☑ Reducing Seclusion and Restraint – Organizational Questionnaire

Information for the Administration and Use of the Questionnaire:

Research and evaluation demonstrate that organizational factors appear to play a greater part in facilitating reduction or elimination of seclusion and restraint as do knowledge about the individual being secluded or restrained (e.g. Colton, 2008; Delaney, 2006; Huckshorn, 2005). This questionnaire was designed to tap into the same constructs that influence organizational culture and climate, as well as use of resources as the *Checklist for Assessing Your Organization's Readiness for Reducing Seclusion and Restraint* (Colton, 2004), but provides a more efficient approach. The original *Checklist* was developed to assist organizations in conducting internal evaluations for quality improvement. However, it was noted that the depth and bread of the process for conducting the evaluation, while providing comprehensive information, took considerable time and staff resources to complete.

Validity and Reliability:

Initial pretesting (factor analysis) with a pilot version of this instrument provides evidence for construct and content validity as items cluster into groups consistent with the factors identified in the *Checklist* including leadership, staff development, treatment planning, consumer involvement and debriefing,

Cronbach's Alpha (between .6 to .8) indicated strong reliability of each construct.

Administration:

The questionnaire should be administered to all staff having contact with consumers (patients, students, clients), such as psychiatric aides/technicians, mental health counselors, nurses, teachers, social workers, psychologists, and the like.

Only the instruction page and 3 page questionnaire should be administered.

The questionnaire should be administered over a timeframe that encourages as many staff as possible to participate, typically up to but no more than two weeks, otherwise a unique or special event could influence responses near or at the time the questionnaire is administered. To enhance the response rate the questionnaire does not ask the respondent to provide identifying information. A collection method, such as a locked box helps to ensure anonymity. Responses rates of 70% or more typically indicate that the respondents are representative of the target population. If the response rate is less than 70% the organization may want to extend the time frame for submitting completed questionnaires. Some organizations also provide incentives, such as a reward to all employees if the response rate is 70% or greater. Sharing the results of the survey with employees may also increase interest and the response rate.

Tabulation:

We tabulate the results in Microsoft Excel although you may choose to use other spreadsheet or statistical software. As you receive completed questionnaires, number the paper copies from 1 to however many completed questionnaires you obtain. Our Excel file contains a worksheet with the items numbered across the top and the respondent/questionnaire number in the left hand column.

Items are coded with a 1 for Agree, 0 for disagree, and left blank for missing data. Missing data includes items that are not checked or items where the respondent makes a mark that is not consistent with the directions. For example, someone might place a check in the space between the boxes to indicate that they neither agree nor disagree. Since this is not an option the item should be treated as missing data and left blank. Items 40 and 41 are coded 1 to 3 reading down so that "Seclusion when implemented properly can be therapeutic" should be numbered 1 and so on.

Count the number of agree, disagree, and missing items. (If you do this manually, you can use the Sort option in Excel under the Data toolbar. However, you will have to sort each item separately.) We tabulate the total number of respondents. This will be the same for every item and is used as a check when tabulating the data. For example, if there were 55 respondents the total number of agrees, disagrees, and missing responses should equal 55. We also tabulate the total number of agree and disagree responses not including the number of missing items. We then calculate the percent of agree and disagree by creating a formula that divides the number of agrees or disagrees by the number of responses.

To tabulate the responses to the demographic item for Role we code the items from 1 to 4: 1 = Direct care staff, 2 = Nurse, 3 = Licensed Clinician, and 4 = Other. In our experience a number of respondents will not want to be identified. This information is not critical but can help in determining if your respondents are representative of the target workforce. We do the same for Years of Service, coding them 1 to 5 reading down so that Less than 1 (year) =

1, More than 1 but less than 5 = 2, and so on. This information is not critical but does provide some context for appreciating the work experience respondents bring to the task.

Finally, we create a separate worksheet and type the respondents' comments into the box exactly as written including spelling or grammatical errors (you can do this in word processing software as well). In addition to providing respondents with a location to provide a narrative response, in our experience some will also write in comments next to and in response to a specific item. You'll want to keep track of these comments as well as they may contain useful information.

Analysis and Use:

The results from administering this questionnaire can be used in two ways. The first is diagnostically. Items 1 to 34 (except items 21 and 30) examine staff perceptions about organizational factors that influence use of seclusion and restraint including leadership, staff development, treatment planning, consumer involvement and debriefing. All the items are worded positively. Agreement with the item indicates the organization is doing the right things, whereas items the majority of respondents rate as disagree indicate areas for improvement.

Items 21, 30 and 35 to 41 assess staff attitudes; they provide information about the existing culture and the level of acceptance of the use of seclusion and restraint. For example, organizations that incorporate trauma-informed care (item 21) tend to implement seclusion and restraint less frequently (Huckshorn, 2005). Item 30 taps into staff attitudes about external control; for example, employees who rely on strict enforcement of rules rather than developing positive relationships with consumers may be more likely to have interactions that end up in power struggles and use of restrictive interventions. Items 40 and 41 also correlate to successful efforts to reduce or eliminate seclusion and restraint as there appears to be a greater commitment to the process when organizational leadership believes that there are no therapeutic benefits to using these interventions (Colton, 2008).

The questionnaire also provides space for comments – qualitative information to help assess organizational performance. This information is often useful in focusing on specific areas in need of improvement.

The questionnaire can also be used as a repeated measure, for example by administering at regular intervals to determine if organizational changes are taking affect. An organization trying to reduce or eliminate seclusion and restraint will engage in multiple activities that require time to implement which may not produce results immediately. Therefore sufficient time (at least 4 to 6 months and typically longer) should be provided between administrations to capture these changes and to minimize the potential for testing affect (where respondents remember and repeat their selections from an earlier administration).

This questionnaire provides *one* source of information about organizational activity to reduce seclusion and restraint. Decision makers are encourage to use other sources to complement this process, such as interviews with personnel and consumers, review of cases and special incidents, and utilization data.

References:

Colton, D. (2008). Leadership's and program's role in organizational and cultural change to reduce seclusions and restraints. Nunno, M., Bullard, L., and Day, D., (Eds.). *For Our Own Safety: Examining the Safety of High-Risk Interventions for Children and Young People.* Washington, DC. Child Welfare League of America. 143-166.

Colton, D. (2004). *Checklist for assessing your organization's readiness for reducing seclusion and restraint.* Web site: http://www.ccca.dmhmrsas.virginia.gov/content/SR%20Checklist.pdf

Delaney, K.R. (2006). Evidence base for practice: Reduction of restraint and seclusion use during child and adolescent psychiatric inpatient treatment. *Worldviews on Evidence-Based Nursing*, First Quarter, 19-30.

Huckshorn, K.A. (2005). *Six Core Strategies to Reduce the Use of Seclusion and Restraint.* Alexandria, VA. National Association of State Mental Health Program Directors.

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Purpose:

To assess staff perceptions about use of seclusion and restraint and the activities your organization is doing to reduce and/or eliminate their use. The results obtained from this survey can be used to identify areas in need of improvement.

Instructions:

- This questionnaire should be completed by all employees providing direct services to consumers[1] such as behavioral technicians, psychiatric aides, activity therapists, psychologists, nurses, physicians, counselors, social workers, and teachers.
- Responses should reflect your personal perception about your organization's activities to reduce seclusion and restraint. There are no wrong or right answers.
- This is an anonymous process. DO NOT write your name, position title or other identifying information on the questionnaire.
- This questionnaire contains 41 items and takes 10 to 15 minutes to complete.
- Read each item carefully and make a selection by checking the box. For example

  ☑ Agree ☐ Disagree

- If you need to change your selection, check the other box and **darken** in your previous selection. Example:

  ■ Agree ☑ Disagree

[1] Other terms may include patient, client, or student to describe service recipients.

1. The director/chief executive of this organization is committed to the goal of reducing/eliminating seclusion and restraint.
   ☐ Agree ☐ Disagree

2. Top management (chief executive and his/her immediate staff) has communicated the organization's plan for reducing/eliminating seclusion and restraint.
   ☐ Agree ☐ Disagree

3. An individual or individuals have been designated to assure the organization is making progress in achieving its goals to reduce or eliminate the use of seclusion and restraint.
   ☐ Agree ☐ Disagree

4. Top management has communicated principles to guide treatment.
   ☐ Agree ☐ Disagree

5. I am confident in top management's ability to lead the process of reducing/eliminating seclusion and restraint in my organization.
   ☐ Agree ☐ Disagree

6. Top management effectively communicates information about the activities the organization is doing to reduce or eliminate seclusion and restraint. (For example, through presentations, meetings, newsletters, emails, Internet, etc.)
   ☐ Agree ☐ Disagree

7. Treatment staff are involved in the change process to reduce/eliminate seclusion and restraint.
   ☐ Agree ☐ Disagree

8. We use data to measure the effects of our efforts to reduce or eliminate the use of seclusion and restraint.
   ☐ Agree ☐ Disagree

9. In my organization adequate numbers of employees are available at critical times, such as during transitions, at change of shift, in the evening, and at times of high acuity.
   ☐ Agree ☐ Disagree

10. After a serious incident, my organization provides opportunities to process the event with staff about our feelings, reactions, and safety concerns.
    ☐ Agree ☐ Disagree

11. My organization provides support groups, counseling, or other approaches to help staff work through our feelings.
    ☐ Agree ☐ Disagree

12. The orientation I received when I began employment prepared me to work with consumers.
    ☐ Agree ☐ Disagree

13. My organization provides ongoing opportunities for training and development in the skills I need to successfully work with consumers.
    ☐ Agree ☐ Disagree

14. During training employees have opportunity to develop mastery of the skills that are taught.
    ☐ Agree ☐ Disagree

15. Staff are provided mentoring, coaching, and/or supervision to support what is taught in training.
    ☐ Agree ☐ Disagree

16. I had to demonstrate competency in the skills that were taught before I was allowed to work with consumers.
    ☐ Agree ☐ Disagree

17. My organization assures that staff have time for needed training beyond new employee orientation.
    ☐ Agree ☐ Disagree

18. Within 48 hours caregiver care staff (mental health aides/technicians) receive information from clinical assessments to help in working with consumers.
☐ Agree ☐ Disagree

19. I am provided information describing the antecedents to aggression and/or self-harmful behaviors.
☐ Agree ☐ Disagree

20. I am provided information about approaches that have been tried, worked or failed in managing aggression and/or self-harmful behaviors.
☐ Agree ☐ Disagree

21. I am less likely to restrain or seclude a consumer who has experienced trauma, such as sexual or physical abuse.
☐ Agree ☐ Disagree

22. In my organization assessment and treatment planning identify strengths and deficits in coping skills.
☐ Agree ☐ Disagree

23. In my organization assessment identifies consumer preferred treatment interventions.
☐ Agree ☐ Disagree

24. In my organization, treatment plans are continually revised and updated in response to changes in a consumer's behaviors.
☐ Agree ☐ Disagree

25. Staff are provided direction and guidance for working with a specific consumer in order to mitigate aggression or self-harm.
☐ Agree ☐ Disagree

26. Caregiver staff (mental health aides/technicians), are involved in treatment decisions, such as decisions about passes, transfers, and readiness for discharge.
☐ Agree ☐ Disagree

27. My organization's treatment philosophy emphasizes a consumer orientation such as including consumers and their families in all aspects of their treatment.
☐ Agree ☐ Disagree

28. We explain the rules and expectations of our program to a consumer when he or she is admitted.
☐ Agree ☐ Disagree

29. Staff implement rules and expectations consistently across shifts.
☐ Agree ☐ Disagree

30. To assure adequate structure, it is important for staff to strictly enforce rules.
☐ Agree ☐ Disagree

31. Staff adjust the process of conducting consumer – staff debriefings based on consumer age and functioning level.
☐ Agree ☐ Disagree

32. The consumer – staff debriefing is used as an opportunity for the consumer and staff to reestablish a therapeutic relationship.
☐ Agree ☐ Disagree

33. During staff-to-staff debriefings we discuss what worked, didn't work, and different approaches that might be tried in the future.
☐ Agree ☐ Disagree

34. Calming or comfort rooms/spaces are effective in de-escalating consumers.
☐ Agree ☐ Disagree

35. I believe seclusion and restraint are high-risk interventions for both consumers and staff.
☐ Agree ☐ Disagree

36. I would be willing to reduce or stop using seclusion and restraint if I was aware of alternatives to these interventions.
☐ Agree ☐ Disagree

37. Physical restraint is used more than necessary in my organization.
☐ Agree ☐ Disagree

38. Seclusion is used more than necessary in my organization.
☐ Agree ☐ Disagree

39. I often experience stress implementing seclusion and restraint.
☐ Agree ☐ Disagree

40. Of the following three statements, which one do you agree with the most? (select just one)

I believe:

☐ Seclusion when implemented properly can be therapeutic.

☐ Seclusion although not therapeutic is necessary to impose when other approaches to helping have been attempted and failed.

☐ Seclusion has no therapeutic benefits and may lead to additional trauma and harm.

41. Of the following three statements, which one do you agree with the most? (select just one)

I believe:

☐ Restraint when implemented properly can be therapeutic.

☐ Restraint although not therapeutic is necessary to impose when other approaches to helping have been attempted and failed.

☐ Restraint has no therapeutic benefits and may lead to additional trauma and harm.

Comments:

Please complete the following items by checking the box for each category. If you believe you can be identified within your organization by checking more than one item, then leave the other item unchecked.

Role:		**Years of Service with this organization:**	
Direct care staff	☐	Less than 1	☐
Nurse	☐	More than 1 but less than 5	☐
Licensed Clinician	☐	More than 5 but less than 10	☐
Other	☐	More than 10 but less than 15	☐
		More than 15	☐