Recommendations for Long-term Monitoring and Oversight of Efforts to Reduce the Hospital's Reliance on Seclusion and Restraint

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Background

A hospital committee was struck to make recommendations about reducing our reliance on seclusion and restraint. Subcommittees are to identify the relevant professional and academic literature, and make recommendations about policy, staff training, best practices, and evaluating outcomes. The last subcommittee's task is long-term oversight—and this document is the summary of those recommendations.

There is reason to believe that the current use of restraint and seclusion at this hospital exceeds that which is clinically necessary and clinically optimal. For example, this hospital reports more seclusion and restraint than comparator hospitals, and hospitals with very similar patient populations report using much less (indeed, almost no) seclusion and restraint. Evident in the overall committee's approach is an understanding that there are several root causes of this reliance on seclusion and restraint. Therefore, this set of recommendation about long-term monitoring and oversight addresses those causes most likely to be relevant here.

A large body of evidence indicates that heavy use of seclusion and restraint in a psychiatric hospital is symptomatic of problems at all levels. In agreement with that, most members of the committee have observed that this hospital's reliance on seclusion and restraint is "cultural." That is, throughout many parts of the organization, seclusion and restraint has been expected, accepted, excused, rationalized, or ignored. And members of the committee, administrators, and the board of directors have expressed a strong desire to change that culture.

Four Paramount Recommendations

Record All Seclusion and Restraint. One troubling aspect of this culture is that this hospital does not record all instances in which patients are subjected to restraint (manual, chemical, or mechanical) or locked seclusion. Various suggestions might be advanced for, as a few examples, not recording seclusion or restraint as such when imposed in conjunction with "individual management plans", not recording seclusion as such when labeled "operational lockup", not recording mechanical restraint as such when in the form of chairs that prevent rising, not recording all *prn* medication for disruptive behavior as chemical restraint, and not recording manual restraint as such when labeled "guidance." It is a strong and preeminent recommendation here that these justifications be abandoned as a clear signal that all leaders of the hospital are truly engaged in the essential cultural change. As distinct from recording and reporting seclusion and restraint internally, what is reported externally depends on the purpose of the external report and comparisons to be made. But all seclusion and restraint in the hospital must be recorded as such. Long-term oversight is impossible without such data.

Implement Formal Therapy Programs for All. A second problematic aspect of the culture is that not all wards have established any formal system to ensure that the interpersonal environment supports enhancing patients' emotional and behavioral strengths and reducing symptomatic, dependent, and destructive behaviors. In such informal environments (i.e., those lacking any formal, manualized system to design the interpersonal environment), research shows that inadvertent and unplanned influences actually contribute to worsening patients' mental conditions (for example, by causing "institutionalization"). Thus, another strong and preeminent recommendation here is that all wards have such formal systems aimed at maximizing patients' successful adjustment to their next placement (long-term care facility, less secure hospital, home and community, and so on). On wards where seclusion and restraint are currently used, this systematic design of the interpersonal environment must also include features aimed at improving patients' adjustment to this hospital. The research strongly supports broad based, social learning and psychosocial programs as the best way to achieve this deliberate design of the interpersonal environment. A key aspect of such programs for present purposes is that clinical staff activities are described in considerable detail and are specified in ways that are observable and accountable.

The research on seclusion and restraint (including that done at this hospital) shows further that a relatively small minority of patients are subjected to most of the seclusion and restraint. This small group requires special individualized behavioral treatment to help them gain control of the behaviors that result in the application of seclusion and restraint. Research shows that for many in this small group, drugs or other somatic interventions will not be effective over the long term, and that poorly designed management plans can worsen patients' conditions. Observations suggest that some current individual management plans are not designed according to best practices in behavioral treatment. It is assumed in these recommendations that the hospital will acquire the clinical expertise to provide these specialized behavioral treatments for all patients that need them.

Optimal long-term oversight is impossible without sufficient specification of staff members' duties, appropriate practice, and behavior, and some effective means to know whether, at the individual level, these duties, practices, and behaviors actually occur.

Measure the Effectiveness of Services. It is recommended that there be routine, independent measurement of each patient's clinical outcomes. This entails measuring post-discharge outcomes independently and systematically on follow-up. One class of outcomes would apply to all former civil clients (e.g., subsequent symptoms and quality of life) and others to all forensic clients (e.g., subsequent criminal or antisocial behavior). Another class would be specific to the reasons for each individual client's admission (e.g., fitness for trial, sexual misconduct in his home facility, risk of suicide, and so on). Information sources would vary somewhat depending on particular referral problems. Thus, while symptoms and quality of life assessment and/or criminal record checks would be conducted on everyone, informants might also be staff of subsequent institutions, family members, courts, and individual police services, as well as former clients themselves.

Without outcome data, there is no way to truly know whether the hospital's clinical services are actually consistent with the intent of its therapeutic programs and overall clinical philosophy (trauma informed, recovery focused, culturally competent, etc.). Without such information, long-term oversight is impossible.

Employ Effective Leadership and Administration. This recommendation is about the application of research on effective organizational practices. It is recommended that there be a formal system of review of instances of restraint and seclusion by responsible physicians, managers, and administrators, and that these reviews not be merely *pro forma*, but should comprise serious and in-depth discussions of the indications and alternatives for the seclusion or restraint employed. These reviews should follow an established format and create a record which is independently reviewed for adequacy. Clinical training for staff members should usually be on-the-job, team-based skill demonstration, practice, and behavioral feedback (not one-shot lecture sessions). Evidence of training should be demonstrations of proficiency and confidence in the skills and information taught (not just attendance at sessions). Clinical supervision, performance reviews, and promotion practices should depend on measures of the enactments of clinically relevant behaviors mandated by program manuals (not informal and nonspecific opinion). Communication of appropriate employee conduct should depend mostly on proper training, feedback, contingent approval, and leaders acting as examples for their subordinates in executing appropriate skills. Indicators of clinical quality should consist of data on those things associated with outcomes and likely to be on the causal pathway to reduced need for seclusion and restraint as discussed below.

Without relevant data on the adequacy of management and administrative performance, there is no way to know why efforts to reduce seclusion and restraint might not be succeeding or why initial successes might be fading. Long-term oversight is impossible without such data.

The advice behind these first four paramount recommendations is that all members of the hospital's leadership be publicly and behaviorally committed to making the most crucial and urgently needed change in the hospital's culture. That is, leaders should engage in actions (which are counted and measured) designed to unmistakably reverse any general misperception of indifference to common uses, and possible abuses, of seclusion and restraint. The leadership should engage in activities (which are measured) to counter any sense of indifference to the clinical value of specific therapeutic processes and the details of how inpatients actually spend their days. And the hospital's leaders should overtly reverse any misimpression of indifference as to whether, after receiving services at this hospital, there is valid independent evidence that former inpatients derived benefit or harm from those services.

Data Recommended for Long-term Monitoring and Oversight

Although sometimes addressed in the following recommendations, it is a general recommendation that all data gathering incorporate means to ensure that the data are

independently gathered and reported consistent with established standards for reliability and validity.

1. It is recommended that:

- Every imposition of restraint or seclusion be recorded as such (except in maximum security between 2300 and 0700).

- Every instance in which a patient is subjected to body contact that limits or controls free movement (manual restraint); being confined alone in a locked room (seclusion); being placed under control with a drug (chemical restraint); having any appliance attached, adjacent to, or worn that restricts free movement (mechanical restraint) should be recorded in a straightforward dedicated computerized system.

- Recording of seclusion and restraint should gather crucial data (e.g., patient, staff, type, date and time, location, purpose, and exact duration of each seclusion and mechanical restraint).

- Recording should be based on clear, observable, specific operational definitions.

- Recording should be supported by training.

- Recording should incorporate validity checks that are independent (by staff not associated with the program or division) physical/visual checks of ward conditions against the records.

- The system should permit data export in a numerical raw form (not just summaries) fully readable by MS Excel.

- Summary reports of the use restraint and seclusion (by ward and team) should be made available monthly and reported widely within the hospital community and to the board of directors and other responsible officials.

- Hospital policy should treat the application of seclusion or restraint without proper recording as a violation of rules forbidding patient abuse.

2. It is recommended that every instance of violent or assaultive behavior by a patient (and such rare but significant events as escape, fire setting, major property destruction, illicit drug possession, and other violations of the Criminal Code) should be recorded in a system designed for the purpose.

3. It is recommended that interactions between patients and staff members be measured according to a formal coding system that characterizes the behavior of staff members and patients into several mutually exclusive and exhaustive categories, with the result that all staff-patient interactions may be captured in a matrix that simultaneously characterizes

staff and patient behavior. In some instances, categories might depend on the particular broad based clinical program implemented on the ward, but generally, the particular staff behavior categories will be common across the facility and objectively vary in their degree of clinical appropriateness. Measurement should consist of unannounced sampling of behaviors by direct observation performed by staff members independent of the program and division. Summary data should be reported monthly to the programs by ward and team. Individual level data should be reported to program and ward managers and to the individual staff member.

4. It is recommended that patient behavioral and program-specific activity data should be gathered using a standardized system. Such data are superior to the informal or nonspecific and unevaluated methods currently employed to characterize patients' clinical conditions. Such data also allow the assessment of clinical and programmatic fidelity (i.e., adherence to specifications for activities prescribed by the formal broad based programs). Again, these data should be sampled by unannounced direct observation by staff independent of the program and division. Reports at the level of the individual patient would be provided to the clinical team and be included in the clinical record. Reports at the level of the ward and team would assess the degree to which specified clinical activities had occurred as described in manuals, role descriptions, and program schedules. Reports at the level of the administrative program would assess the proportion of patients' time spent in structured clinical activities specifically designed to meet identified individual needs. Summary data and trends on these should be reported at the ward and team level to managers, administrators, and CEO.

5. It is recommended that current assessments of patient satisfaction be enhanced by adding standardized measures of ward atmosphere. In addition, to the extent that the adoption of general philosophies of care (e.g., recovery-focused, trauma-informed, culturally sensitive and compassionate) can be described in operational terms, patient measures that articulate the degree to which such philosophies are actually implemented should also be developed or applied. Participation in this data gathering should not be subject to prior selection by staff members. Results should be summarized at the ward and team level and reported widely within the hospital community.

6. It is recommended that relevant administrative data be gathered. Research indicates that the stability of staff work assignments is related to program effectiveness. It is recommended that there be administrative audits that measure, on a sampling basis, the degree to which clinical supervision, written performance reviews, and promotions are based on data on the enactment of clinically relevant activities and behaviors. It is recommended that there be independent (i.e., performed by staff members external to the program and division) numerical evaluation of the quality and thoroughness (according to an objective system) of investigations of assaults, complaints of abuse, and reviews of instances of restraint and seclusion. Data should be recorded and reported at the level of the individual manager or administrator.

7. It is recommended that there be a process of clinical and program audits. Clinical audits would examine clinical records independently sampled to measure the degree to which adherence to clinical practice guidelines, hospital policies, and legal requirements were in evidence. Such assessments should include, as examples, the adequacy of psychosocial histories, criminal record checks, violence risk assessments, psychological testing, clinical goal-setting, drug prescriptions, suicide risk judgments, and the behavioral competence of individualized management plans. Regular analyses of the data will permit an evaluation of the degree to which hospital policies are in fact being followed. Program audits would involve independent reviews of the broad based therapeutic programs and individual treatment plans. Assessments would address the evidence base for the programs implemented and professional adequacy of the services delivered. Again, the sampling and measurement should be independent of the program and division and summaries widely reported within the hospital community at the program level.

8. Lastly, it is recommended that the cost of all aspects of the plans to reduce the use of seclusion and restraint be tracked in detail. Thus, as examples, the costs of training, clinical program development, and monitoring would be tracked separately. Of course, costs associated with employing seclusion and restraint (e.g., overtime, medications, WSIB fees and claims, etc.) would also be tracked. Research shows that successfully reducing seclusion and restraint actually saves money. As well, implementing efficacious clinical services is cost effective in actually reducing patients' reliance on publicly supported services. These observations include the costs associated with the additional data gathering. This can usually be achieved by ending the gathering of data that are not in fact used for anything and are of poor or unknown quality. More broadly, research shows that implementing high quality mental health treatment can best be achieved by fundamentally changing, re-focusing, and re-organizing what everyone does (instead of simply adding more tasks), thus avoiding large cost increases.

How Should All These Data Be Used?

Because the details of the plans to effect improvement have not been finalized, the present recommendations must be based on some reasonable assumptions about the forthcoming plan. Thus, the recommendations above are based on what has been reported to be relevant in the literature describing such efforts in other organizations.

In particular, it is assumed that a big part of the overall cultural change sought is a transition away from custodial care (plus somatic treatment) with nonspecific, unstructured activity—a culture in which a philosophy of care is espoused in very general terms, but the mechanics of operationalizing the philosophy never fully addressed until being abandoned when the next general philosophy of care is espoused. It is assumed here that we all seek a culture in which leaders and clinicians are overtly engaged in the details of the complete design, implementation, execution, and effective monitoring of specific clinical and therapeutic activities. Toward these ends, therefore, clinical and therapeutic activities need to be organized around formal programs and well enough specified so that it can be determined independently

whether they actually occur as specified. The tasks, duties, and behaviors of front-line clinicians, managers, and administrators need to be sufficiently well specified so that the execution of these functions can be independently measured and reported. Inherent in these present recommendations are means to independently assess the effectiveness of the various aspects (training, policy, clinical service, etc.) of the plan so that any shortcomings in subcomponents can be detected and remedied. Also essential is gathering independent follow-up evidence about whether the hospital's services actually benefit or harm its patients, and some means to use such outcome data to improve services. Thus, and as recognized by the committee's terms of reference, the monitoring and oversight system will require ongoing evaluation of several aspects of the hospital's operations because these are all on the causal pathway to the use of seclusion and restraint.

In many instances, the recommended data gathering and reporting above will be sufficient in themselves. That is for example, training clinical staff effectively to perform required behaviors, measuring enactments, and providing reports of individual staff behaviors to managers who exhibit contingent expressions of approval will produce high levels of proficiency. Similar processes in gathering and reporting data on administrative and clinical leadership duties would be effective for the performance of managers and administrators. In cases where this is insufficient, additional training (the efficacy of which is measured) will be indicated, and in very rare cases, reassignment might be required. Gathering and reporting data on the use of restraint and seclusion at the team level and, when necessary as indicated by out-of-range scores, having sincere in-depth discussions about indications for use and possible alternatives (the quality of which are monitored and recorded) with the staff members employing the restraints/seclusions will produce real decreases in avoidable use. To be clear, the tone of such discussions should be very searching but supportive towards the staff members. The purpose is not to scold or reprimand, but to review events in as much detail as possible sincerely looking for ways to handle things differently next time, while acknowledging that sometimes seclusion or restraint is actually best practice.

The conjoint analysis of the outcome data and fidelity measures achieves the best available means to improve clinical quality. Clinical activities that are implemented with high fidelity and are shown to have positive outcomes are the best candidates for expansion or enhancement. Activities implemented with high fidelity but shown to have null or negative outcomes are prime candidates for overhaul or replacement. Those implemented with low fidelity require actions to increase fidelity. If fidelity cannot be improved, low fidelity services should be replaced. This kind of quality assurance process together with the results of clinical and program audits should form the basis of annual "quality reviews" and an annual report by the CEO to the board of directors.

In conclusion, the aim of the present set of recommendations is to independently gather valid useable data on as many of the causes of restraint and seclusion as possible. And to do so in a manner that drives improvement by providing positive accountability at all levels.

Formal Research Evaluation of the Overall Plan to Reduce Seclusion and Restraint

The hospital's efforts to reduce seclusion and restraint could form the basis of a publishable research study. By first establishing a valid baseline, the simplest design would be pre-post. That is, after demonstrating valid measurement of all instances of restraint and seclusion in a baseline period, the full plan or intervention (staff training, culture changes, new policies, etc.) would be implemented throughout. Continuing to measure all use of seclusion and restraint would permit inferences about whether the prevalence truly changed, and this could be reported as a research study. Several such studies have been published previously so that it is unclear now whether the field would regard such a replication as a worthwhile contribution to the literature. This is partly because this uncontrolled pre-post design is the least rigorous from a methodological perspective in that it does not permit unambiguously attributing any reductions in seclusion and restraint to the planned intervention itself, or to any aspect of the intervention. Because it appears that aspects of the planned intervention (e.g., "recovery training" and "training in trauma-informed care") will be implemented before demonstrating a valid baseline, this design might be unfeasible anyway.

If, however, valid baselines were properly demonstrated before beginning implementation of the intervention, the pre-post research design might still make a contribution if many or most of the other aspects of oversight measurement above (in addition to demonstrating the valid measurement of all forms of restraint and seclusion) were also incorporated in the methods.

More rigorous research designs that more clearly permitted attributing reductions in the use of restraint and seclusion to the planned intervention, and to specific components of the intervention, would be possible. No worthwhile research design is available without demonstrating the valid baseline measurement of all forms of restraint and seclusion before beginning implementation of the planned intervention.

Literature

The literature on these issues is voluminous and references may be obtained upon request. Also relevant are:

Andrews, D.A. & Bonta, J. (2010). *The psychology of criminal conduct* (Fifth Edition). New Providence, NJ: M. Bender & Co.

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Quinsey, V.L., Harris, G.T., Rice, M.E., & Cormier, C.A. (2006). *Violent offenders: Appraising and managing risk* (Second Edition). Washington, DC: American Psychological Association.

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