, M.D.
JCAHO testimony,1999

Learning Objectives

Upon completion of this module the participant will be able to:
- Define and outline the benefits, underlying values, and key elements of consumer-driven supports.
- Develop and apply a Wellness Recovery Action Plan (WRAP).
- Identify benefits of drop-in centers, recovery through the arts, technical assistance centers, and service animals.
- Name key elements to implement a comfort room and describe what staff can do to support these consumer-driven supports.
- Guide a consumer in developing a Psychiatric Advance Directive/Prime Directive.
- Identify and implement effective communication strategies that prevent the use of seclusion and restraints, including Alternative Dispute Resolution and Mediation.

MODULE 5: STRATEGIES TO PREVENT SECLUSION AND RESTRAINT

BACKGROUND

BACKGROUND FOR THE FACILITATORS: CONSUMER STRATEGIES TO PREVENT SECLUSION AND RESTRAINT

Overview

"Consumer/survivor operated self-help programs are a relatively recent phenomenon. Over the last twenty years, consumers/survivors have shifted from passive recipients of mental health services to become increasingly involved in planning, providing, and evaluating mental health services. The U.S. Department of Health and Human Services cites the following benefits of self-help groups: peer support, coping strategies, role models, affordability, education, advocacy, non-stigmatizing, and "helper's principle." In addition, several other features distinguish self-help from other forms of professional services: non-reliance on professionals, voluntary participation, egalitarian and peer-based, non-judgmental, and informality" (U.S. Department of Health and Human Services, 2001).

Self-help is a concept, not a single program model. Self-help is a way in which people become empowered, begin to think of themselves as competent individuals and present themselves in new ways to the world. Self-help, by its very nature, combats stigma and discrimination. The negative images of mental health consumers as needy and helpless ultimately must give way to the reality of consumers managing their own programs and taking on increased responsibility for their own lives.

Consumer-run programs that develop independently differ from those that grew directly out of mental health system initiatives to promote self-help. Members of mental health consumer movement programs tend to be skeptical about the value of the mental health system and traditional psychiatric treatment. Individuals usually gravitate to consumer movement programs because they have had negative experiences in the mental health system. Often they are angry and the program members see their anger as healthy. At the same time, members, despite their distrust of the system, may simultaneously be involved in professionally run programs. Members of consumer-run services are free to combine their participation in self-help groups with professionally run services, in whatever proportion and combination each member determines.

There is no question that self-help programs foster autonomy. Members are encouraged to look to themselves and to one another for support and understanding, and to see themselves as having strengths and abilities. The experience of being a helper is empowering. Encouraging group members to turn to one another develops and strengthens natural support networks. This helps to end the isolation that is characteristic of many who have a mental illness. Similar to other kinds of groups and organizations, consumer-run programs may experience problems and difficulties. This can be discouraging to group members and may serve to confirm some of the negative beliefs about themselves. These experiences also have a positive aspect since they can be used to help members see that problems and difficulties are normal events

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as people work together and that the group has the ability to solve problems in the same way that other groups do. In this way power struggles, personality conflicts, or differences in organizational style become recognized as "normal problems" rather than being specific to people who have been psychiatrically labeled. Solving these problems becomes a confirmation that group members have resources to cope with life's ups and downs.

Successfully functioning self-help groups also serve indirectly to educate clinicians and family members who initially may have been doubtful of a group's ability to manage itself. Either by direct observance of a group's activities, or through hearing group members make presentations about their work, many former skeptics have become convinced of the value of self-help and have come to see the strength and abilities of psychiatrically labeled people, not just their deficits and needs.

Through successes experienced in self-help groups, members are enabled to take a stronger role in advocating for their own needs within the larger mental health system. Empowerment within the groups leads to a sense that members should have a say in mental health matters generally and a rejection of the role of passive service recipient. Group members find themselves moving naturally into the role of advocate and representing the needs of consumers through membership on panels, boards, committees. and the like. This may require some accommodation on the part of other members, such as administrators, policymakers, legislators, family members, and others who typically have listened to everyone but consumers about consumer needs.

Direct care staff, such as psych techs, nurses, and therapists, play a critical role in the elimination of seclusion and restraint. This module explores how communication that includes listening as well as speaking can be an effective tool, especially in times of crisis. This module also explores environmental factors and the role they can play in behavior and mood. Establishing "comfort rooms" is one tool that can add to the efforts to eliminate seclusion and restraint. And finally, Alternative Dispute Resolution and mediation are more formalized strategies that staff can employ. Although both Alternative Dispute Resolution and mediation do require special training beyond the scope of this manual, it is well worth the effort. Consumers, once given the opportunity, learn to speak for themselves. Staff learns new techniques that minimize the need for adversarial techniques. Mediation promotes dialogue and fosters a less confrontational atmosphere.

On the national level, all staffs are being urged to reduce and/or eliminate the use of seclusion and restraint. Charles Curie, SAMHSA Administrator, sets his agenda as follows. "Reducing use of seclusion and restraint of individuals in mental health treatment is one of my major priorities. Seclusion and restraint—with their inherent physical force, chemical or physical bodily immobilization and isolation—do not alleviate human suffering. They do not change behavior. And they do not help people with serious mental illness better manage the

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thoughts and emotions that can trigger behaviors that can injure them or others. Seclusion and restraint are safety measures of last resort. They can serve to retraumatize people who already have had far too much trauma in their lives. It is my hope that we can create a single, unified policy—a set of primary principles that will govern how the Federal Government approaches the issue of seclusion and restraint for people with mental and addictive disorders" (Curie, 2002).

Wellness Recovery Action Plan (WRAP)

Literature on the WRAP is found in the works of Mary Ellen Copeland, the developer of the plan and a mental health educator/consumer from Vermont. The WRAP appears in her books *Wellness Recovery Action Plan* (2000) and *Winning Against Relapse* (1999). Portions of the WRAP and the use of the Wellness Toolbox also appear in her books *Living Without Depression and Manic Depression: A Workbook for Maintaining Mood Stability* (1994) and *The Depression Workbook* (2001).

The WRAP can be used by anyone who wants to create positive changes in the way they feel, or increase their enjoyment in life. WRAP is a structured system for monitoring symptoms through:
  • Planned responses, that reduce, modify, or eliminate symptoms
  • Planned responses from others when you need help to make a decision, take care of yourself, or keep yourself safe

The WRAP is divided into six sections:
  • Daily Maintenance Plan
  • Triggers
  • Early Warning Signs
  • Symptoms that Occur When the Situation is Worse
  • Crisis Plan
  • Post Crisis Plan

Mary Ellen Copeland's resources are available through her Web site: www.mentalhealth recovery.com or by checking your local bookstore. In addition to books and workbooks, audio and videotapes are available.

The booklet, *Recovering Your Mental Health: A Self-Help Guide* is available for free from the Center for Mental Health Services. This booklet was developed with the assistance of a focus group of ten people from around the country, people who are working on their own recovery. You can get free copies from SAMHSA's National Mental Health Information Center at 1-800-789-2647 or www.mentalhealth.samhsa.gov. Refer to booklet SMA#3504. We strongly recommend that facilitators read this resource and have a copy on hand for the training.

Strategies to Prevent Seclusion and Restraint

BACKGROUND

Drop-In Centers
(Source: www.mhselfhelp.org)

A consumer run drop-in center is a central place for consumer self-help, advocacy, and education about mental health issues and resources. Through a drop-in center, consumers develop their own program to supplement existing mental health services or provide an alternative to those services.

> *"My concept of a drop-in center is a self-help clubhouse that serves as a meeting place for socialization and advocacy efforts. It's an opportunity to empower consumers through involvement in these activities."* —Brian Disher

Consumers are often socially isolated and lonely. They may not have the emotional support they need to help them deal with their problems. At a drop-in center, consumers can come together to make friends and socialize. The drop-in center offers a non-judgmental atmosphere, acceptance, and true empathy from people who have "been there." It can be hard for consumers to find these qualities in programs managed by mental health professionals, in their families, and in the community.

Instead of focusing on whether people are sick and in need of treatment, drop-in center activities focus on the wellness, capabilities, and talents of their participants. Through joining in a variety of meaningful activities, consumers build their self-confidence, self-esteem, and employment skills.

Drop-in center activities vary depending on the particular wishes and needs of the consumers involved. These activities may include self-help group meetings (also called mutual support or rap sessions); weekly or monthly socials or parties; guest speakers; a consumer speakers' bureau or "mental health players" group as a community-education project; individual and systems advocacy to protect people's rights, help people get services and/or financial benefits, and improve mental health services; a referral bank for mental health services; and assistance with employment or housing searches, such as a roommate referral network. A drop-in center may also simply be a place to come and talk over a free cup of coffee.

Recovery Through the Arts
(Source: *Reaching Across with the Arts: A Self-Help Manual for Mental Health Consumers,* edited by Gayle Bluebird)

We strongly encourage you to read *Reaching Across with the Arts: A Self-Help Manual for Mental Health Consumers* as background for teaching this section. To order, write to Blue Bird Consultants, Gayle Bluebird, 110 Charley Ave., Ft. Lauderdale, FL 33312, call (954) 967-1493, or e-mail gayleb@advocacycenter.org. The manual provides a wonderful overview of the many modalities of arts that can be used as empowerment tools and offers excellent examples of artwork.

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The arts can serve as a vehicle for creative self-expression, social change, and personal empowerment. They enable people who have been labeled with stigmatizing diagnoses to convey their personal experiences of madness and recovery to others. Arts can be used as a means of self-healing and spiritual growth—for connecting mind, body, and spirit. The ability to experiment and explore one's inner self through a variety of mediums helps to build self-confidence and self-worth.

The mental health system is beginning to recognize the importance of art. Art therapy has been a part of the hospital environment, but many art therapists have been interpreters of art instead of helpful art instructors. A self-help approach to art encourages consumers to do their work without being scrutinized for pathology. Artists must feel that anything they create is acceptable. There are many modalities that can be used in recovery through the arts including journal writing, poetry, music, and alternative healing methods.

Susan Spaniol, arts professor at Lesley College in Massachusetts, writes extensively on the subject of art therapy. Her Web site is www.lesley.edu/faculty/estrella/spaniol.html.

Comfort Rooms

Our environment impacts our mood and behavior. Health care has been using the concept of "comfort rooms" in a variety of settings for many years. For example, some hospitals have special rooms for family members while they are waiting for their loved ones during surgery. Often, oncology units have rooms furnished with couches, fish tanks, and reading materials. Birthing centers market a "home-like atmosphere." The Mayo Clinic even has a room filled with reclining chairs and soft lighting for consumers and families to use at their leisure.

Most inpatient psychiatric facilities do not convey a warm and welcoming environment. The walls are often stark white with few home-like decorations. The sparse furnishings are often outdated.

Gayle Bluebird has used her innovative work in using comfort rooms as a preventive tool to reduce the need for seclusion and restraint at Atlantic Shores Hospital in Florida. Comfort rooms were one part of an overall task force plan that successfully reduced the use of seclusion and restraints. Gayle Bluebird originally developed the material on comfort rooms. Please give her credit as you are presenting this material.

As people diagnosed with mental illnesses are empowered in their recovery process, we must listen to what they have to say about their surroundings and environment. We as staff, get to go home to our own "comfort rooms" at the end of the shift. Let's provide the same opportunities for the people we serve.

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This section includes a definition of a comfort room, items that might be included in a comfort room, guidelines for using a comfort room, an exercise to identify characteristics of calming rooms, the importance of input and feedback from people diagnosed with mental illnesses, and a step-by-step plan for establishing a comfort room. If the participants you are working with already use the concept of a comfort room, you may want to skim over this material.

Service Animals

Mental health service providers are increasingly recognizing that service animals are an excellent resource for consumers. Service animals can provide companionship, physical assistance, and often help develop therapeutic bonds that provide psychological, emotional, and social benefits. Scientific research has begun to validate the role of service animals/service dogs for people with disabilities. A 1996 study by Allen and colleagues found that people with disabilities that had service dogs scored higher for psychological well-being, self-esteem, community integration, and the amount of control they could exert over their environment. The same study also found that the number of human care hours decreased by an average of 78 percent—which represents a significant savings in health care costs (Allen, 1996). Other documented research benefits include improved self-esteem, independence, social acceptance, lowered blood pressure, moderation of stress, improved motivation, decreased serum cholesterol, and mitigation of the effects of loneliness.

The Americans with Disabilities Act (ADA Title III, 28 Code of Federal Regulations Sect. 36.104) states that a service animal is any animal that is individually trained to help a person with a disability. By law, service animals are not pets and they may be of any breed or size. Service animals can do mobility, hearing, guide, seizure alert, emotional support, and other work needed by the person because of their disability (Federal ADA 28 CFR Sect. 38.302). State laws protect the rights of individuals with disabilities to be accompanied by their trained service animals in taxis, buses, stores, restaurants, doctors' offices, school, parks, housing, and other public places.

If you are not familiar with service animals, please look them up on the Web before presenting this section. One place to start is www.deltasociety.org. If possible, find a local consumer to come in and talk about his or her service animal.

Psychiatric Advance Directive (PAD)
(Adapted from www.nmha.org and www.bazelon.org)

In the past 30 years, thinking in the field of medicine has shifted significantly. Years ago, the physician made all of the decisions related to health care. Today, the "patient" has a much stronger voice and is a partner in making decisions about his or her own health care.

A psychiatric advance directive offers a clear written statement of an individual's medical treatment preferences or other expressed wishes or instructions. It can also be used to assign decision-making authority to another person who can act on that person's behalf during times of incapacitation.

Psychiatric advance directives offer several key benefits. Correctly implemented and executed, they can:
- Promote individual autonomy and empowerment in the recovery from mental illness;
- Enhance communication between individuals and their families, friends, healthcare providers, and other professionals;
- Protect individuals from being subjected to ineffective, unwanted, or possibly harmful treatments or actions; and
- Help in preventing crises and the resulting use of involuntary treatment or safety interventions such as restraint or seclusion.

Anyone creating an advance directive must be able to do so without coercion, with choices regarding implementation and revocability, and with full knowledge and understanding of the implications of his or her decisions.

Most States require the appointment of an agent or proxy in order for an advance directive to be valid. The agent can be authorized to make decisions about the person's health care that may or may not be in a PAD. It is critical that the agent be someone who can be trusted and who understands the wishes of the person diagnosed with a mental illness. In nearly every State, PADs are irrevocable after the loss of capacity to make informed decisions. Reasons why a PAD may be overridden include (1) a court order to prevent physical injury; (2) after a specified period of time if a particular treatment choice is unsuccessful; (3) "emergency" situations, and (4) a civil commitment. In most States, the agent cannot make decisions unless the person diagnosed with a mental illness is determined unable to make decisions.

Prime Directive

The prime directive for young people under the age of 18 is based on the advance directive. *My Prime Directive* and its companion, *My Prime Directive Journal* (Tenney, 2001) are self-help tools for young people and were developed by Lauren Tenney of the New York State Office of Mental Health, Bureau of Children and Families. Their purpose is to open the lines of communication between young people and the professionals who are serving them. It gives young people a voice about the services they are receiving. The young person can choose to share or not to share their directive and journal.

My Prime Directive Journal was designed to offer young people hope for the future, educate them about alternative coping mechanisms, and outline a concrete way for them to start planning for the rest of their lives. The first part of the journal includes notes that include insights

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such as "It's okay to be different," "No matter where you have been or what you have been through, you can move on," and "Don't let people's judgments affect you. Be confident who you are and accept yourself."

The journal also encourages young people to think about things such as "I feel my best/worst when..." "The real me is…" "Someday I'd like to…" "Ten years from now I'd like my life to be or not to be…" and "For my life to look like that in 10 years, I would have to do the following things in the next 5 years…" Young people can poignantly articulate what it is they think they need from the mental health system. These self-help tools give them an opportunity to express their wishes in an organized manner.

Communication Strategies

Most mental health workers have extensive training in active listening. The goal of this section is not necessarily to teach new skills, but to provide an opportunity to hear things in new ways. Communication is especially critical in times of crises. As leaders, it is important not only to communicate the viewpoint of people diagnosed with a mental illness, but also to carefully listen to the perspectives of mental health workers. They, too, have experienced trauma and are struggling in their own ways within the system. By creating a dialogue, this section sets the tone for more the complicated issues that follow.

This section includes issues of power and control, the use of respectful language, types of listening and necessary conditions for listening, ways of verbally responding, things people diagnosed with a mental illness would like to hear, humor, and roadblocks to active listening.

Alternative Dispute Resolution/Mediation

Alternative dispute resolution (ADR) techniques have been widely used in a variety of settings such as education, employment, and family disputes. Mental health settings have been slow to adopt these techniques. These techniques include mediation, negotiation, facilitation, conciliation, and dialogue. The Center for Conflict Management in Mental Health, based at the University of South Florida, is working to change this. One major difference in the mental health setting is that there is unequal power between providers and consumers.

The Center for Conflict Management in Mental Health provides different services. Some of these include product development and testing, research and evaluation, consultation and technical assistance, information sharing, and conflict management skills training. This training is for consumers, family members, mental health providers, and mental health administrators. They also sponsor national and regional conferences and provide workshops in mediation skills.

BACKGROUND

Laurie Curtis, a co-author of a curriculum on managing conflict in mental health systems, points out, "Most mental health professionals support consumer choice, as long as everyone agrees" (Blanch, 2000). She emphasizes that conflict management can help mental health professionals and consumers understand concepts such as consumer directed services in new ways.

Judi Higgenbotham, Human Rights Coordinator at Arizona State Hospital in Phoenix, states, "It almost always boils down to a communication issue—the doctor or treatment team either hasn't listened to what the consumer is saying or hasn't explained things well"(Blanch, 2000).

The Center for Conflict Management in Mental Health believes that alternative conflict resolution strategies can minimize the need for and the consequences of adversarial techniques. This preserves dignity, enhances empowerment, and promotes recovery.

Mediation is a process where parties distance themselves from their positions and discover the underlying reason or interest in their positions. It is a process for people to discover their own solutions. Mediation promotes dialogue.

Consumers and family members have been trained as mediators in some States. Ohio has taken the lead. It has revised its consumers' rights regulations to include mediation at any stage. An Associate Professor of Nursing and Psychiatry at the Ohio State University notes, "This is the beginning of a cultural change in the mental health field. Conflict resolution is so compatible with the recovery movement—they mesh together completely. Consumers learn to speak for themselves and have control over their lives" (Blanch, 2000). Mediation fosters a less confrontational atmosphere.

Technical Assistance Centers

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services supports technical assistance centers and the National Institute on Disability and Rehabilitation Research. Services may include technical assistance, information and referrals, on-site consultation, training, library services, publications, annotated bibliographies, and other resources. Many services are available free of charge, but in some cases, charges may apply. The technical assistance centers can be used as a resource for up-to-date information relating to the elimination of seclusion and restraint.

PRESENTATION

Welcome participants, review names, and make sure everyone has a nametag or name tent. It may be helpful to provide a quick review of Module 4: Understanding Resilience and Recovery from the Consumer Perspective. Begin Module 5 by going over the learning objectives.

Learning Objectives
Upon completion of this module the participant will:

- Define and outline the benefits, underlying values, and key elements of consumer-driven supports

- Develop and apply a Wellness Recovery Action Plan (WRAP)

- Identify benefits of drop-in centers, recovery through the arts, research and technical assistance centers, and service animals.

- Name key elements to implement a comfort room and describe what staff can do to support these consumer-driven supports.

- Guide a consumer in developing a Psychiatric Advance Directive/Prime Directive

- Identify and implement effective communication strategies that prevent the use of seclusion and restraints, including Alternative Dispute Resolution and Mediation

Overview

- Over the past 20 years, consumers have shifted from being passive recipients of mental health treatment to becoming increasingly involved in planning, providing, and evaluating mental health services.
- Direct care staff, such as psych techs, nurses, and therapists, play a critical role in the elimination of seclusion and restraint.
- On the national level, all staff are being called on to reduce and/or eliminate the use of seclusion and restraint.
- Charles Curie, SAMHSA Administrator, sets his agenda as follows.

"Reducing use of restraint and seclusion of individuals in mental health treatment is one of my major priorities. Seclusion and restraint - with their inherent physical force, chemical or physical bodily immobilization and isolation - do not alleviate human suffering. They do not change behavior. And they do not help people with serious mental illness better manage the thoughts and emotions that can trigger behaviors that can injure them or others. Seclusion and restraint are safety measures of last resort. They can serve to retraumatize people who already have had far too much trauma in their lives. It is my hope that we can create a single, unified policy - a set of primary principles that will govern how the Federal government approaches the issue of seclusion and restraint for people with mental disorders."

Charles Curie

PRESENTATION

- Consumer-driven supports can be divided into two categories:
  ○ Support systems which consumers develop, run, evaluate, and maintain on their own, such as drop-in centers, crisis teams, art co-ops, and peer support.
  ○ Contributions consumers make to traditional mental health systems by being involved in program development, policy formation, program evaluation, quality assurance, system designs, education of mental health service providers, and provision of direct services.
- "In order to maximize their potential contributions, their involvement should be supported in ways that promote dignity, respect, acceptance, integration, and choice. Support provided should include whatever financial, educational, or social assistance is required to enable their participation" (Position Statement on Consumer Contributions to Mental Health Service Delivery Systems from the National Association of State Mental Health Program Directors, 1998).
- This training will focus primarily on support systems that consumers develop, run, evaluate, and maintain.
- First, let's look at the research-based evidence related to consumer-driven supports.
- The U.S. Department of Health and Human Services cites the following General Benefits of Consumer-Driven Supports (DHHS, 2001):

PRESENTATION

General Benefits of Consumer-Driven Supports (CDS)

- Self-help is a way in which people become empowered and begin to think of themselves as competent individuals and present themselves in new ways to the world.

- Fosters self-advocacy

- Fosters autonomy

- Ends isolation

- Educates family and providers

Underlying Values of Consumer Self-Help Include:

- Empowerment

- Independence

- Responsibility

- Choice

- Respect & Dignity

- Social Action

Key Elements for Consumer/Survivor Self-Help:

- Peer Support

- Hope

- Recovery

PRESENTATION

Wellness Recovery Action Plan
- Wellness Recovery Action Plan = WRAP.
- Mary Ellen Copeland is the developer of the WRAP and is a mental health educator/consumer from Vermont.
- She has written several books, including *Wellness Recovery Action Plan* (1997). If possible, please have a copy of this book to pass around.
- Her Web site, www.mentalhealthrecovery.com, is a great resource.
- One can develop a WRAP for work, using the same categories. It would revolve around a work plan environment.
- A teen WRAP is also available and is modeled after the original WRAP.
- The WRAP can be used by anyone who wants to create positive changes in the way they feel or increase their enjoyment in life, including those who do not have a mental illness. It works well for those dealing with chronic physical illnesses as well.

The Wellness Recovery Action Plan (WRAP) is a structured system for monitoring symptoms through

- Planned responses that reduce, modify, or eliminate symptoms

- Planned responses from others when you need help to make a decision, take care of yourself, or keep yourself safe

- The WRAP stems from a self-care paradigm—which places the emphasis for health on the consumer, not the medical system.
- The WRAP assumes it is the responsibility of each individual to do self-care to maintain optimum health.

PRESENTATION

The WRAP is divided into six sections:

- Daily Maintenance Plan (including Wellness Toolbox)

- Triggers

- Early Warning Signs

- Symptoms that Occur When the Situation is Worse

- Crisis Plan

- Post Crisis Plan

- The Daily Maintenance Plan includes writing down and reminding ourselves of the things we all need to do every day to maintain our wellness.
- On the surface, the Daily Maintenance Plan may seem simple; however, it is a good reminder of what "being well" feels like.
- The Wellness Toolbox is a list of things that help us stay healthy and on track.
- Triggers are external events or circumstances that, if they happen, may produce symptoms that are or may be very uncomfortable. We talked about some of these in *Module 2: Understanding the Impact of Trauma*.
- It's important to recognize triggers and respond to them so symptoms don't get worse.
- Early warning signs are internal, subtle signs of change that may be unrelated to reactions to stressful situations.
- Again, being aware of early warning signs helps prevent symptoms from worsening.
- Symptoms may progress to the point where they are very uncomfortable, serious, even dangerous, and where the situation has gotten much worse but has not yet reached a crisis.
- At this point, it is necessary to take immediate action to prevent a crisis.
- Crisis situations mean that others will need to take responsibility for our care.
- This section is often the most difficult section to develop and needs to be done when you are feeling well.
- The Post Crisis Plan is a new addition to the WRAP and is different from other parts of the WRAP. It changes as you heal.
- It may be helpful to refer to your Wellness Toolbox.
- WRAP assists in keeping one well after release from the hospital.

PRESENTATION

"I remember coming home from the hospital, feeling great and as soon as I got there I was bombarded with loneliness, other peoples' problems and all the stuff that probably helped put me in the hospital to begin with……"
L. Belcher, Consumer

Distribute the handout Examples of Consumer WRAPs*, which includes three actual WRAPs from consumers in Minnesota. Take a minute to look these over.*

Exercise/Discussion—Module 5

Developing a Wellness Recovery Action Plan (WRAP)

PRESENTATION

OBJECTIVE: Participants will understand how to develop a WRAP for themselves and will be able to transfer these skills to their work with consumers.

PROCESS: Refer participants to the handout *Examples of Consumer WRAPs* and give them time to review the WRAPS in class. Give each participant a copy of the handout *Developing a WRAP,* which gives instructions on how to complete a WRAP. Ask each participant to develop one section of a WRAP. Remember, a recovery plan does not have to be for psychiatric symptoms. It can be for any physical condition or for recovery from a difficult or traumatic life experience.

Divide the group into four or five smaller groups and have each person share one part of his or her WRAP. Reconvene as a large group and facilitate a discussion.

DISCUSSION QUESTIONS:
- What are the similarities between consumer and staff WRAPs?
- What are the differences between consumer and staff WRAPs?
- How could you use this tool in your work environment?

MATERIALS REQUIRED: Paper and a writing utensil for each participant
Examples of Consumer WRAPs handout
Developing a WRAP handout

APPROXIMATE TIME REQUIRED: 30 minutes

SOURCE: WRAP materials from Mary Ellen Copeland

PRESENTATION

Drop-In Centers

- Drop-in centers are a central place for consumer self-help, advocacy, and education about mental health issues and resources.
- Through a drop-in center, consumers develop their own programs to supplement existing mental health service or provide an alternative to those services.
- Consumers come together to make friends and socialize—which helps combat the isolation and loneliness often associated with mental illnesses.
- A drop-in center could be a snack bar or canteen within a hospital setting. It can be a place to gather and socialize.
- Drop-in center activities focus on the wellness, capabilities, and talents of their participants.

> *"Ex-patients have similar feelings and experiences and they can understand and support each other in a way that's different from family or professional services. We can do mutual support and understand the way we were treated. There's nothing else out there on the weekends and evenings."* Peg Sullivan

- Drop-in activities vary depending on the particular wishes and needs of the consumers involved.

Drop-In Centers Activities

- Rap sessions (self-help group meetings)

- Socials or parties

- Guest speakers

- Individual and systems advocacy

- Serve as a referral bank for mental health services

- Assist with employment or housing searches

How can mental health workers support consumer run, consumer-driven drop-in centers?

- Advocate for space, financial support, zoning

- Make referrals

- Provide materials and resources, if asked

- Offer to be a guest speaker

- Referral bank for mental health services

- Assistance with housing or employment searches

Recovery Through the Arts

- The arts can serve as a vehicle for creative self-expression, social change, and personal empowerment.
- The arts enable people who have been labeled with a stigmatizing diagnosis to convey their personal experiences of madness and recovery to others.
- Arts can be used as a means of self-healing and spiritual growth—for connecting mind, body, and spirit.
- The ability to experiment and explore one's inner self through a variety of mediums helps to build self-confidence and self-worth.
- Art therapy has been a part of the hospital environment, but many art therapists have been interpreters of art instead of helpful art instructors.
- A self-help approach to art encourages consumers to do their work without being scrutinized for pathology. Artists must feel that anything they create is acceptable.
- There are many modalities that can be used in recovery through the arts including journal writing, poetry, music, alternative healing methods, painting, and sculpting.
- Please add local resources related to recovery through the arts and/or show examples of consumer artwork.

Comfort Rooms

Distribute the handout How to Set Up a Comfort Room *by Gayle Bluebird.*

- Our environment significantly impacts our mood and behavior.
- Health care uses the concept of a "comfort room" in other aspects of the hospital environment. Examples include surgery waiting rooms, oncology family units, and birthing centers.
- Typically, inpatient psychiatric facilities do not portray a warm and welcoming environment.
- Gayle Bluebird, R.N., has does innovative work in using the comfort room concept as a preventive tool to reduce the need for seclusion and restraint in Florida.
- Gayle's Web site is www.contac.org/bluebird.
- As people diagnosed with a mental illness are empowered in their recovery process, we must listen to what they have to say about their surroundings and environment.
- Consumers clearly indicated in the National Association of Consumer/Survivor Mental Health Administrators survey (2000) that having a comfortable environment would help prevent the need for seclusion and restraint. Here are some direct quotes from the survey.

PRESENTATION

What would have been helpful in preventing the use of seclusion or restraints for you?

- A homey setting – soft chairs, drapes, pictures

- A big overstuffed, vibrating, heated chair with a blanket, headphones, and gentle soft music

Comfort Room Definition:

The Comfort Room is a room that provides sanctuary from stress and/or can be a place for persons to experience feelings within acceptable boundaries. (Gayle Bluebird)

PRESENTATION

- The comfort room is not an alternative to seclusion and restraint; it is a preventive tool that may help reduce the need for seclusion and restraint.
- It is critical that people diagnosed with mental illnesses be made an integral part of decision making for the development and policymaking of the comfort room.
- Consumers should ask to make comments and rate their degree of personal satisfaction with the comfort room and make suggestions for improvement.
- The comfort room is to be used voluntarily, although staff members might suggest its use and may be present if the person desires it.
- The comfort room is set up to be physically comfortable and pleasing to the eye. It may include a recliner chair, walls with soft colors, murals (images to be the choice of persons served on each unit), and colorful curtains.
- Comfort items can be made available to persons wishing to use the room.
  - Stuffed animals
  - Soft blanket
  - Headphones
  - Quiet meditative audio tapes
  - Bright colored pillow cases
  - Journaling materials
  - Reading materials
- Persons who wish to use the room will be asked to first sign their names in the sign-in book and talk to a staff member before entering.
- A sign on the door may look like this:

Comfort Room Door Sign

A special place where you may spend some time alone. You may ask any staff member to use this room. There are items that you can sign-out to help you calm down and relax (stuffed animals, soft blanket, music, magazines, and more). Persons who wish to use the room will be asked to first sign their names in the sign-in book and talk to a staff member before entering.

PRESENTATION

Service Animals

- Service animals can provide companionship and physical assistance, and often help humans develop therapeutic bonds that provide psychological, emotional, and social benefits.
- Scientific research has begun to validate the role of service animals/service dogs for people with disabilities.
- A 1996 study by Allen and colleagues found that people with disabilities that had service dogs scored higher for psychological well-being, self-esteem, community integration, and the amount of control they could exert over their environment.
- The same study also found that the number of human care hours decreased by an average of 78 percent—which represent a significant savings in health care costs (Allen et al., 1996).
- Other documented research benefits include improved self-esteem, independence, social acceptance, lowered blood pressure, moderation of stress, improved motivation, decreased serum cholesterol, and mitigation of the effects of loneliness (DHHS, 2001).
- The Americans with Disabilities Act (ADA Title III, 28 Code of Federal Regulations Sect. 36.104) states that a service animal is any animal that is individually trained to help a person with a disability.
- By law, service animals are not pets, and they may be of any breed or size.
- Service animals can do mobility, hearing, guide, seizure alert, emotional support, and other work needed by the person because of their disability.
- Federal (ADA 28 CFR Sect.38.302) and State laws protect the rights of individuals with disabilities to be accompanied by their trained service animals in taxis, buses, stores, restaurants, doctors' offices, school, parks, housing, and other public places.
- Encourage participants to look up service animals on the Web. One place to start is www.deltasociety.org.

PRESENTATION

Psychiatric Advance Directives (PADs)

• Psychiatric Advance Directives are similar to other types of health advance directives.

"What is a Psychiatric Advance Directive (PAD)?"

A PAD is a legal document that becomes part of the medical chart that provides the following information:

- Treatment preferences, including seclusion, restraint, and medications

- Naming an "agent" or proxy who will make decisions about mental health care when the person with a mental illness is not capable of informed decision-making

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Psychiatric Advance Directive

- **Instructional** – refers to a person's treatment wishes (i.e., what you want in the way of treatment or services and also what you don't want.) Also known as a "living will."

- **Agent Driven** – gives another individual the power to make decisions for you when you are deemed incapable of making decisions for yourself (i.e., who you would want to make decisions for you. Also called durable power of attorney, surrogate decision maker, or a proxy.)

Module 5   **Strategies to Prevent Seclusion and Restraint**

The handout Why Should I Fill Out a Psychiatric Advance Directive? *is a more detailed version of the PowerPoint Slide.*

Why Should I Fill Out a Psychiatric Advance Directive? (Or, sometimes the best defense is a good offense)

It is very important to work with the provider(s) and your proxy in developing the PAD and to make sure significant people have copies of the PAD.

- Maintain choice and control in treatment
- Increase continuity of care
- Decrease possibility of involuntary treatment
- If hospitalized, PAD may affect kind/type treatment received
- Provides opportunity to discuss crisis plan with family and friends
- Establishes clear boundaries for release of information
- Provides an effective alternative to court appointed guardian
- Establishes plans for caring for family, finances, and pets
- Restores self-confidence

PRESENTATION

Module 5 **Strategies to Prevent Seclusion and Restraint**

Exercise/Discussion—Module 5

Creating My Own Psychiatric Advance Directive

OBJECTIVE: Each participant will fill out a Psychiatric Advance Directive practice worksheet.

PROCESS: Refer participants to the handouts *Ten Tips for Completing an Effective Advance Directive* and *Psychiatric Advance Directive Practice Worksheet*.

Divide the participants into small groups of 4 to 5 each. Ask each participant to review the list of Ten Tips. Ask each participant to think of their own "mental health," whether it is stress or a diagnosed mental illness, and ask them to fill out the worksheet as completely as possible.

DISCUSSION QUESTIONS:

- Why do you think a psychiatric advance directive is important? How would you compare it to a living will, if at all? What are the differences?
- When is the most appropriate time to write such a directive?
- What type of assistance, if any, should be offered? Cite some reasons why this might be important.
- What do you believe are the goals or outcome of having such a directive?

MATERIALS REQUIRED: Handouts of *Ten Tips for Completing an Advance Directive* and the *Psychiatric Advance Directive Practice Worksheet*.

APPROXIMATE TIME REQUIRED: 30 minutes

PRESENTATION

Advance Directive Resources

- National Mental Health Association www.nmha.org or 800-969-6642

- The Bazelon Center for Mental Health Law www.bazelon.org/advdir.html or 202-467-5730

- National Association of Protection and Advocacy Systems www.napas.org or 202-408-9514

- Peer Education Project 518-463-9242
- Centers for Medicare & Medicaid Services (CMS) www.cms.hhs.gov

Prime Directives

- The idea behind the Prime Directive is similar to the Advance Directive.
- In January 2000, the Prime Directive Initiative in New York State began with the vision of former consumers of children's mental health services who are now advocates.
- A group of young people, family members, professionals, and policymakers developed a draft of *My Prime Directive Journal* (Tenney, 2001).
- This document was then presented at focus groups around New York State. These focus groups were composed of young people, family members, and professionals.
- A final draft was then edited and made available for distribution.
- Pass around a copy of *My Prime Directive Journal* (Tenney, 2001).

Use of <u>My Prime Directive Journal</u> and <u>My Prime Directive</u> is completely voluntary and is NEVER to be mandatory

Prime Directives are self-help tools and DO NOT replace a treatment plan.

Strategies to Prevent Seclusion and Restraint

- Six essential steps are seen as necessary to bring both the Prime Directive and Prime Directive Journal to young people.

Distribute the handout Six Essential Steps for Prime Directives*.*

SIX ESSENTIAL STEPS FOR PRIME DIRECTIVES

1. Getting the "buy-in" of the facility or program that will pilot the project.

2. Meeting with the core group of staff and reviewing the materials and goals.

3. Meeting with the staff of the facility/program and review the materials and goals.

SIX ESSENTIAL STEPS FOR PRIME DIRECTIVES

4. Meeting with the young people, filling in a survey, reviewing the materials and goals, answering questions and developing a working relationship with the young people.

5. Ongoing technical assistance through the pilot process.

6. In three months, re-administer the surveys and see if there was a notable difference.

What Young People Are Saying About Involving Youth In Their Services and Systems

·   "We are young, but need to be treated as human beings and not as a problem or disorder."

·   "We are prototypes, not to be treated as stereotypes."

·   You can do all the research you want, but if you forget who we are and what we need as people, and if you don't respond to our needs in the system and in individual treatment, you will fail, the system will fail, and we will bear the burden as we do now. You must involve youth, bring us to the table, and when we show up, you must listen. LISTEN."

PRESENTATION

What Professionals Are Saying About Involving Youth In Their Services and Systems

- "Another step is being taken when individual young people are able to speak with a powerful voice in planning their own services…."

- "Involving youth during treatment and service planning….Proactively solicit treatment ideas and therapeutic activities from the individual youth…Offer more treatment options. True informed consent is really about more treatment options." (Juliet K. Chol, consultant on children's mental health programs, Fall 2000)

- Both the Prime Directive and the Journal have anticipated benefits for the three groups most affected: young people, their family members, and programs (professionals).

Distribute the handout Anticipated Benefits of Prime Directives.

Strategies to Prevent Seclusion and Restraint

PRESENTATION

ANTICIPATED BENEFITS/OUTCOMES FOR YOUNG PEOPLE

- A concrete voice in treatment and service planning, including wishes and concerns.

- Opportunities to ask questions that are difficult to ask.

- A concrete plan for goals for future life.

- Increased self-esteem, hope and trust as they begin on the road to recovery.

ANTICIPATED BENEFITS/ OUTCOMES FOR PARENTS

- A forum to hear from their children what has been difficult to hear in the past.

- An intermediary when communication is difficult.

- Insight to their children's wants and needs.

- An active role in understanding their children's goals for recovery.

ANTICIPATED BENEFITS/ OUTCOMES FOR PROGRAMS

- Better informed recipients of services.

- More aware/responsible program staff.

- Provides a quality assurance mechanism.

- Uses a recovery oriented model.

- Reduction of seclusion, restraint, and coercion.

- Better understanding of recipients wants and needs.

PRESENTATION

- The underlying goal of using consumer-driven supports such as prime directives and psychiatric advance directives is to create partnerships between consumers and staff.

PRESENTATION

> "An important shift occurs when we begin to work with our clients as partners in their treatment, instead of working on them."
>
> Cheryl Villiness
> Devereux Georgia Treatment Network
> Focal Point, Fall 2000

Communication Strategies

- Many direct care staff have already been trained extensively in communication strategies.
- The purpose of this session is not necessarily to teach new skills, but provide opportunities to hear things in new ways.
- Direct care staffs have lots of valuable and important information about the practice of seclusion and restraint—it affects you, too! So it's important for us to hear what you have to say.
- Communication is very complicated, even though it may appear to be simple. This next exercise demonstrates this.
- Excellent communication is essential in times of crisis. It's important to know who is in charge, who makes decisions, and how this process will take place before a situation escalates.

Exercise/Discussion—Module 5

How Hard Can Communication Be?

OBJECTIVE: To demonstrate the complexity of communication.

PROCESS: Have participants get in pairs and sit back to back so they can't see each other. Have them choose who will be the talker and who will be the listener.

Before the session, develop several designs on 8.5 X 11 paper using markers. Use general shapes such as squares, circles, triangles, stars, straight lines, squiggly lines, etc. Give the talker a copy of one of the designs. Give the listener a blank sheet of paper and a pencil. The one with the design begins to give directions on what to draw. The goal is to have the design and the drawing turn out as similar as possible. The participant who is drawing cannot ask questions or talk at all. Give 3 minutes to complete the task. As participants finish, have them compare their drawings with the original designs. Tape each pair's results together as a visual reminder during the rest of this module. Facilitate a discussion around communication skills.

DISCUSSION QUESTIONS:
- What was it like to be the person giving directions?
- What was it like to be the person drawing?
- How does this exercise relate to the work environment?
- How does this exercise relate to working with people diagnosed with a mental illness?

MATERIALS REQUIRED: Blank paper, writing utensils, designs to hand out, and tape

APPROXIMATE TIME REQUIRED: 15 minutes

PRESENTATION

Communication Strategies: Issues of Power and Control

- The words we all use to communicate are powerful and do indeed make a difference
- A consumer from Minnesota named David created the following cartoon.
- The cartoon is a good example of how sometimes everyday words and symbols may be confusing and have multiple meanings.
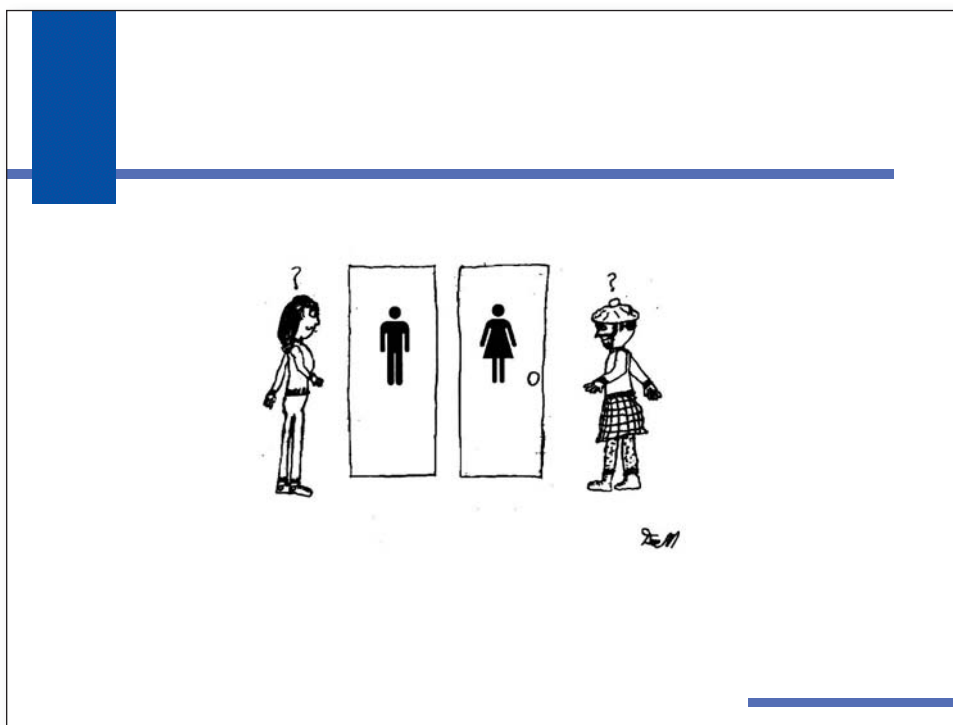
- There has been a great deal of debate in the field of mental health around terminology.
- For example, the word "patient" it is often associated with a lack of power, someone who is "ill," needs professional help to get better, and depends on the system to take care of him or her, etc.
- Using the word "client" still puts the person in a one down position, but is a better choice than the word "patient."
- The word "consumer" may still be associated with a power differential, but it adds a piece of power because it reminds us of the business strategy to listen to the "consumer" or "customer."
- What is our cultural attitude about "customers"?
- Among consumers, some prefer to be referred to as "people diagnosed with mental illnesses." This may mean they do not accept the diagnosis, but a medical professional has given it to them.
- Mental health has its own language and words that are used on a routine basis.

PRESENTATION

Old & New Language

OUT WITH THE OLD	IN WITH THE NEW
Resistant families	Families with unmet needs
Dysfunctional families	Overwhelmed and underserved
Case management	Service coordinator
We offer this	What do you need? Make it up as we go
Staff a case	Families and professionals creating intervention plans together
The chronics	People with mental illnesses (person-first language)
Disturbed child	Child with emotional disturbance
The mentally ill	People with mental illnesses and consumers

Old & New Language

OUT WITH THE OLD	IN WITH THE NEW
Professionals as providers	Families as preferred providers
Schizophrenics	People with schizophrenia
We need placement for this child; where to next?	Let's develop a community plan with this child and family
That's your job	Match each other's offers
SED, SMI	Say the words: Seriously Emotionally Disturbed, Severe Mental Illness
Do an assessment on	Do an assessment with
Do treatment on	Do treatment with
Talk about	Talk with
Develop services for	Develop services with

• The following poem by Elaine Popovich clearly demonstrates the use of language

You and I

by Elaine Popovich, adapted by Laurie Curtis

From the Consumer Network News, Autumn 1995

I am a resident. *You reside.*
I live in a program. *You live in a home.*
I am placed. *You move in.*
I am learning daily living skills. *You hate housework.*
I get monitored for tooth brushing. *You never floss.*
I have to be engaged in "meaningful activity" every day. *You take mental health days.*
I am learning leisure skills. *Your shirt says I am a "couch potato."*
I am aggressive. *You are assertive.*
I am aggressive. *You are angry.*
I am depressed. *You are sad.*
I am depressed. *You grieve.*
I am depressed. *You try to cope with stress.*
I am manic. *You are excited.*
I am manic. *You are thrilled.*
I am manic. *You charge the limit on your credit card.*
I am non-compliant. *You don't like being told what to do.*
I am treatment-resistant because I stop taking medication when I feel better. *You never complete a ten-day course of antibiotics.*
I am in denial. *You don't agree with how others define your experience.*
I am manipulative. *You act strategically to get your needs met.*
My case manager, therapist, R.N., doctor, rehabilitation counselor, residential counselor, and vocational counselor all set goals for me for next year. *You haven't decided what you want out of life.*
Someday I will be discharged…maybe. *You will move onward and upward, perhaps even out of the mental health system.*
I have problems called chronic; people around me have given up hope. *You are in a recovery process and get support to take it one day at a time.*

PRESENTATION

Communication Strategies: Listening

> "I'm not sure it's the exact words that are most important, but rather, the tone of voice, body language and the physical environment of the verbalization. The words need to be firm but kind, spoken by someone with whom the 'patient' has had prior positive experiences. The words should include references to experiences and people that the staff has determined ahead of time will help the 'patient' become grounded."

What makes up the meaning of an interaction?
- Words: 7%
- Facial expression: 55%
- Tone of voice: 38%
- So, not only the words we all use, but how we say them is critical and conveys our underlying feelings, assumptions, and beliefs.

PRESENTATION

Strategies to Prevent Seclusion and Restraint

"THE CONSUMER TALKS BACK"

- At a recent training, people diagnosed with mental illnesses developed the following list. This list was taken from Mary Ellen Copeland's *Mental Health Recovery Newsletter* (2002, February).

What Consumers Want to Hear From Staff

- *You're doing well*
- *How can I help you?*
- *I'm here for you*
- *We can work together through this*
- *It's OK to feel like that*
- *I accept you and love you the way you are*
- *What do you need at this time?*

PRESENTATION

What Consumers Want to Hear From Staff

- *You've come a long way*
- *You're' a strong person*
- *I admire your courage in dealing with this pain*
- *I encourage you*
- *Don't give up*
- *I can't promise, but I'd do my best to help*
- *I don't understand. Please tell me what you mean*

Communication Strategies: Roadblocks to Active Listening

- It is easy to become preoccupied with ourselves and our own needs in such ways that we are kept from listening clearly to those needing assistance.
- Everyone experiences roadblocks—the key is to recognize when it's happening for you.

ROADBLOCKS TO ACTIVE LISTENING

- Attraction
- Physical condition
- Concerns
- Overeagerness
- Similarity of problems
- Prejudice
- Differences
- Defensiveness
- Anger

- *Attraction.* You find a person either attractive or unattractive. You pay more attention to what you are feeling than to what the person is saying.
- *Physical condition*. You may be tired or sick. Without realizing it, you tune out some of the things the person is saying.
- *Concerns*. You may be preoccupied with your own concerns. For instance, you keep thinking about the argument you've just had with your partner.
- *Overeagerness*. You may be so eager to respond that you listen to only a part of what the person has to say. You become preoccupied with your responses rather than with the person's revelations.
- *Similarity of problems*. The problems the person is dealing with are similar to your own. While the person talks, your mind wanders to the ways in which what is being said applies to you and your situation.
- *Prejudice*. You may harbor some kind of prejudice toward the person. You pigeonhole him or her because of race, sexual orientation, nationality, social status, religious persuasion, political preferences, lifestyle, or some other characteristic.

PRESENTATION

PRESENTATION

- *Differences*. The person and his or her experience are very different from you and your experience. The lack of commonalities is distracting.
- *Defensiveness*. A person takes another's difference of opinion as an attack upon him/herself.
- *Anger.* Anger in a person or within a group may distort communications.

Alternative Dispute Resolution/Mediation

- Traditionally, conflict has been viewed as being destructive and divisive. However, conflict can be managed effectively when recognized as an opportunity for growth.
- Conflict is the natural and unavoidable response to change. Every time we are asked to do something differently, think of something differently, or encounter a new situation, we experience change and conflict.
- Conflict encourages us to accept new roles and responsibilities. By embracing conflict, individuals can learn to manage their way through turmoil while maintaining individual respect, integrity, and team participation.
- With the help of a neutral party, those experiencing conflict with one another can enter into creative solutions to their clearly defined problems.
- This training is not intended to teach how to do Alternative Dispute Resolution or Mediation, but will just give a spoonful of information about these topics.
- If staff is interested in further training in this area, please seek out experts for this type of training.

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Alternative Dispute Resolution Definition:

The term Alternative Dispute Resolution applies to the creative solving process that does not engage in litigation through the courts.

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Strategies to Prevent Seclusion and Restraint

• There are several forms of alternative dispute resolution. The most common form is mediation.

Mediation Definition:

Mediation is not the practice of law; it is the art and science of bringing disputing parties to mutual agreement in resolving issues. Mediation does not find fault or blame.

Another definition of Mediation:

Mediation is a dispute resolution process in which a neutral third party assists the participants to reach a voluntary and informed settlement.

PRESENTATION

In mediation the goal is to clearly identify:

- The issues,

- The needs of the disputants with respect to the issues,

- A range of possible solutions, and

- A solution agreeable to all parties involved.

- A key component to any mediation process is letting each person tell his or her own story and then feel as if someone understands his/her perspective. Just knowing someone understands reduces the tension level in the conflict.

The following are the usual steps in the mediation process:

- Those in dispute agree to mediation.

- Those in dispute agree upon a mediator.

- Those in dispute agree upon the ground rules.

- Each person tells his/her own story.

PRESENTATION

> **In order for mediation to be successful participants should be willing to:**
>
> - Solve the problem
> - Tell the truth
> - Listen without interrupting
> - Be respectful
> - Take responsibility for carrying out the agreement
> - Keep the situation confidential

- Mediation provides a problem-solving approach to disputes, focusing on the needs and interests of the participants, with consideration to fairness, privacy, self-determination, and the best interest of all.

Technical Assistance Centers

- The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services supports technical assistance centers, including consumer and consumer supporter technical assistance centers.
- Services may include technical assistance, information and referrals, on-site consultation, research, training, library services, publications, annotated bibliographies, and other resources.
- Many services are available free of charge, but in some cases, charges may apply.
- Many times consumers may not be aware of these resources. You can help by making sure consumers know about these resources.
- If you are not familiar with these resources, we strongly encourage you to check out several of the Web sites in the handouts.

Distribute the handouts Research, Training, and Technical Assistance Centers *and* Children's and Adolescents' Mental Health Services Technical Assistance and Research Centers.

Examples of Consumer WRAPs

	Consumer WRAP #1
Wellness Toolbox	Listen to soothing music, talk to my parrot, read, talk to a support person, go for a walk, play on the computer, e-mail, watch TV
Daily Maintenance Plan	Things I must do: feed my parrot, eat regular meals, take medications, bathe regularly.
Triggers	TV news, anniversaries of hospitalizations and episodes, being overtired and stressed, family friction, being judged, self-blame, being around abuse or someone who reminds me of past abuse
Early Warning Signs	Anxiety, feeling slowed down, overeating, compulsive behavior, secretiveness, feelings of abandonment and rejection, beginning irrational thought patterns **Things I must do during Early Warning Signs** Do daily maintenance whether I like it or not, talk to a support person about what's going on, check in with a friend once a day, spend extra time with my parrot, listen to soothing music and sing with it, spend time in nurturing places like Barnes and Noble and The Good Earth
When Things Are Breaking Down	Feeling very needy, feeling fragile, irrational responses, racing thoughts, risk-taking behaviors, bizarre behaviors, dissociation, suicidal thoughts, paranoia
Crisis Plan	None

HANDOUT

Examples of Consumer WRAPs

	Consumer WRAP #2
Wellness Toolbox	Crochet, bake/cook, treadmill, attend support group, take a nap, connect with therapist, play computer games, talk to therapist, talk to a friend, listen to music, journaling, wear makeup, work on genealogy, go fishing
Daily Maintenance Plan	**What I'm like when I'm well** Calm, capable, confident, content, organized, reliable, focused, reserved, competent, neat/clean, productive, flexible, intelligent, articulate, professional, analytical, determined, positive **What keeps me feeling well: things I do every day** Use treadmill 30 minutes a day, eat regular meals, get 7½ hours sleep a night, have time alone, take medications, regular schedule/routine **Extra things to do to stay well (weekly/monthly):** Bake, spend time with kids, crochet, shop, socialize, intellectual conversation, clean house, play computer games, watch a movie with spouse, play cards, visit family, take a bike ride, meet with job coach
Triggers	Being judged/criticized, anniversary of traumatic event, overstimulation, spending time with family (mother) on holidays, someone else's anger, stress, financial problems, feeling left out, medication changes that are not effective **Triggers Action Plan** Check in with therapist or psychiatrist, positive self talk, take a nap, vigorous exercise, be assertive, verbally express my feelings, take a break/time out/go home, journaling, ask others for support, follow daily maintenance plan
Early Warning Signs	Helplessness/hopelessness, negative thinking/talk, apathetic, lack of motivation, avoiding daily maintenance routine, isolating/withdrawing, back pain/pressure, short tempered/irritated, crying, increased appetite, irrational fear of abandonment **Early Warning Signs Action Plan** Check daily maintenance plan and follow it, contact therapist, ask for help from people around me, attend a support group, take a nap, exercise, express feelings
When Things Are Breaking Down	Suicidal thoughts/wanting to die, no appetite, racing thoughts, intense feelings, waking up between 3 and 6 AM, not feeling, respond as a victim, inability to follow through with commitments, not wanting to leave home, doing things in excess **Breaking Down Action Plan** Talk to a support person, make appointment with therapist, readdress/focus on wellness plan, avoid outside stimulation, take time for self, exercise, journaling, follow daily maintenance plan

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HANDOUT

Consumer WRAP #2 (continued)

Crisis Plan	**When feel out of control:** Not able to get out of bed after 10 AM, quitting job, missing appointments, isolating, staying in bed, crying and rocking, neglecting personal hygiene, not getting dressed, not taking shower, staring into space, not responding to anyone around me **Supporters**: spouse, sister, therapist, coworker **Don't want:** mother, father (no understanding of mental illness) **Medications:** prozac **Don't want:** serzone, wellbutrin, generic prozac works, not currently taking: lithium, nortriptyline **Don't want:** depakote, paxil **Treatments:** day treatment at mental health center **Facilities:** St. Cloud Hospital **Help from others:** spouse: hold me while I cry **ALL:** don't talk about my problems **Spouse:** take care of financial responsibilities **Things that make it worse:** Pushing me to do things I'm not ready to do. Being angry or aggressive. Criticism. If I am in danger, take me to the community hospital.

HANDOUT

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Module 5

Strategies to Prevent Seclusion and Restraint

Examples of Consumer WRAPs

	Consumer WRAP #3
Wellness Toolbox	Attend support group, take a nap, do crossword puzzles, play cards, play computer games, pool therapy, take a warm bath, listen to classical music, read, journaling, deep breathing/focusing, call a friend, put picture albums together, meditate, creative activity like quilting or crocheting.
Daily Maintenance Plan	**What I'm like when I'm well** Natural leader, happy/content, endearing, responsible, reliable, calm, persistent, optimistic, capable, spontaneous, confident, competent, supportive, kind **What keeps me feeling well** Taking medications, eat 3 healthy meals, quiet time before bed, 30 minutes of meditation, cup of herbal tea, shower/wash hair, get up by 8 AM, go to bed at same time—11 PM, avoid junk food, keep a routine, drink 8 glasses of water a day, take Vitamin C, brush my teeth **Extra things to do to stay well** Plan something fun for weekend, spend time with grandchildren, read, play games, cards with family and friends, plan a vacation
Triggers	Dad's death—April, movies about abuse, overtired, being interrupted, relationship ending, too many needy people, excessive stress, overstimulation, car problems, loud noises, arguing—especially family holidays and especially Christmas **Triggers Action Plan** Do everything on daily maintenance list, screen phone calls, get feedback from supporters, listen to classical music, take time off for myself, on holidays take care of my emotions and express what I'm feeling
Early Warning Signs	Forgetfulness, anxiety, anger, irritable, physical problems, obsession with something, negative thinking, impulsive, irrational thought patterns, feeling inadequate/worthless **Early Warning Signs Action Plan** Do everything on daily maintenance list whether I want to or not, call supporter/therapist, readjust schedule/slow down, do one hour of something fun from the Toolbox, relaxation exercises, ask someone to do housework—especially the dishes **Things I would choose to do** Make an appointment with doctor, read a good book, listen to good music, ask friends who are positive to spend time with me

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HANDOUT

Consumer WRAP #3 (continued)

When Things Are Breaking Down	Unable to sleep for 2 days, increased physical pain—back and neck, avoid eating, wanting to be totally alone, racing thoughts, pacing, spacing out, not feeling, obsessed with negative thoughts that can't be controlled, paranoid, defensiveness **Breaking Down Action Plan** Call psychiatrist, call physical doctor, do everything on daily maintenance list, take time off from work, journal, ask daughter to come over and stay with me, give medications, checkbook, car keys to adult children, do 3 deep breathing exercises, do 2 focusing exercises **Other things I may choose** Do a creative activity—crocheting & crafts, ask doctor to check my medications
Crisis Plan	**Symptoms when supporters take responsibility:** Not sleeping for one week, excessive pacing, can't stay still, anger and weeping within 5 minutes time, poor decision making, severe pain, agitated depression, flat affect, not doing any home responsibilities for one month, extreme guilt, disconnected sentences, anger that people don't understand **Supporters:** Son: pick up mail, pay bills Son: keep car running Daughter: visit me, cancel appointments, bring clothes and personal items Daughter-in-law: clean house before coming home, feed cat, change litter Daughter-in-law: visit me, bring grandchild Son-in-law: mow lawn, shovel snow, visit me Coworker: cancel any trainings or appointments, handle messages **Medications:** Currently use: depakote, zoloft, vioxx, lipitor Medications to use if necessary: ativan Avoid: antihistamines, sulfa Treatments: massage therapy, pool therapy, cognitive therapy Treatment to Avoid: ECT Facilities: St. Cloud Hospital Avoid: Regional Treatment Center (State hospital): increases symptoms **Help from others:** Listen to me, let me pace, encourage me, validate my feelings, let me rest, feed me good food, check on me, call me, stay overnight **Don't:** Talk constantly

HANDOUT

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Developing a WRAP

In your Seclusion and Restraint Journal, please complete the following information for a WRAP. Remember, a WRAP does not have to be related to psychiatric symptoms—it could be for any physical condition or recovery from a difficult or traumatic life experience.

Daily Maintenance Plan
- Describe yourself when you are feeling well. Make a list of descriptive words.
- Make a list of things you know you need to do for yourself every day to keep yourself feeling all right.
- Make a list of things it would be good to do.

Triggers
- Make a list of those things that, if they happened, might cause an increase in your symptoms. They may have triggered or increased symptoms in the past.
- Make a list of what you will do if triggers occur.
- Make a list of additional things you could do that would be helpful.

Early Warning Signs
- Make a list of Early Warning Signs for you.
- Make a list of things you must do when you experience Early Warning Signs.
- Make a list of things you could choose to do if they feel right.

Symptoms
- Make a list of the symptoms which, for you, mean that things have worsened and are close to the crisis stage.

Crisis
- Make a list of what you are like when you are well.
- Make a list of symptoms that would indicate to others that they need to take over responsibility for your care and make decisions in your behalf.
- Make a list of people who you want to take over for you when the symptoms you list come up. They can be family members, friends, or health care professionals. Have at least five people on your list of supporters. You may want to name some people for certain tasks like taking care of the children or paying the bills. For each person, list his or her name, connection/role, and phone number. Also make a list of people that you do not want involved in your care and why you do not want them involved.
- Medication. Make a list of the medications you are currently using and why you are taking them. List those medications you would prefer to take if medications or additional medications became necessary and why you would choose those. List those medications

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Developing a WRAP (continued)

that would be acceptable to you if medications became necessary and why you would choose those. List those medications that should be avoided and give the reasons.
- Treatments. List the particular treatments that you would like in a crisis situation and some that you would want to avoid.
- Home/Community Care/Respite Center. Many people are setting up plans so that they can stay at home and still get the care they need if they are in a crisis by having around-the-clock care from supporters and regular visits with health care professionals. List what you have planned for this.
- Treatment Facilities. Using your personal experience and information you have learned through your own research or though talking with others, list those treatment facilities where you would prefer to be hospitalized if that became necessary, and list those you with to avoid.
- Help from others. List those things that others can do for you that would help reduce your symptoms or make you more comfortable.
- Describe the symptoms, lack of symptoms, or actions that indicate supporters no longer need to use this plan.

Post-Crisis Planning
- Describe how you would like to feel when you have recovered from this crisis.
- List post recovery support people.
- List things you must do after returning home, things others can do for you, things that can wait until you feel better.
- List things you must do for yourself every day.
- List people and things to avoid.
- List signs that may be the beginning to feeling worse and list Wellness Tools to use to help you.
- Issues to consider:
  ○ People to thank
  ○ People to apologize to
  ○ People with whom you need to make amends
  ○ Medical, legal, financial issues that need to be resolved
  ○ Things you need to do to prevent further loss (i.e., canceling credit cards, getting official leave from work, etc.)
- Develop a reasonable timeline for resuming responsibilities.
- Consider whether any changes are needed in your WRAP.

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How to Set Up a Comfort Room
by Gayle Bluebird

1. Establish a plan for comfort room and submit it to the hospital administration. Approval from top-level administration is necessary including attendance at planning meetings and memoranda to support the effort.

2. Organize a planning committee which includes all levels of staffing. Two coordinators are helpful, one whom will work directly with staff and clients.

3. Involve people diagnosed with a mental illness in every aspect of planning. Allow them to actively participate in decorating the room with their input regarding preferences in design.

4. Conduct research regarding all furnishings and equipment that will be used in the comfort room for safety as well as comfort.

5. Create a comfort box with items that can be used in the comfort room including stuffed animals, headphones, reading materials, and other requested items.

6. Conduct training with staff and people diagnosed with a mental illness regarding the guidelines for usage.

7. Develop the room in graduated steps, introducing each new item and testing for efficiency, safety, and satisfaction.

8. Have sign-up book for each person to sign before and after using the comfort room.

9. Make sure a de-escalation preference form is filled out and placed on the record for helping to insure individual preferences about what is helpful and what is not in times of stress.

10. Keep an accurate record of progress.

11. Inform total staff with regular progress reports.

12. Congratulate direct care staff for participating in the implementation of the comfort room. Allow staff to participate in presentations or tours. Encourage their feedback or suggestions for improvement.

13. Collect data regarding use of and feedback for research purposes.

Module 5 **Strategies to Prevent Seclusion and Restraint**

Why Should I Fill Out A Psychiatric Advance Directive?
(or, sometimes the best defense is a good offense)

HANDOUT

An advance directive spells out what you want done in a time of crisis as a result of your mental illness. It also enables you to choose who you want to make medical decisions for you. It can also let others know your plans for the care of your children, pets, or home. This directive does not "activate" unless your capacity to make rational decisions becomes impaired. You can also use this document to describe those behaviors which are "indicators" of impaired capacity and which you think ought to activate the advance directive. An advance directive helps you maintain control in a time of mental health crisis and may prevent the crisis from worsening. Here are a number of important reasons why consumers should consider completing advance directives for mental health care:

1. An advance directive helps you maintain choice and control in the treatment you receive, according to your knowledge of what works best for you in managing your mental health care. This includes medication and treatment you do and do not want.

2. An advance directive increases the possibility that there will be continuity of care in times of crisis, including place, type, and personnel involved in treatment.

3. An advance directive may decrease the possibility of involuntary treatment.

4. If involuntary treatment does occur, a mental health care directive may have a direct impact on the treatment you do receive, including time in the hospital, the use of medications, place of treatment, and treatment plan upon release.

5. Preparing a mental health care directive affords an excellent opportunity to develop an effective crisis intervention plan and to discuss it with family, friends, and others before the crisis arises. This includes the opportunity to discuss approaches that are effective and those that hinder rather than help in times of crisis.

6. An advance directive allows you to authorize the release of information at a time when your capacity to make authorization is clear, and it enables you to state whom you do and do not want notified at the time of hospitalization.

7. An advance directive, particularly the appointment of a proxy whom you trust, can be an effective alternative to the court-appointed guardian.

8. An advance directive can include how you want your family, pets, and finances cared for while you are receiving treatment.

9. The implementation of an advance directive can help restore self-confidence and allay fears and panic in a time of crisis. This helps in terms of stabilization and recovery.

Module 5   **Strategies to Prevent Seclusion and Restraint**

Ten Tips for Completing an Effective Advance Directive

1. Think of your directive as a relapse prevention plan or crisis intervention plan. Who do you need to be involved in your plan to make it work?

2. Write your advance directive at a time when your illness is not severe enough to impair your judgment or to raise questions about the validity of the document. You probably do not want to fill out an advance directive while you are in the hospital or under commitment; unless the professionals treating you agree that your capacity is presently not impaired. If this is the case, consider asking them to witness your document.

3. Sit down and discuss the directive with people you trust and who can give you good feedback about your concerns and problems in times of crisis. Ask them what they would include in the directive if they were you. You do not have to include their suggestions, but shared wisdom may produce a stronger document with others invested in making it work.

4. Discuss your treatment concerns and the instructions you are thinking of putting in the directive with those who will be involved in your treatment and care. This should include your doctor, case manager, therapist, personal care assistant, and others directly involved in your care. Do this before you write your directive.

5. Discuss the contents of your advance directive with the person who will be your proxy before you finalize the directive. Can that person carry out the instructions as you wish and be a good advocate for you? If not, can you live with whatever limits that person may have?

6. Although it is important to get the opinions, thoughts, and ideas of those involved in your life and care, you, of your own free will, must decide what goes into the directive. If you are not comfortable with the directive, if it reflects pressure from others rather than your own choices, then it is more likely that you will reject the directive at a time when you are in crisis. Therefore, family, friends, and providers must be careful not to pressure you into choices that are not really yours.

7. Include your knowledge of what works for you based on your own experiences. While this is a legal document, you do not need to write it in legalese. Use your own words to describe your needs in time of crisis; what has worked and not worked for you; and what has caused negative reactions or actually hindered progress. You can use a story format, but do not make it too long.

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Ten Tips (continued)

8. Read over the form until you understand it and do drafts of your directive before you actually write up your final document. Do not be afraid to ask for help figuring out the parts you do not understand. If you fill out the directive without really understanding it, you may end up writing a directive that is not valid.

9. Think about the following things that may need to be put into your directive:
   - What is the best way to describe my mental health problem?
   - What triggers my crisis, in particular, the point at which I would like to be hospitalized or given medications? Answering this question gives you an idea of when your directive should kick in.
   - What are your experiences, wishes, and concerns about medications and ECT? Would you prefer seclusion to the use of emergency medications? Are seclusion and restraints out of the question because they are contraindicated by your personal history?
   - What other concerns do you have about the way you might be treated?
   - What else has worked well for you in the past? Individual or group therapy? Time to be alone? Regular visits from particular family members or friends? Assurances that the rent is paid or your family is being cared for?
   - If you are a smoker, think about how your need to smoke may be addressed, particularly if there are hospital limitations on smoking.
   - If you want to be treated in the hospital by a particular doctor, make sure that doctor has hospital privileges.

10. Be reasonable in what you put in the directive. Do not include treatment or services that you know that you will not be able to get, particularly while in the hospital. Also, if your directive is not reasonable, you may be raising questions about the validity of your directive.

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Psychiatric Advance Directive Practice Worksheet

(Source: www.nmha.org)

HANDOUT

Advance directives are based on the principles of personal choice and self-determination. The preferences you express regarding future treatment or services, a person you authorize to make decisions for you, the ability to revoke your advance directive, or any other issues are for you to decide, without anyone exerting any control or coercion over you. You also have the right to change your mind and change your advance directive at any time, but it is your responsibility to make sure that all copies of the advance directive are kept up to date and copies are shared with the appropriate people.

This practice worksheet is not a legal document, but is designed to help you start thinking about what you want to include in your own advance directive. It can also help you start gathering the information you will need when you write one that is legally binding. More detailed information about psychiatric advance directives is available from the National Mental Health Association.

Your "Expressed Wishes"

An advance directive is your opportunity to express what treatments or services you choose to have, or not to have, during a psychiatric crisis. These statements are known as your expressed wishes. If you have ever been hospitalized before, think back about those things that were helpful to you, and those things that were not.

What types of treatments or services are helpful to you during a crisis? This can include medications (and dosages), what facilities or healthcare professionals you want to be involved in your care, what helps you calm down if you're feeling overly agitated, who can help you in other ways (such as taking care of children, pets, plants, or paying bills), people you want as visitors if you're hospitalized, etc. Try to be as specific as possible. You may need to use additional sheets of paper:

_____

_____

_____

_____

_____

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HANDOUT

Practice Worksheet (continued)

What types of treatments or services are NOT helpful to you during a crisis? This can include medications (and dosages) that you know will not be helpful, what facilities or health care professionals you wish to avoid, ways that people treat you that make you upset or angry, people who you don't want to see if you are hospitalized, etc. Again try to be as specific as possible:

_____

_____

_____

_____

Your Choice of Agent(s)

An agent is someone who you authorize to make decisions for you at a time when you have been determined unable to make decisions for yourself. It's important that you choose someone you trust and who you think will do a good job as your advocate. You may wish to choose one person as the primary agent, and choose a second person as a backup in case the first person is no longer able or willing to serve as your agent.

1st Agent's Name: _____

Address: _____

City, State, and Zip: _____

Daytime phone: _____

Evening phone: _____

Mobile phone: _____

E-mail address: _____

2nd Agent's Name: _____

Address: _____

City, State, and Zip: _____

Daytime phone: _____

Evening phone: _____

Mobile phone: _____

E-mail address: _____

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Practice Worksheet (continued)

Your Choice of Revocability

Revocability is a controversial issue. Some individuals want to be able to revoke their advance directive even while they're in crisis, possibly because they may change their minds about their expressed wishes or because they may become dissatisfied with the decisions their agent was making. Other people know that they don't make good decisions when they are in crisis, want the decisions they made ahead of time to apply throughout a crisis, and therefore want their advance directive to be irrevocable. Laws around revocability vary from State to State. Therefore, you will need to consult your State law before drafting these provisions.

If it is determined you are unable to make your own decisions, and you choose to revoke your advance directive at that time, your agent will no longer be able to advocate for your expressed wishes, you will lose the benefits of having an advance directive, and it will be as though you never had one. You may wish to discuss this issue with your friends, relatives, and/or healthcare providers before you decide whether or not your advance directive should be revocable.

Please circle the answer that's right for you: **Even if I were in the middle of a psychiatric crisis, I (would) (would not) want to be able to revoke my advance directive.**

Explanation of your choice of revocability, if you choose to give one:

_____

_____

_____

Summary

Hopefully this worksheet helped you to get started thinking about what you want in your own psychiatric advance directive. Some States require that advance directives be done in a particular way for them to be considered legal documents. You should consult with an attorney or someone from your State's Protection and Advocacy (P&A) program (www. napas.org or 202-408-9514) for legal information specific to your State.

For more information on psychiatric advance directives issues and for a listing of additional resources, see the National Mental Health Association's Psychiatric Advance Directives Toolkit, available by calling 800-969-6642 or visiting www.nmha.org

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Module 5   **Strategies to Prevent Seclusion and Restraint**

Six Essential Steps for Advance Directives

1. Get the "buy-in" of the facility or program that will pilot the project.

2. Meet with the core group of staff, review the materials and goals.

3. Meet with the staff of the facility/program, review the materials and goals.

4. Meet with the young people, fill in a survey, review the materials and goals, answer questions, and develop a working relationship with the young people.

5. Get ongoing technical assistance through the pilot process.

6. In three months, readminister the surveys that were given earlier to the young people and see if there is a notable difference.

HANDOUT

Module 5   **Strategies to Prevent Seclusion and Restraint**

Anticipated Benefits of Prime Directives

Anticipated benefits/outcomes for young people
- A concrete voice in treatment and service planning, including wishes and concerns.
- The opportunity to ask questions that are difficult to ask.
- A concrete plan for goals for future life.
- Increased self-esteem, hope, and trust as they begin on the road to recovery.

Anticipated benefits/outcomes for parents
- A forum to hear from their children what has been difficult to hear in the past.
- An intermediary when communication is difficult.
- Insight into their children's wants and needs.
- An active role in understanding their children's goals for recovery.

Anticipated benefits/outcomes for programs
- Better informed recipients of services.
- More aware/responsible program staff.
- Quality assurance mechanism.
- Recovery-oriented model.
- Reduction of seclusion, restraint, and coercion.
- Better understanding of recipients' wants and needs.

HANDOUT

Children's and Adolescents' Mental Health Services Technical Assistance and Research Centers

HANDOUT

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, support the following Technical Assistance, Research, and Training Centers and Clearinghouses. Services may include technical assistance, information and referral, on-site consultation, training, library services, publications, annotated bibliographies, etc. Many services are available free of charge, but in some cases, charges are applicable.

Center	Services Provided
National Indian Child Welfare Association 5100 SW Macadam Ave. Suite 300 Portland, OR 97239 Phone: (503) 222-4044 Fax: (503) 222-4007 www.nicwa.org	• Technical assistance for community development • Public policy development • Information exchange • Technical assistance and training for Tribal grantees of the Child, Adolescent and Family Branch of the Center for Mental Health Services
Technical Assistance Partnership for Child and Family Mental Health 1000 Thomas Jefferson Street, NW Suite 400 Washington, DC 20007-3835 Phone: (202) 403-5600 Fax: (202) 403-5007 E-mail: tapartnership@air.org www.air.org/tapartnership	• Education, family involvement and advocacy • Child welfare • Peer mentors • Youth coordinators
Center for Evaluation of Child Mental Health Systems Judge Baker Children's Center 53 Parker Hill Avenue Boston, MA 02120 Phone: (617) 232-8390; (800) 779-8390 Fax: (617) 232-8399	• On-site consultation on management information systems • Meetings and conferences • Topic-based conference training modules • Networking and organization collaborations
Research and Training Center on Family Support and Children's Mental Health Regional Research Institute of Portland State University P.O. Box 751 Portland, OR 97207-0741 Phone: (503) 725-4040 Fax: (503) 725-4180 E-mail: frieseb@rri.pdx.edu	• Research and training focused on family support issues, family/professional collaboration, and diverse cultural groups • Annual research conference on family support issues • Information on publications and events through an electronic bulletin board

Research, Training, and Technical Assistance Centers

The Substance Abuse and Mental Health Services Administration, Center for Mental Health Services supports these Research, Training, and Technical Assistance Centers. Services may include technical assistance, information and referrals, on-site consultation, training, library services, publications, annotated bibliographies, and other resources. Many services are available free of charge, but in some cases, charges may apply.

Center	Services Provided
National Research and Training Center on Psychiatric Disability 104 South Michigan Avenue Suite 900 Chicago, IL 60603 Phone: (312) 422-8180 Fax: (312) 422-0740 www.psych.uic.edu/uicnrtc	• Psychiatric rehabilitation research and training in 9 major areas: peer support and consumer service delivery, treatment models, vocational rehabilitation, managed care, women's issues, HIV/AIDS, familial experience, diversity issues, and transition-age youth • Extensive dissemination and technical assistance at replacement cost or no cost • Workshops, seminars, academic courses, and training to providers • Technical assistance to Federal, State, and local agencies for public policy initiatives
The Evaluation Center Human Services Research Institute 2269 Massachusetts Avenue Cambridge, MA 02140 Phone: (617) 876-0426 Fax: (617) 497-1762 www.tecathsri.org	• Consultation program through site visits or telephone/e-mail • Topical evaluation network program • Tool kits to provide evaluators with tested methodologies and instruments • Evaluation materials program • Mini-grant program for system-of-change evaluation projects • Training program on evaluation-related skills • Multicultural issues in evaluation

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Research, Training, and Technical Assistance Centers (continued)

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Center for Psychiatric Rehabilitation Sargent College of Health and Rehabilitation Sciences Boston University 940 Commonwealth Avenue West Boston, MA 02215 Phone: (617) 353-3549 Fax: (617) 353-7700 E-mail: w.anthony@bu.edu www.bu.edu/sarpsych	• Consultation and training using psychiatric rehabilitation technologies and topics related to rehabilitation and recovery • Workshops, conferences, professional development programs, and academic degree programs • Service demonstration programs for consumer/survivor rehabilitation and recovery • Information dissemination via a newsletter, journal, Web site, and catalog • Research on psychiatric rehabilitation and related topics
National Mental Health Consumers' Self-Help Clearinghouse 1211 Chestnut Street Suite 1207 Philadelphia, PA 19107 Phone: (800) 553-4539 Fax: (215) 636-6312 E-mail: info@mhselfhelp.org www.mhselfhelp.org	• Consumer information and referrals • On-site consultation • Training events • Teleconferences and national conferences • Consumer library • Newsletter • Consumer and consumer-supported nationwide database
Center for Support of Mental Health Services in Isolated Rural Areas Frontier Mental Health Services Resource Network Western Interstate Commission for Higher Education Mental Health P.O. Box 9752 Boulder, CO 80301 Phone: (303) 541-0256 Fax: (303) 541-0291 E-mail: dmohatt@wiche.edu www.wiche.edu/MentalHealth/Frontier	• Knowledge synthesis • Technical assistance to organizations • Human resource development • Conferences and workshops • Demonstrations and evaluations
National Resource Center on Homelessness and Mental Illness Policy Research Associates, Inc. 345 Delaware Avenue Delmar, NY 12054 Phone: (518) 439-7415 Fax: (518) 439-7612 Email: pra@prainc.com www.prainc.com	• On-site technical assistance to demonstration grantees on topics related to service delivery, program organization, research design, and instrumentation • Workshops, training institutes, and substantive papers on issues related to service delivery to homeless persons with serious mental illnesses • Database of 4000+ articles, annotated bibliographies on topic clusters, and specialized database searches

Research, Training, and Technical Assistance Centers (continued)

National Technical Assistance Center (NTAC) for State Mental Health Planning National Association of State Mental Health Program Directors 66 Canal Center Plaza Suite 302 Alexandria, VA 22314 Phone: (703) 739-9333 Fax: (703) 548-9517 www.nasmhpd.org/ntac.cfm	• State, regional, and national consultation • Special topic technical assistance and training • Consensus development conferences and teleconferences • Consultant database • Publications and reports • Model service system standards review and analysis
Training and Advocacy Support Center (TASC) National Association of Protection and Advocacy Systems 900 Second Street, NE Suite 211 Washington, DC 20002 Phone: (202) 408-9514 Fax: (202) 408-9520 TTY: (202) 408-9521 E-mail: info@napas.org www.napas.org	• Centralized repository for training and technical assistance information and coordination for federally mandated Protection and Advocacy (P&A) programs • Information dissemination via a Web page, online interactive library, publications, and public service announcements • Technical assistance with expertise rosters/brokering and P&A legal backup centers • On-site peer consultation, development of model policies and procedures, and outcome measures to increase P&A effectiveness • On-site training, conferences, tapes and other visual or auditory training tools, and development of competency-based curriculum systems
Projects for Assistance in Transition from Homelessness (PATH) Technical Assistance Center Advocates for Human Potential, Inc. 490-B Boston Post Road, Suite 200 Sudbury, MA 01776 Phone: (978) 443-0055 Fax: (978) 443-4722 E-mail: info@ahpnet.com www.ahpnet.com	• Training curricula in topic areas identified through a comprehensive needs assessment of State PATH contacts • Ad hoc technical assistance to State and local PATH programs in response to special requests

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Strategies to Prevent Seclusion and Restraint

Research, Training, and Technical Assistance Centers (continued)

The National GAINS Center for People with Co-Occurring Disorders in the Criminal Justice System Policy Research Associates, Inc. The GAINS Center 345 Delaware Avenue Delmar, NY 12054 Phone: (800) 311-4246 Fax: (518) 439-7612 Email: Gains@prainc.com www.prainc.com	• Integrated technical assistance network for knowledge development • Analysis of state-of-the-art practices and synthesis documents • Targeted fact sheets, briefs, and brochures • Specially designed training sessions and workshops delivered on-site and via e-mail
Consumer Organization and Networking Technical Assistance Center (CONTAC) West Virginia Mental Health Consumers Association P.O. Box 11000 Charleston, WV 25339 Phone: (888) 825-TECH (8324) (304) 345-7312 Fax: 304-345-7303 www.contac.org	• Resource center for consumers/survivors/ex-patients and consumer-run organizations across the United States • Services include materials development and dissemination, training, skill development, interactive communication opportunities, networking, and other activities to promote self-help, recovery, and empowerment • Technical assistance to organizations in identifying and exemplifying points of entry into consumer programs • Outcome orientation for non-traditional services • Leadership and organizational development • Information sharing through a national Web network
National Consumer Supporter Technical Assistance Center 2001 N. Beauregard Street, 12th Floor Alexandria, VA 22311 Phone: (800) 969-6642 Fax: (703) 684-5968 E-mail: consumerTA@nmha.org www.ncstac.org	• Information and referrals • Technical assistance on site and by phone • Resource library • Coordination of local coalitions • Training conference

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Module 5   **Strategies to Prevent Seclusion and Restraint**

Research, Training, and Technical Assistance Centers (continued)

National Alliance for the Mentally Ill Colonial Place Three 2107 Wilson Boulevard Suite 300 Arlington, VA22201 Phone: (703) 524-7600 (800) 950-NAMI (6264) TDD: (703) 516-7227 Fax: (703) 524-9094 E-mail: Elizabeth@nami.org www.nami.org/about/pact.htm	• Technical assistance in developing pro-grams of assertive community treatment • Teleconferences on various aspects of PACT program planning and implementation • Information dissemination via mail and a Web site
National Center for American Indian and Alaska Native Mental Health Research University of Colorado Health Sciences Center Department of Psychiatry Nighthorse Campbell Native Health Building P.O. Box 6508, Mail Stop F800 Aurora, CO 80045-0508 Phone: (303) 724-1448 Fax: (303) 724-1474 www.uchsc.edu/ai/ncaianmhr	• Research, research training, • Information dissemination • Technical assistance provided on American Indian and Alaska Native populations. • Cross site evaluation of 9 sites in the Circles of Care grant program.
National Empowerment Center 599 Canal Street Lawrence, MA 01840 Phone: (800) 769-3728 Fax: (978) 681-6426 www.power2u.org	• Consumer/survivor ex-patient TA • Information and referrals • Technical assistance on site and by phone

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