Aligning Behavioral Health Management of Patient Aggression with State and National Initiatives

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ABSTRACT

In 1997, Pennsylvania introduced a program to reduce the use of restraints and seclusion in state behavioral health hospitals. Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm. Between January 1, 2012, and August 31, 2013, coercive interventions (i.e., restraints and seclusion) were the most frequently identified interventions used to manage patient-to-patient aggression in behavioral health patient aggression-related event reports submitted through the Pennsylvania Patient Safety Reporting System. Analysts, interested by this finding, explored how patient aggression is managed in two behavioral health hospitals that have incorporated the philosophy and principles of the Pennsylvania Recovery and Resiliency program to inform the management of patient aggression using noncoercive techniques. The Recovery and Resiliency program promotes trauma-informed care and the Sanctuary Model to address patient issues and build a restraint-free environment. (Pa Patient Saf Advis 2015 Jun;12[2]:49-53.)

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INTRODUCTION

*It is 3 p.m. on the adult behavioral health unit when inpatient Joe starts to appear agitated about another patient, Bob. Suddenly, Joe punches a wall. A peer tells Joe to make a good choice and please stop hitting the wall and encourages him to ask staff for help.**

Patient aggression is an anticipated behavior in acute care inpatient behavioral healthcare settings. Aggressive patients can direct their aggression toward themselves, staff, or other patients. In Pennsylvania, patient-to-patient aggression in behavioral health hospitals and acute care inpatient behavioral health units was the leading type of inpatient aggression event reported through the Pennsylvania Patient Safety Reporting System (PA-PSRS).[1] Coercive interventions, such as restraint and seclusion, were the most frequently described responses to patient-to-patient aggression events for pediatric and adult patients when interventions were identified. In the geriatric population, coercive interventions and interventions that were not specifically identified in the literature as noncoercive or coercive (e.g., patient distracted or redirected) were described with equal frequency. See the Figure.

Based on the Pennsylvania Patient Safety Authority's findings that coercive interventions were most frequently reported, the analysts were interested to learn more about how behavioral health hospitals within Pennsylvania address patient aggression; approaches from two facilities are presented. For a description of the data query and analysis of interventions, see "Patient Aggression Management Strategy Analyses."

Patient-to-patient aggression can present as a verbal confrontation between patients that escalates to a physical confrontation or can begin, without warning, as a physical confrontation between patients.

Staff who engage with patients involved in aggression-related altercations often have opportunities to diffuse the situation, calm the patients down, and help the patients deal with their anger or frustration in a nonviolent way. The following PA-PSRS event narrative[†] illustrates this issue:

> *A patient grabbed another patient's [neck] and started punching that patient [in the face]. Staff immediately responded and separated the patients.*

Patient aggression is a complex issue that arises from a mix of patient risk factors, such as history of violence, and environmental risk factors, such as lack of structured activity or frequent use of temporary staff.[2] Interventions—classified as noncoercive or coercive—have the potential to defuse patient aggression. Use of noncoercive interventions, such as de-escalation techniques, is the preferred method to manage patient aggression whenever possible because it promotes patient engagement and preserves dignity.[2-8] Coercive measures (i.e., restraints and seclusion) may only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm.[4,9,10]

In 1997, a program was introduced by Charles Curie, then Pennsylvania deputy secretary of mental health and substance abuse services, to reduce seclusion and restraint use in state behavioral health hospitals. The basis of the program was tied to his philosophy that "most [state hospital] patients are already the victims of trauma. There is no need to reinforce that trauma."[11]

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* Patient names and circumstances are fictitious and used for example purposes only.

† The details of the PA-PSRS event narratives in this article have been modified to preserve confidentiality. None of these event narratives came from Philhaven or Southwood Psychiatric Hospital.

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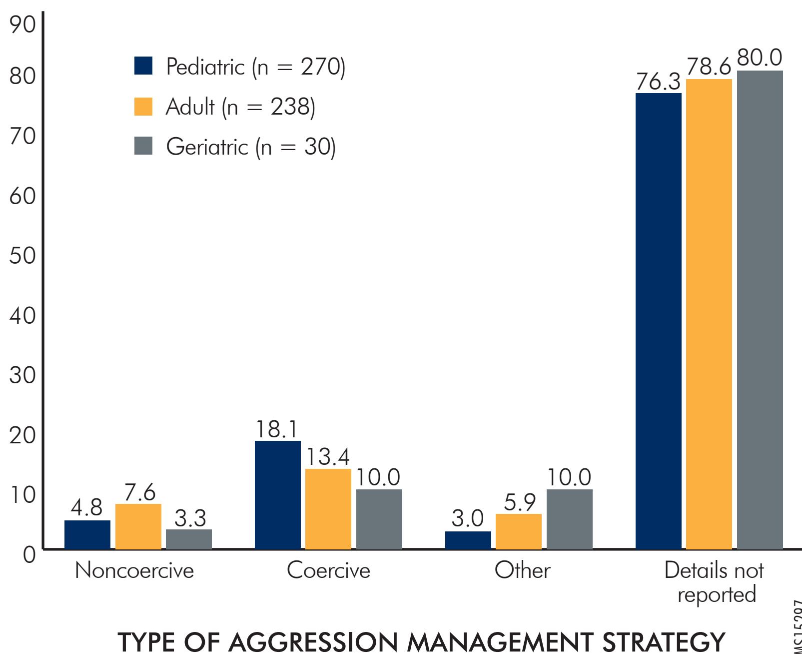
In the following year, the *Hartford Courant* published a series of reports about patient deaths associated with the use of restraints in patients needing psychiatric care[12] In the initial *Hartford Courant* report, where ages could be identified, "more than 26 percent of [deaths involved] children—nearly twice the proportion they constitute in mental health institutions."[12] A follow-up review conducted six years later showed patient deaths caused by restraints were still occurring.[13]

In 2006, the Pennsylvania Department of Human Services, formerly the Department of Public Welfare, urged providers of child residential care to move toward reducing or eliminating the use of restraints. A kickoff event, Alternatives to Coercive Techniques, and 12 other forums were held across the state, addressing organizational change, leadership, de-escalation, incident debriefing, data collection, and youth and family involvement. The forums were designed to help providers understand the vision for building a restraint-free system and gain their support for creating organizational change by introducing the trauma-informed care (TIC) philosophy using the Sanctuary Model.[14,15]

As a result of the forums and recommendations, the Sanctuary Model was brought to Pennsylvania. "Preliminary data from implementation of the Sanctuary Model in other states showed positive results, including a decrease in the use of restraints, less staff turnover, and better outcomes for children and youth."[15]

Figure. Patient-to-Patient Aggression Interventions Reported through the Pennsylvania Patient Safety Reporting System January 2012 through August 2013



TWO BEHAVIORAL HEALTH FACILITY APPROACHES

Two behavioral health organizations, Philhaven and Southwood Psychiatric Hospital, discussed their organizational philosophies and approaches to managing patient aggression with the analysts.

Philhaven is a multisite behavioral health organization serving patients of all ages in the Lancaster, Lebanon, York, and Harrisburg areas. Analysts met with Heidi McMullan, RN, MSN, chief nursing officer; Brent Swope, director of milieu and behavior management training program; and others at the Mt. Gretna facility and were given a tour of the facility.

Southwood Psychiatric Hospital, located in the southwest region of Pennsylvania, is a private for-profit children's behavioral hospital that is part of Acadia Healthcare, a national behavioral healthcare corporation. The director of nursing at Southwood Psychiatric Hospital, Kim Owens, DrPH, RN, and the analysts held a conference call to discuss her organization's philosophy and approach to managing patient aggression. Analysts found similarities in the facilities' philosophies and programs.

Organizational Culture

Both organizations have a culture that fosters a proactive approach to prevent and address patient aggression while helping patients learn more effective ways to manage their emotional challenges. Philhaven attributes the adoption and maintenance of its proactive approach to a stable long-term commitment in senior leadership, including a medical director who began working at Philhaven as a psychiatrist in the 1980s, succession planning for future leadership personnel, education and training of staff, and board support.

Leadership commitment to proactively address one of the potential consequences of patient aggression, property damage, is evident in an example provided by Ms. McMullan, who said, "Leadership recognizes that patient aggression is a potential aspect of a psychiatric patient's mental

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PATIENT AGGRESSION MANAGEMENT STRATEGY ANALYSES

Analysts used the 538 Pennsylvania Patient Safety Reporting System patient-to-patient aggression event reports identified in a previous *Pennsylvania Patient Safety Advisory* article.[1] Analysts also used the previously identified age categories—pediatric (i.e., age 18 or younger), adult (i.e., age 19 to 64), and geriatric (i.e., age 65 or older)—to analyze the type of strategies used to manage patient-to-patient aggression. The categorization of aggression-related management strategies was based on a taxonomy identified by Davison: noncoercive, coercive, and strategies not clearly explained in the event reports (e.g., separated, pulled apart, staff intervened).[2]

A detailed analysis of intervention strategies used by behavioral healthcare providers was performed to identify trends in the event reports. Analysts discovered that the majority (more than 75%) of the event reports did not identify specific intervention strategies used to manage patient-to-patient aggression. In the event reports in which intervention strategies were identified, coercive interventions (i.e., restraints and seclusion) were the most frequently reported. Several population-specific analyses were performed: harm score and intervention type by patient population, aggressor or victim status by patient population, and combination of intervention strategies used during an event (e.g., coercive alone, coercive and noncoercive) by patient population. These analyses, however, resulted in extremely small numbers that limited conclusions about the patient aggression management strategies behavioral health hospitals implement and were subsequently excluded from further study.

Notes

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2. Davison SE. The management of violence in general psychiatry. *Adv Psychiatr Treat* 2005;11:362-70.

illness and when designing the facility for safety, takes into account the potential for property damage."[16] Philhaven's organization-wide effort to change its philosophy to reduce restraint use, initiated by leadership in the early 2000s, is now a fundamental part of its organizational culture and day-to-day operations.

Southwood Psychiatric Hospital's organizational philosophy uses a similar proactive approach to preventing and addressing patient aggression. Southwood Psychiatric Hospital attributes the adoption and maintenance of its proactive approach to recruitment and retention of the right staff, beginning with a robust orientation program. Dr. Owens stated, "New hires, including myself, are screened for their approach toward managing patient aggression. Staff are put through a rigorous orientation prior to working with the patients." Anticipating the potential for aggressive situations and planning for them proactively provides leadership, physicians, and frontline staff with the necessary tools to reduce the occurrence and mitigate the consequences of patient aggression.

Southwood Psychiatric Hospital, like Philhaven, is data-driven in using key performance indicators and participating in national benchmarking. For example, both organizations participate in the Joint Commission's Hospital-Based Inpatient Psychiatric Services measure set. The physical restraint use rates for June 2013 through July 2014 for these two organizations are lower than national and state average rates for the same time period. Philhaven's and Southwood Psychiatric Hospital's overall rates of physical restraint use per 1,000 patient-hours were 0.0869[17] and 0.0923,[18] respectively, compared with the national average rate of 0.5226 and state average rate of 0.3303.[17,18]

Theoretical Foundation: Trauma-Informed Care

TIC is a nationwide movement and part of a larger statewide initiative, the Pennsylvania Recovery and Resiliency program, managed by the Pennsylvania Office of Mental Health and Substance Abuse Services.[15] Dr. Owens stated that the recovery and resiliency movement in behavioral health started "years ago [2006]" and represents a change from what mental health services did "*to* you [the behavioral health patient]" to what they do "*with* you" and involves the patients' families.[15,19]

TIC is a theoretical framework that is identified as "a program, organization, or system that is trauma-informed [and]:

1. Realizes the widespread impact of trauma and understands potential paths for recovery;
2. Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist re-traumatization."[20]

Philhaven and Southwood Psychiatric Hospital have adopted these principles to transform their cultures of restraint use.

The American Psychiatric Nurses Association position statement identifies the "growing awareness that inpatient treatment must be shaped by the principles of trauma-informed care and the recovery movement and that these philosophies will create a collaborative spirit that is essential to restrain reduction and elimination efforts."[21]

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Sanctuary Model

The Sanctuary Model, introduced in 2006 as part of the implementation of the TIC philosophy in Pennsylvania, represents a "theory-based, trauma-informed, evidence-supported, whole culture approach . . . to teach individuals and organizations the necessary skills for creating and sustaining nonviolent lives and nonviolent systems and to keep believing in the unexplored possibilities of peace."[14] The Sanctuary Model, a part of the Pennsylvania Recovery and Resiliency program, focuses on training staff consistently to build relationships with patients and among staff.[14] Philhaven's residential program is a certified sanctuary program.[22]

Therapeutic Crisis Intervention

Philhaven and Southwood Psychiatric Hospital have adopted the Therapeutic Crisis Intervention program, originally developed for child and youth populations, to educate staff on how to prevent and manage a crisis[23] and to align with the TIC model. Philhaven adapted and implemented this program for all inpatient units, regardless of patient age. According to Mr. Swope, "Staff are trained on the Therapeutic Crisis Intervention model to reduce behavioral crises, support patients and staff in the day-to-day management of patients, and help patients learn new behavioral health management skills."[24] Upon hire, new employees are required to attend and successfully complete an initial 24 hours of training in Therapeutic Crisis Intervention. Training is then provided on a quarterly basis, during which staff are exposed to additional role-play and simulations of behavioral events.

At Southwood Psychiatric Hospital, staff receive a two-and-a-half day initial training in Therapeutic Crisis Intervention that focuses on de-escalation and attend a four-hour refresher course annually.[19] This training also includes role-play and simulation.

The Importance of Milieu

Both organizations stressed the importance of milieu in the management of aggression. The "milieu" includes the surroundings and environment of patients and staff.[25] As depicted in the scenario in the introduction, unit culture in the form of positive peer interaction and proactive staff response to aggression is an important aspect of the milieus both facilities try to foster.

At Philhaven, the milieu includes the physical structure, patient and unit routines, and patient relationships with staff. The physical building at Philhaven has a lot of natural light, wide hallways, and many private rooms. Every patient is assigned a staff member who is their primary contact for purposes of encouragement, goals review, and general support. Staff are constantly reminded about tailoring de-escalation techniques to fit the client's needs or character, as illustrated in the following PA-PSRS event narrative:

> *Patient was punched in the face when arguing with a female peer on the unit. No injury apparent. Patient followed verbal redirection and went to [her] room to calm down.*

At Southwood Psychiatric Hospital, milieu management includes the following: (1) creating and maintaining a calm and safe environment, (2) encouraging positive interactions between staff and patients, and (3) addressing the environmental elements outside of group therapy, such as unit routines. Dr. Owens related that staff "gauge activities that are appropriate for the patients. Keeping children in smaller groups and reducing stimuli and clutter can help manage agitation and aggression. For example, some children need help with brushing their teeth, getting a shower, or making their bed; clear prompts are provided by staff about completing these activities, and these prompts help address impulsive issues."[24]

Southwood Psychiatric Hospital employs the principles of normalizing the environment. This concept supports physical healthcare delivery by focusing on holistic design and promoting socialization by integrating public and private spaces in a secure manner.[26] When caring for children, both organizations provide information and education for parents.

CONCLUSION

State and national trends emphasizing noncoercive strategies in the management of patient aggression in the behavioral health setting began two decades ago with the intention of reducing the use of restraints and seclusion. Operationalizing organizational changes to effect noncoercive patient care strategies requires a long-term commitment that starts with leadership.

In Pennsylvania, Philhaven and Southwood Psychiatric Hospital have aligned their philosophical and operational approaches to noncoercive management of patient aggression with state and national initiatives. Both facilities continually evaluate the effectiveness of their approaches and adapt as circumstances dictate, achieving overall restraint use rates that are lower than state and national averages.

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NOTES

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