

# How to Create and Evaluate a Seclusion and Restraint Prevention Plan

*Patient Safety Plans are a very important way to reduce seclusion and restraint episodes. Read on to find out ways to write and review them.*

■ Kim J. Masters, M.D.

Seclusion and restraint prevention plans are the most powerful tools that child and adolescent psychiatrists have because they allow patients to inform facilities of preferred ways to handle their irritability and anger.

Safety plan forms can be obtained from several sources, including the National Executive Training Institute Manuals and in the publication *Psychiatric Services* (see the reference list at the end of this article for the specific article and issue). However, all of the ones I reviewed had some limitations. The forms often lacked instruction about how to elicit information in a developmentally appropriate format: they did not challenge the patient's maladaptive coping strategies (for example, throwing things or hitting people); they did not review facilities' preferred ways of handling aggression; they did not require practice sessions to assess the effectiveness of the anger management strategies; and finally, they were not customized to reflect the tone or language of the therapeutic relationship between the child and his/her psychiatrist, upon which the acceptance of treatment may be based.

In order to make the Safety Plan "all it can be," it is essential to examine each element that makes up the document, in much the same way that one assembles bricks to build a wall. Armed with this information, one can see what is essential and how the parts fit together. If it is done well, the document clearly communicates the child or adolescent's worries, fears, and needs and the institution's compassionate understanding and collaborative approach to dealing with them.

### Element 1: Review of Anger Triggers

A patient's anger may be set off by a variety of factors: daily living issues such as hunger, anger, loneliness, tiredness, or elements of past trauma such as bed times, darkness, yelling, raised hands; or social problems such as teasing or rejection. Each person's triggers have unique components based on his/her age, environment, and experience.

### Element 2: Trauma history, especially related to seclusion and restraint

This is by far the most important element in the entire plan because it is often the source of intense memories and affect.

Patients may unleash a flood of distressing details when they review

past abuse, particularly if this occurred during previous seclusion or restraint experiences. A potentially beneficial therapy for these symptoms would be one modeled on the "abreaction, context, and correction" experience that is described in *Wild Child* (Terr 2005). With other patients, imagined trauma, like being tied up or "jumped" or "crushed" during a restraint that hasn't occurred, will be the major issue. While reassurances would naturally occur during these discussions, they must take a back seat to elaborations of fears and memories if the goals are to increase the patient's sense of trust and safety in the treatment setting.

### Element 3: Medical Risks

- A) A history of specific physical risks for a traumatic outcome during a seclusion or restraint needs to be elicited. Examples include: asthma; obesity; cardiac dysfunction, especially electrical conduction abnormalities; fragile bones; collagen disorders, like Marfan's Syndrome; and having a full stomach.
- B) A history of pre existing anxiety should be noted. There can be an interaction between extreme anxiety and medical conditions which result in a person effectively being "scared to death," so a panic attack could trigger reactive airway constriction, arrhythmia, or vomiting.
- C) The impact of the patient's current medications need to be assessed, especially during a restraint, particularly if they can increase heart rate or promote prolonged qt intervals, like thioridazine does or can trigger asthma attacks, like beta blocking agents do.

### Element 4: What works when one is "mad" but can still listen

Review strategies that the patient uses to self soothe and calm down. Eliciting these may require specific questions. Strategies can encompass all sensory modalities: touch, taste, and smell, visual, auditory, and kinesthetic. Examples include common comforts such as listening to music, playing with clay, and drawing, or more exotic options such as rolling up in a blanket, chewing something, smelling incense,

rubbing one's arms with an ice cube, putting a warm wet cloth on one's head, etc. (These should be tried out in practice sessions if they are acceptable to the facility and the family. If they are unacceptable this information should be recorded in the chart along with new strategies that will be developed).

**Element 5: What works when one is angry and cannot listen**

Strategies for this level of distress must take into consideration the patient's inability to hear and process suggestions. The goal of this element is to find coping skills, such as sitting on one's hands, being quiet, and distracting oneself, until the anger simmers down and listening and discussion are again possible.

**Element 6: What the institution expects**

A dialog about anger management techniques the facility wants patients to use is important because these strategies may be expected along with the patient's own self controlled methods. This discussion may be especially useful if the patient's own coping strategies are dangerous or difficult to carry out in the facility. These conversations may also diminish the patient's fear that the institution will use abusive "control" methods which many patients have previously experienced elsewhere.

**Element 7: What practice sessions will follow**

Anger management strategies should be subjected to frequent drills and role

plays to make sure they work. This also affords an opportunity for patients to learn strategies for dealing both with being upset and with being enraged. The sessions will help both them and the staff remember what to do in an anger crisis.

**Element 8: Prepare a card with essential anger prevention information**

Once the plan is finished, help the child or adolescent write it on a laminated 3x5 card that he or she carries at all times. The card should include the child or adolescent's name and list: 1) the special ways the child or adolescent shows that he/she is getting angry and 2) the calming strategies work best for him/her.

**Element 9: Review and modify the plan with any seclusion or restraint or during treatment when the strategy for anger control changes**

To keep the plans current, it is necessary to work with them, in much the same way as one modifies an exercise regimen. The psychiatrist should play a major role in this element because it ensures that patients' safety plans are being scrutinized and supervised by the person ultimately responsible for ordering them.

**Element 10: Have the patient present the plan to parents and supervising adults at discharge to use in anger management practice efforts and with angry outbursts in the patient's post discharge daily life**

This strategy ensures that patients demonstrate "facility tested," safe

methods for identifying, understanding, and controlling anger at discharge. Also, reading this plan to parents and other supervising adults provides patients the opportunity to have pride in their achievements.

For child and adolescent psychiatrists, the role of leadership in aggression management work can find no more productive outlet than the development and interpretation of patients "Safety Plans." I hope that this article has stimulated your interest in exploring the treatment possibilities that this type of document offers.

If you have success stories with a patient safety plan and would like to share them in this column, please contact me by email at [kimmasters@brontosaur.org](mailto:kimmasters@brontosaur.org). ■

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**References**

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