

# Preventing Violence, Trauma, and the Use of Seclusion and Restraint in Mental Health Settings

## *Identifying and Managing S/R Risk Factors A Core Strategy © A Primary Prevention Tool*

*(Huckshorn, LeBel, Nihart, & Stromberg)*



# Objectives

1. Become familiar with the concept of risk assessments and what role they play in helping to prevent violence or injuries
2. Understand the common models used to explain predictors for violence as these relate to inpatient mental health settings
3. Understand the physical/emotional factors important in assessing an individual's risk for injury or death resulting from S/R interventions

# Assessing Risk Outline:

## ■ Aggression & Violence Risk

Identify risks for aggression or violence in order to prevent the use of seclusion or restraint (S/R)

- Individual, environmental, & situational risk factors

## ■ Medical/Physical Risk

Assess and understand medical risks when S/R is used to reduce the possibility of serious injury and/or death

# What is Risk?

Dictionary Definition: “exposure to the chance of injury or loss, danger, hazard”  
(*Webster’s Dictionary, 2001*)

*Risk is a complicated concept that refers to the ‘nature’ of a hazard, the ‘likelihood’ that the hazard will occur, the ‘frequency or duration’ of the hazard, the ‘seriousness’ of the hazard’s consequences, and the ‘imminence’ of the hazard*  
(*Johnstone & Cooke, 2007*)

The concept of *Risk* is “*inherently contextual or situational*” or, in other words, risks emerge and exist in specific circumstances  
(*Otto, 2000; Johnstone & Cooke, 2007*)

# Risk Assessment is not about *Prediction*

- Risk assessment is about providing a context where a full discussion can occur about the individually-specific clinical and environmental risk factors that may be present
- Includes the conditions that may serve to increase or decrease the likelihood of a problem occurring (whether conflict or violence or physical health issues when implementing hands on restrictive interventions)

*(Hart et al, 2003; Hart, Michie & Cooke, in press)*

# Institutional Violence

- Includes behavior that involves verbal threats, and/or physical or sexual assault in a secure environment
- Institutional violence is a serious problem, Duhart (2001) found rates for mental health professionals to be 68.2%, for custodial staff 69% per 1000 persons *(Duhart, 2001)*
- Effects of violence in institutions include staff and client physical and emotional injury, property destruction, expense, lawsuits, increased restrictiveness, morale issues *(Johnstone & Cooke, 2007)*

# Understanding 3 Violence Models

- 1) Patient characteristics (blame the patient...)
- 2) Environmental factors (setting “triggers”)
- 3) Situational: a combination of the above
  - The situational model has been the most useful in understanding the violence that leads to S/R use
  - Attention to only the person or setting ignores this multi-dimensional relationship and the variables that inter-relate to lead to conflict
  - Popcorn metaphor: individual risk factors cause the first corn to pop...should we assess each piece of corn or turn down the heat?  
*(Folger et al, 1995)*

# Situational Risk Factors

- Situational risk factors are those negative or sometimes neutral features of a healthcare (or other setting) where the violence takes place
- These factors include the setting's violence levels, organizational and management structures, leadership styles, policies, the physical environment, quality and skills of staff, quality of life factors, and treatment interventions *(Megargee, 1982)*

# Literature on Causes of Violence in MH Settings

- In 1973, David Rosenhan published a research study titled “On Being Sane in Insane Places”, (for which he and colleagues were quite criticized...)
- 8 pseudopatients were admitted to 12 different hospitals. *(Rosenhan, 1973)*

# Literature on Causes of Violence in MH Settings

- All facilities quite different, in different US states, public and private, large and small
- All “participants” were admitted by reporting that they “heard voices” but that was all that was changed in the “patient’s” reported admit history
- Once admitted, each reported that the “voices” were gone and they acted as they had on the “outside”

*(Rosenhan, 1973)*

# Literature on Causes of Violence in MH Settings

During their admissions these “patients” took a lot of notes on unit activities and staff behaviors.

Several findings are particularly germane:

1. “Normal” behaviors (note taking, anxiety, boredom) were seen as pathologic and symptoms of mental illness, per nursing staff recordings
2. “Real” patients’ behaviors (observed) were often misinterpreted by staff

# Literature on Causes of Violence in MH Settings

3. Often a “patient” would become violent because of mistreatment by staff but rarely would a nurse inquire into the environmental causes, rather assuming “pathology” was cause
4. “Never” were the staff noted to assume that either they or other environmental factors had anything to do with patient behaviors” (p. 6).

# Literature on Causes of Violence in MH Settings

In 1989, Elaine Morrison, a nurse researcher, performed a months-long ethnographic study on 3 inpatient units, titled “A Tradition of Toughness: A Study of Nonprofessional Nursing Care in Psychiatric Settings.” She found:

1. A lack of individualized care, rigid use of the medical model, and highly routinized staff tasks (giving meds, assuring wake and bedtimes, escorting)

# Literature on Causes of Violence in MH Settings

2. Unit “norms” included the need for physical restraint and “it’s not you we don’t trust”
3. Roles for non-professional nursing staff included enforcing, policing, supermanning and “putting on a show”
4. New staff were introduced and coerced into compliance with these roles and were “punished” by peer staff if they did not

*(Morrison, 1989)*

# Literature on Causes of Violence in MH Settings

5. Staff roles were described as the “process of carrying out the rules aimed to control patient behaviors”
6. Staff were “valued” according to their “abilities to physically manage patients”
7. Rules that denied access to cigarettes or personal belongings often ended in violence, and
8. Staff “hid” their tough behavior from administrators

*(Morrison, 1989)*

# Literature on Causes of Violence in Mental Health Settings

- In 1985, Robert Okin, MD looked at a variety of psychiatric hospitals' use of S/R in one state alone, for 5 months
- He found that use of S/R varied significantly and differences could not be explained by patient demographics or pre-admit aggressive behavior
- He concluded that “factors related to the individual hospitals practices and conditions” were responsible” for these different rates of use

*(Okin, 1985)*

# Literature on Causes of Violence in MH Settings

- Fisher (MD), in 1994, provided a large meta-review of the current S/R literature and found the current research to be inconclusive regarding pros and cons of S/R.

# Literature on Violence in Mental Health Settings

Fisher was concerned about injury rates resulting from S/R and noted that “staff training” was fundamental to safe use and must include (but did not):

1. Informing staff about issue (violence & S/R)
2. “Attitude therapy” (for staff)
3. Understanding the “patient’s perspective”
4. Training on appropriate staff responses

*(Fisher, 1994)*

# Literature on Causes of Violence in Mental Health Settings

Petti, Mohr, & Somers performed another review in 2001. Found current studies inconclusive and focused on the “patient” as cause of restraint use. This study’s findings included:

1. That the medical record “jargon” did not adequately describe events, for instance, “aggressive” could mean anything from cursing to spitting to hitting...

# Literature on Causes of Violence in Mental Health Settings

2. A need for a more precise assessment on event antecedents instead of the repetitive rationale of “safety” (if you could not tell what had happened you would never be able to prevent it)
3. An attitude change in staff, led by leaders, that valued and learned from the consumer’s experience, and
4. The need to understand, better, why staff reported these events very differently than service users did

*(Petti, Mohr, & Somers, 2001)*

# Literature on Causes of Violence in Mental Health Settings

- Mohr and Anderson, in another study in 2001, found that the 4 most common reasons used to support the use of S/R did not meet the criteria stipulated by US federal regulations
- Reasons for coercion were based on old attitudes, disrupting the environment, a refusal to obey orders, and preventing property damage
- Reasons documented were very subjective

# Literature on Causes of Violence in Mental Health Settings

- Duxbury, a UK nurse, (2002) found that the “internal model” of blaming the “patient” for S/R events was pervasive. She found that institutional factors were a primary reason for violence and included overcrowding, lack of privacy, shift changes, temperature, poor basic service provision, staff gender, staff experience, and staff training.

*(Duxbury, 2002)*

# Literature on Causes of Violence in Mental Health Settings

- Another study in 2004 reviewed 215 assaults in a 2-month time frame in a child facility. Significant causal factors to violence were noted to include staff verbal directions, re-directions, and limit setting. Service user ages, history with DJJ, diagnosis, and gender were not noted to be significant.

*(Ryan, Hart, Messick, Aaron, & Burnette, 2004)*

# Literature on Causes of Violence in Mental Health Settings

In 2005, another study explored the perceptions of service users in inpatient settings. Participants described a high prevalence of “sanctuary harm” in settings. Descriptive findings emerged:

1. Feeling a constant threat of violence from peers and staff
2. The idiosyncratic use of ‘the rules’

*(Robins, Sauvageot, Suffoletta-Maierle, & Frueh, 2005)*

# Literature on Causes of Violence in Mental Health Settings

3. Staff not “knowing” service users as individuals/being treated impersonally
4. Unfair treatment practices
5. Being embarrassed or disrespected in the treatment setting

*(Robins, Sauvageot, Suffoletta-Maierle, & Frueh, 2005)*

# Literature on Causes of Violence In Mental Health Settings

- Two nurses, O'Brian & Cole (2004), did a study in an psych intensive care unit in Australia to develop an understanding of the experiences of patients, relatives and nurses
- They found that violence appeared to be related to environmentally driven behavior such as “forced compliance” with rules and not a result of intrinsic illness issues.
- They also found that violence management relied on control and containment, not preventative measures

*(O'Brian & Cole, 2004)*

# How to Assess Risk Factors for Conflict and Violence?

- We need to assess individuals for triggers, historical responses to stress, and coping behaviors when under threat
- Need to assess our *environment of care* for institutional triggers that might increase risk for certain individuals, including staff attitudes
- We need to look at both, together
- Proactively develop effective interventions to avoid or minimize conflict

# Assessing Individual Risk Factors

Previous violent behavior #1 individual risk factor for re-occurrence

- Previous history physical or sexual aggression
- Previous history of S/R use
- Command hallucinations with intent to harm
- Intoxication or detoxification
- Planned Aggression vs. Spontaneous

*(National Executive Training Institutes, 2005)*

# Assessing Environmental Risk Factors

Events related to hospitalization are common triggers to aggression & violence

- Anger related to enforcement of hospital policies
- Anger related to a sense of unfair treatment
- Anger related to long wait times

*(May, Grubbs, & Binder, 2000)*

- Anger related to mandatory strip searches or automatic disrobing *(Stefan, 2006)*

- Human aggression is typically the product of interpersonal interactions wherein two or more persons become involved in a sequence of escalating moves and counter moves, each of which successively modifies the probability of subsequent aggression...

*(Cox & Leather, 1994)*

# Environmental Triggers Contribute to Violence

- Practices that “shame or humiliate”

*(Hodas, 2004)*

- Controlling & restrictive environments with unfair rules have been found to increase assaults
- Authoritative systems that dominate from the top down with persons served having the least value and little voice

*(Morrison, 2001, 1998, 1992, & 1989; Lanza et al, 1994)*

# Other Environmental Factors Contributing to Violence & Aggression

- Spatial crowding (i.e., corridors, shared spaces, ER's)
- Limited or no staff training in conflict prevention and management
- Younger staff with less experience
- Stretches of time with nothing to do, waiting in lines or on stretchers
- Lack of peer supports and other natural supports; no one to talk to

# Environmental Factors that Contribute to Violence

The significant point here is this...

*All of the preceding environmental stressors or triggers are completely preventable*

*No longer can we act like inpatient conflict is due to unknown or magical factors*

# Staff Response To Conflict: Key Training Issue

- Spontaneous and random acts of violence with no precipitant are relatively rare
- Most incidents develop over some period of time
- Usually behavioral clues that “something” is going on
- Key is to intervene early and effectively
- Another key is for staff to empathize with a person’s past experience with police or other facilities and to work to interrupt negative expectations

# Staff Need to Understand Behaviors on a Continuum

- Assessing behaviors and levels of danger are important skill sets
- Use of a scale can give staff common language
- This only works if everyone appropriately understands behavioral signs and is trained and competent in use of tools

# Use a Behavioral Scale to train

- Avoid over-reacting - Safety First
- Use least restrictive intervention that has minimum impact on individual and the environment
- From lowest level of concern to highest
- 5 Levels of Behavior from lowest level of concern to highest directs staff response:
  - Agitated
  - Disruptive
  - Destructive
  - Dangerous
  - Threat of Lethal

*(Lalemond, 2004)*

# Agitated Behavior

- Behavior change that is more subtle & often ignored
- Include behaviors such as low level pacing, quietly talking to self, tapping foot or hands, rocking, repetitive requests that are ignored
- Second level message “I’m Distressed”

*(Lalemond, 2004)*

# Disruptive Behavior

- Behavior starts to become more disruptive because it involves other people
- For instance “pacing” in front of TV (disruptive) is higher level than pacing in bedroom (agitated); talking loudly enough for others to hear
- Second Level message here is “Pay Attention”

*(Lalemond, 2004)*

# Destructive Behavior

- Behavior often includes destruction of property, throwing things, verbal threats without weapons or ability to follow through
- Defined by an increase in gross motor activity and sometimes increased affect
- Second level message “Losing Control”

*(Lalemond, 2004)*

# Dangerous Behavior

- Behavior clearly observed to be dangerous to self or others
- Behaviors such as threatening to hit someone, hurt self by risky behavior, use a weapon (like furniture or projectile) and clear ability to follow through
- Second level message is “Lost Control”
- Usually includes gross motor movements and loud voice

*(Lalemond, 2004)*

# Lethal Behavior

- Lethal Behavior is the threat of suicide or homicide.
- Secondary Message is “Stop Me”
- Staff response is always “Don’t do it”
- Is the most dangerous but seen the least

*(Lalemond, 2004)*

# Staff Response Options to 5 levels

- Safety first
- Find the distress, relieve the distress
- Open up communication
- Make others safe
- Use least restrictive intervention that matches behavior
- S/R is only used for Dangerous/Lethal behaviors, in most situations, if staff are trained and can mitigate

*(Lalemond, 2004)*

# Assessing Risk for Violence ~ *Conclusions*

- Know the potential contributors to violence, including individual history & unique triggers. Use assessment tools and address in strategies in advance
- Assure for a thorough review of institutional and environmental factors to minimize these triggers

# Assessing and Managing Medical Risk Factors

Take Downs, Physical Restraint  
& Seclusion

# Use of Take Downs, Physical Holds & Mechanical Restraints are Inherently Dangerous

- Anytime we put “hands on” – potential problems with:
  - Airway Obstruction
  - Injuries to all involved
  - Exacerbation of unknown or known medical disorders
  - These may occur in combination

# Airway Obstruction/Position: Positional Asphyxia

**Positional Asphyxia** occurs when body position interferes with respiration, such as:

- Prone positioning (face down), especially when obese, panicked, small build, respiratory problems
- Flexion of the head into the chest
- Basket Holds, compression on back or chest for any reason

*(Mohr, Petti, & Mohr, 2003; Paterson et al, 2003)*

# Positional Asphyxia (continued)

Additional body positions/practices that interfere with breathing also include:

- Neck compression
- Any weight placed on the body that limits the intake of air
- Placing a towel or sheet over the persons' head to protect against spitting or biting

*(Tracy, Donnelly, & Stultz, 2002; Morrison, 2002; Mohr, Petti, & Mohr, 2003)*

# Prone Restraint Risk Factors

- Compression or restriction of rib cage limiting chest expansion for breathing
- Abdominal organs are pushed against diaphragm and further limits space for lung expansion
- Staff cannot see person's face; difficulty in communicating or assessing status

*(PAI, 2002; Tracy, Donnelly & Stultz, 2002; Parkes, 2000; Mohr & Mohr, 2000)*

# Prone Restraint Risk Factors

- More frightening for person if they cannot see
- Many experts advise against the use of prone restraint due to danger and high risk and a number of US State Mental Health Systems prohibit (**need Mandt email**)
- A majority of deaths have occurred in prone take-downs and in prone restraints

*(PAI, 2002; Tracy, Donnelly & Stultz, 2002; Parkes, 2000; Mohr & Mohr, 2000)*<sub>49</sub>

# Aspiration

- Supine position, during which the person is immobile and/or decreased or altered level of consciousness, interferes with the ability to protect one's airway
  - The person may aspirate vomit, regurgitated gastric juices, or excessive saliva
- Greatest risk occurs after the person has recently ingested food or fluids or is taking medications that produce excess saliva
- Since face up, problems can be noted and response can be immediate

# Other Medical Risks Factors

- History of recent surgery
- Spinal Injury/back problems
- Respiratory problems, including asthma, bronchitis, emphysema, chronic pulmonary disease, or other breathing difficulties
- Unknown Cardiac conditions, history of arrhythmias under stress
- Obesity, pregnancy, or other conditions of enlarged abdomens

*(NAPHS, 2003; Mohr, Petti, & Mohr, 2003; Morrison, 2002; Tracy, Donnelly & Stultz, 2002)*

# Other Medical Risks Factors

- Catecholamine (Adrenal) Rush/ Cortisol Flood
  - During agitation or prolonged physical struggle, humans release an extreme amount of adrenal catecholamine's (fight, flight, freeze response)
  - A flood of epinephrine and norepinephrine may produce rhythm disturbances in the heart that can lead to sudden death
  - This may be exacerbated by increased heart rate and decreased available oxygen

*(NAPHS, 2003; Mohr, Petti, & Mohr, 2003; Morrison, 2002; Tracy, Donnelly & Stultz, 2002)*

# Other Medical Risks Factors

- Excited Delirium Syndrome
  - Delirium can alter sensation and render person capable of extreme (abnormal) exertion
  - Can lead to Cardiovascular collapse

*(Mohr, Petti & Mohr, 2003)*

# ***Best Way to Avoid Injury or Death***

***...Avoid using Restraint (hands on) in the first place - we will never know all the risk factors a person may have coming in the door...***