The Development and Implementation of "No Force First" as a Best Practice

Lori Ashcraft, Ph.D.
Michelle Bloss, M.Ed.
William A. Anthony, Ph.D.

The mental health field continues to be concerned about the use of seclusion and of mechanical and chemical restraints in treatment settings. Recovery Innovations, Inc. (RI), a nonprofit corporation that operates a range of recovery-oriented programs, successfully eliminated use of seclusion and nonchemical restraints in a crisis center. This success was the impetus behind implementation and evaluation of a "no force first" (NFF) policy, described in this column, that targeted the crisis center's use of chemical restraint. Successful implementation of the policy in the crisis center led to the concurrent adoption of the NFF policy as a best practice at all of RI's 19 behavioral health programs. (*Psychiatric Services* 63:415–417, 2012; doi: 10.1176/appi.ps.20120p415)

Recovery Innovations, Inc. (RI), a nonprofit corporation founded in 1990, is a mental health agency that currently operates a range of recovery-oriented programs in four states in the United States and at a site in New Zealand. Early in 2000, the leadership at RI became increasingly disillusioned with the dismal outcomes produced by the traditional approach to service delivery. The potential of service recipients was not being tapped. The belief that severe mental illnesses had poor prognoses and that service recipients were "treatment resistant" no longer explained or excused the organization's results.

This mindset provided fertile ground for the growing body of information about the possibility of recovery that had begun to emerge on the national level at this time (1). As RI moved toward a recovery vision, RI personnel were strongly encouraged to eliminate force in presentations made to them by one of the authors (WAA). The presentations were based on extensive writings on the concept of recovery in the 1990s, in which Anthony coined the terms "recovery vision" and "recovery-oriented services." With respect to coercion and the recovery vision, Anthony (2) asserted that "force elimination is both a necessary and reasonable goal as we move further down the path of recovery. . . . There is no such thing as 'forced recovery.'" The leadership of RI believed that force is so incompatible with the values of recovery—values such as choice, self-determination, and personhood—that use of force had to be addressed immediately. They believed that secluding or restraining a person was the most glaring example of actions that were incongruent with the principles of recovery.

"No force first" policy

The policy of "no force first" (NFF) was instituted in 2006 and quickly became a dynamic force throughout the company, shaping the way recovery services were delivered in all levels of care, including crisis services, where force would be most likely to be used (3). The NFF policy states that force of any kind, including chemical restraints, is used only as a last resort, even when people may appear to be a danger to themselves or others. As outlined in the box on page XXXX, the policy mandates expansion of the repertoire of staff members' responses to crisis situations in any program and requires that force of any kind be relegated to the bottom of the list of possible responses. Although some of the goals listed in the box reflect the goals of many organizations, it is our experience and the experience of the RI leadership that a "best practice" effort is needed to meet these goals, including the creation of coercion elimination benchmarks and holding organizations accountable for implementing the additional strategies needed to meet these goals.

Implementation strategies

Implementation of NFF throughout RI, and particularly in its crisis centers, used a variety of strategies, including changing the mission and policies, hiring peers, changing the staff culture, selecting and orienting new staff, adopting compatible procedures, and emphasizing healing environments. Additional information on RI's crisis services, background rationale, settings, and staffing has been reported previously (3).

Changing mission and policy. The first step was changing the RI mission statement from one that focused on stabilization to one that embodied a vision of and a commitment to recovery. The new RI mission statement is "To create opportunities and environments that empower people to recover, to succeed in accomplishing their goals, and to reconnect to themselves,

Dr. Ashcraft and Ms. Bloss are affiliated with Recovery Innovations, Inc., Phoenix, Arizona. Dr. Anthony is with the Center for Psychiatric Rehabilitation, College of Health and Rehabilitation Sciences, Boston University. Send correspondence to him at 940 Commonwealth Ave. West, Boston MA 02215 (e-mail: wanthony@bu.edu). William M. Glazer, M.D., is editor of this column.

No force first (NFF) policy of Recovery Innovations, Inc.

1. Make public the Recovery Innovations, Inc., NFF policy.
2. Define the use of force and coercion as a treatment failure.
3. Have an active program to avoid and eliminate the use of force, including seclusion, mechanical restraint, and pharmacological restraint and forced medication, that includes:
   a. staff training in effective deescalation techniques and the NFF process,
   b. a debriefing that includes the service recipient whenever coercion or force occurs,
   c. a critical incident review for any use of coercion or force, and
   d. a performance improvement process that includes tracking and reporting of all types of forced interventions and feedback to staff and stakeholders.
4. Seek to avoid the use of outpatient commitment through advance directives, active outreach and engagement, and peer support.
5. Use involuntary inpatient treatment only for individuals who present a clear danger to self or others and then only after rigorous interventions to engage the individual in choice-based voluntary alternatives.
6. Characterize relationships with service recipients, including facility-based programs, as "risk-sharing" partnerships instead of "risk management" control.
7. Design and implement, with service recipient input, self-directed programming, including education and self-advocacy to reduce reliance on "compliance-oriented" services such as medication monitoring.
8. Support and assist with the training of law enforcement personnel, families, and guardians in the NFF process.

others, and meaning and purpose in life." RI defined a person's recovery as "remembering who you are and using your strengths to become all you were meant to be." One of the more profound policy transformations was initiated by a declaration from the president and chief executive officer of RI, Gene Johnson, who mandated that seclusion and restraint practices would no longer be used and that the NFF policy would be implemented companywide, including in its crisis centers.

Hiring peer employees. RI began a hiring process that to this day includes training and hiring of peers with the goal of developing a blended workforce throughout the organization. Over 50% of RI staff members are peer support specialists, who through their own experience understand the trauma caused by the use of force and coercion. This has created an increased awareness of and accountability to sustain the NFF culture and to reduce even the subtle use of coercion. RI leadership believes that hiring peers is fundamental to NFF implementation.

Changing the staff culture. The staff culture at the time of NFF policy implementation was embedded in a traditional approach to service provision. The staff were neither noticing nor reinforcing the values of recovery. They were operating in crisis mode or reacting to a situation or problem rather than responding to a person. They could not see the strengths of the people whom they were serving because they were focused on problems. The goal of staff interaction was stabilization and moving people on rather than planting the seed of hope.

RI leadership was committed to creating an environment for people to recover, which included clinical staff members. First, the leadership team held open forums for staff members to express their fears associated with elimination of seclusion and restraint. People shared their fear that without seclusion and restraint, the staff would be hurt. They described previous training with other agencies that had a much different policy with respect to the need for force. Staff also shared their personal prejudices against people who abuse drugs and alcohol and people who are homeless. Staff expressed their reluctance to work with peers on the team.

The strategy of allowing people to vent about possible negative outcomes was needed to create space for possibilities. When all the negative thoughts were dumped on the table, the RI leadership methodically replaced them with the recovery values of hope, choice, and empowerment and a recovery culture that stresses the importance of helping to develop meaning, purpose, and spirituality in people's lives. Once the concerns and training of existing staff had been addressed, new staff were selected and trained in recovery principles and the NFF policy.

Selecting and orienting new staff. The NFF policy is stressed throughout the new employee selection and orientation process and is deepened and sustained by the recovery environment. Care is taken to select only employees who embrace the RI mission and the NFF policy. Staff members learn the characteristics of recovery and nonrecovery environments and how these principles are lived and modeled by RI. Training of new and old staff is reinforced through weekly e-mails presenting stories and videos of the downside of using force.

Adopting compatible procedures. In crisis recovery settings, staff are trained that the only restrictive intervention allowed in the facility is emergency forced psychotropic medication. This is also the only time in which a supportive hold can be administered and only for the duration needed to provide medication. This procedure requires an exhaustive process before the medication can be ordered. Physicians are personally reluctant to employ this intervention, and thus it is rarely used. When it is used, a thorough debriefing with the person to whom the medication was administered is conducted, including whether he or she wants someone else contacted about the incident. The report is reviewed with quality management personnel and is part of the ongoing training for staff.

In housing settings, people are not forced into housing that they do not want. In outpatient services, case management has been enhanced or replaced by peer recovery coaching. In all RI programs the emphasis on no force has been replaced by procedures to encourage people's choice.

Emphasizing recovery partnerships. Team members are taught that cooperation comes from connection and not coercion. The recovery partnership process focuses on what people want and emphasizes each per-

son's strengths. In crisis settings, a morning recovery activity is designed to create an atmosphere of community by having people share something about themselves and connect with one another through acceptance rituals. RI has developed a unique "electronic recovery record" in which the individuals served, in partnership with staff members, create electronic recovery and personal wellness plans and jointly document progress in an electronic "wellness journal."

Reinforcing a healing environment. The NFF policy is reinforced in all programs by the use of recovery language and by receipt of services in a noninstitutional environment. In the crisis centers, people have their own key and home-cooked food; liberal property management processes are employed. In all RI environments, including crisis centers, the policy is not to cut people off from their usual sources of support. Computer stations provide access to e-mail. Individuals keep their own phones, and families and friends are welcome to visit. This healing environment also reminds staff that they are partners—they do not "own" the people they serve and they appreciate the gifts and acknowledge the challenges of each individual.

Outcomes of NFF in a crisis center

As a check on NFF implementation, RI examined use of force in the program in which force elimination would be most challenging. A previously published study on the elimination of seclusion and mechanical restraint at two RI crisis centers found that 32% of service recipients were brought to the crisis center involuntarily by police and others who believed them to be a danger to themselves or others and that 44% had either a primary or a secondary diagnosis of substance abuse (3). Other diagnostic groups were as follows: 27%, schizophrenia, schizoaffective, or psychotic disorder; 32%, major depression or mood disorder; and 16%, bipolar disorder. Furthermore, the crisis center contract with the managed care company included a no-refusal policy, ensuring that everyone who came to the center, whether voluntarily or involuntarily, was served. People were in crisis and were not visiting the center for scheduled appointments. All individuals in the study were enrolled in public insurance programs, such as Medicaid.

Descriptive data were collected over a two-year period to examine the use of chemical restraints in one of the RI crisis centers that had already eliminated seclusion and mechanical restraints (3). For this evaluation, chemical restraint was defined by Arizona Revised Statute 36513 as "a drug or medication when it is used as a restriction to manage the behavioral health recipient's behavior or restrict the behavioral health recipient's freedom of movement and is not a standard treatment or dosage for the behavioral health recipient's condition." [Tables presenting data on sample characteristics and details pertaining to the frequency of use of chemical restraint are available online as a data supplement to this column.]

At the crisis center, chemical restraint was used for 56 of 12,346 people served over the two-year period (.45%). The percentage of service recipients who received chemical restraint in any month ranged from 0% to 1.27 %. As a result of the previous initiative to eliminate seclusion and mechanical restraint (3), neither of these practices was used during this data collection period. For rough comparative purposes, data were obtained from state records on the use of restraints by comparable programs: chemical restraints were used for 3.9% of individuals served statewide, and 2.4% experienced mechanical restraints.

Discussion

The initiative to reduce use of chemical restraint in a crisis center that had already eliminated seclusion and mechanical restraint helped to clarify that the elimination of chemical restraint is a reasonable goal in NFF policy implementation. The data are descriptive only. No inferential statistics were used, no randomized control group testing of an alternative strategy was mounted, and no data are presented showing that development and implementation of an NFF policy are applicable to other settings with different characteristics.

Yet the descriptive data collected and the NFF policy implemented by this crisis center shed light on an important issue. Will organizations that eliminate seclusion and restraint simply rely on chemical restraint practices to achieve the same objective? Will a person's behavior still be managed in a way that reduces risk to self or others by temporarily restricting the person's freedom of movement but without mechanical restraints? We argue that it does not need to be so. Using chemical restraint at a crisis center for .45% of service recipients in a two-year period is evidence that crisis services can be successfully provided by adopting recovery approaches that do not rely on seclusion and mechanical or chemical restraints. Force must be the last response considered, and its use implies a treatment failure.

Conclusions

RI leaders believe that elimination of all types of force has many benefits to their organization. The presence of coercion within their crisis centers would reflect poorly on all the other programs run by RI, and most important, it would harm the people whom RI is trying to help. RI believes that the highest price of all is the price paid by the people who are restrained: their recovery is stalled by a practice that can disempower them, break their spirit, and reignite a sense of helplessness and hopelessness. The use of force is traumatizing, especially for those who have a history of physical or sexual abuse. Development and implementation of an NFF policy within a recovery approach has convinced us that no force first should become a best practice in the treatment of people with severe psychiatric disorders.

Acknowledgments and disclosures

The authors report no competing interests.

References

1. Anthony WA: A recovery oriented service system: setting some system level standards. Psychiatric Rehabilitation Journal 24:159–168, 2000
2. Anthony WA: Editorial: an elephant in the room. Psychiatric Rehabilitation Journal 29:155, 2006
3. Ashcraft L, Anthony WA: Eliminating seclusion and restraint in recovery-oriented crisis services. Psychiatric Services 59:1198–1201, 2008