Ontario Shores
Centre for Mental Health Sciences

Proceedings of the Fifth Annual Mental Health Thought Leadership Forum on Preventing Restraint & Seclusion

Ontario Shores Centre for Mental Health Sciences

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Forum Sponsors

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Welcome and Reconnecting with Thought Leadership

SPEAKERS

Dr. Phil Klassen, Vice President, Medical Affairs, Ontario Shores Centre for Mental Health Sciences

Dr. Ian Dawe, Physician-in-Chief, Ontario Shores Centre for Mental Health Services

Dr. Phil Klassen welcomed participants and thanked Borden and Ladner Gervais LLP for sponsoring the 5th Annual Mental Health Thought Leadership Forum. Dr. Klassen acknowledged the leadership of Glenna Raymond, past CEO of Ontario Shores, in making the first forum happen five years ago and ensuring its continued success.

Ontario Shores espouses a philosophy of recovery as a "compelling approach to partnering with people with mental health disorders," and therefore views restraint and seclusion as practices to be avoided, as they are traumatic for patients.

Dr. Ian Dawe said that attending his medical school class's 20-year reunion had given him occasion to reflect on the evolution of his thinking about the use of restraint and seclusion.

During the majority of his career in emergency psychiatric services, these techniques were used in the normal course of treatment. Through his tenure at Ontario Shores, Dr. Dawe said he has come to see how restraint and seclusion do more harm than good, as they do not teach how to handle a similar situation better next time.

"By restraining agitated patients, we are failing them," Dr. Dawe said. "Restraining only furthers their isolation. The evidence and our belief system tell us this is not good enough." He said it was a pleasure to be part of a forum that is pushing for changes in how patients are treated.

Summary of the First Four Years

SPEAKER

Barb Mildon, Vice-President, Professional Practice and Research, & Chief Nurse, Ontario Shores Centre for Mental Health Services

> "When an idea takes hold nothing can stop it." –Stephen Richards

Barb Mildon said that while five years might not sound like a long time, when she stopped to consider the range of topics that have been covered and the progress that has been made, it felt as though a great deal of time had elapsed.

For instance, she said, the forum's effort to move the conversation from "reduction" or "prevention" of restraint and seclusion to "elimination" has been taken up at conferences around the world. As well, significant changes have been made around team planning and collaboration. Forum participants have joined together to implement and evaluate several initiatives designed to support reduction in utilization of restraint and seclusion.

In year one, significant time was devoted to a "deep dive" into practice, to learn "how and why restraint and seclusion became so embedded, and what changes would be required." Next, participants learned about trauma-informed care, and how to apply its principles, not just for patients but for staff as well.

Reflecting the push for a patient-directed model of care, the forums have sought to include the patients' perspectives in its discussions. Courageous speakers have offered testimonials of their own experiences to carry the message forward about transformational care. The forum's focus on finding methods to predict and prevent the use of aggression by staff has even included a look at how a facility's architectural design can help or hinder these efforts.

Mildon described improvements Ontario Shores has made over a range of areas, including in its treatment of patients; communications with staff, patients, and families; emphasis on evidence-based practice; and support of staff after a "code white" or "code blue" event. She pointed to data showing a significant reduction in the use of restraint and seclusion over the last five years at Ontario Shores as a sign that these changes are having the desired impact.

The next step is to help implement these practices in facilities across Ontario's mental health system, and beyond. Noting that this kind of change requires time and patience, Mildon said she hoped participants "would each leave with one piece of the program that you will share with your organization. You are each a spark that makes a difference. I hope one day we will be all able to say we are restraint- and seclusion-free."

Keynote
Theories on Restraint Related Deaths: Learning Lessons the Hard Way

SPEAKER

Joy Duxbury, Professor in Mental Health Nursing, University of Central Lancashire

Citing a number of restraint-related deaths covered in the UK media recently, Joy Duxbury said that in her country there seems to be a "lack of compassionate care, right across the board, not just in psychiatric care." In response, the government has "taken a huge leap of faith" by implementing policies designed to avoid such incidents in the future.

Many of the techniques for manual restraint used in hospitals were adopted from prison service, "which is a worrying influence." Duxbury recalled that when she began her career as a psychiatric nurse, she was taught to inflict pain on patients, for example, by using certain wrist holds that put pressure on joints. Now, however, the National Institute for Health and Care Excellence (NICE) guidelines, instituted in 2005, make it very clear that pain infliction is not acceptable.

According to data compiled by National Health Service (NHS) Protect, 40,000 instances of assault were reported in the mental health system in 2011–12, though the understanding of the term "assault" varies widely; and 38 restraint-related deaths were recorded from 2002–12.

"What upsets me is that people will say to me, 'Only 38 deaths in 10 years,' but to me, *one* is too many. This should not be happening; these people are coming to our care to be looked after." Duxbury said additional research showing that staff very rarely cited violence as a reason for the use of restraint confirms her belief that "physicians think restraint is part of the toolkit."

This year, Mind—a UK-based lobbying group for the rights of mental health patients—used the *Freedom of Information Act* to request that hospital trusts (or boards) supply it with statistics on the use of restraints. This strategy, and the trusts' muddled response to it, "upped the ante and did me an immense favour," Duxbury said. "All of a sudden, I'm getting into government offices, getting invited by hospitals who are saying 'This is a problem, what do we do?' The press has gotten hold of it and the power of the media is intense. I'm starting to think there is going to be change."

Duxbury said the training process used by hospitals for dealing with violence and aggression needs to be reformed. "Hospitals will go to anyone who can teach about this," which means they might hire a fitness instructor, or someone with a martial arts background.

While it is a complex issue with many contributing factors, a growing body of evidence indicates that the use of restraints is psychologically and physically traumatic for both patients and staff. Duxbury quoted her colleague Sabine Hahn as saying, "If we keep our patients safe, we keep our staff safe."

The facts in the case of Olaseni Lewis, a graduate student who died in a hospital as the result of being tasered by police, highlight a "worrying trend" of institutionalized racism toward black and ethnic minority patients. These groups experience higher levels of restraint and violence from hospital staff, and Duxbury said her review of this case revealed it to be an "inappropriate use of restraint—clearly abuse." In the wake of increased scrutiny around the use of aggressive tactics, pressure is mounting on the government to regulate the training of all hospital staff.

A research review conducted into restraint-related deaths shows that those populations at highest risk are

- Individuals with serious mental illness
- Black and minority ethnic groups
- Men between 30–40 years old
- Those restrained in the prone position

Duxbury headed the group that did this research, and she said she was concerned about two of its findings: anywhere from 2–15 staff members have been involved in restraint-related deaths, and the total time in restraint ranges from 10–45 minutes. She said it was easy to see how having that many staff restraining one person could lead to a patient dying, and noted that 45 minutes is a very long time to hold someone down.

"The thing that scares me is that the people involved didn't realize that the patients were in distress, dead, or dying." Duxbury said the mentality that seems to take hold is, "When someone stops struggling the job is done."

Some outside groups see the fact that police were involved in 29 of the 38 restraint-related deaths as evidence that the police are to blame, but Duxbury noted, "It's the nurses calling the police in the first place." The hospitals' records concerning these deaths are generally so poor it is difficult to know what role the police or staff played in the outcome.

The high correlation of the prone position with restraint-related deaths has led many, including the patients' rights lobbying group Mind, to call for a ban on its use. Duxbury said that while she is sympathetic to those who hold that opinion, she thinks the answer is more complex. As she reported saying to UK Prime Minister David Cameron, "Maybe it should be banned, but how would we enforce it?" She added, "This is a multi-modal problem. The research shows the supine position is also dangerous."

From this point on, Duxbury said the focus needs to be on effective research to improve understanding of what hospitals and their staff can do to avoid the use of restraint. She has put a bid in to introduce the "Six Core Strategies" in the UK.

- Strategy One—Leadership towards organizational change
- Strategy Two—Using data to inform practice
- Strategy Three—Workforce Development
- Strategy Four—Use of seclusion and restraint reduction tools
- Strategy Five—Service user/consumer roles in inpatient units
- Strategy Six—Debriefing techniques

Processes need to be developed to identify the most vulnerable patients, to ensure that restraint is always used as a last resort, to conduct post-incident reviews, and to routinely conduct audits and root cause analysis.

Duxbury concluded by reviewing work that is currently being done in the UK to reduce the use of restraints, including the Safe Wards and No Force First initiatives, and a toolkit called "Calm Down Methods." She said much work remains to be done in this area, but she feels hopeful that she will be able to return to this forum with news of what the UK government has done to make things better.

Discussion

A participant asked whether it is more appropriate for security personnel to intervene to restrain people, so as to allow staff to preserve a trusting relationship with their patients. Duxbury disagreed, noting that this could be the case if staff had an agreement in place with a

patient about what steps would be taken in response to a given behaviour. Otherwise, it is not appropriate for non-medical staff to do this work.

"It's a worry to me, when your mental state is not as it should be, to have security guards deal with you in your most frightened state," she said. "That just feels wrong to me."

Asked whether she has done any research into the connection between staffing levels and the use of restraints, Duxbury said management teams must understand the environment of their hospitals, because there is no one-size-fits-all solution to reducing the use of restraints. Numerous factors are at play, including baseline aggression levels among the patient population and the skill mix of the staff.

A participant asked about the most effective way to change staff attitudes. Acknowledging that it might sound cynical, Duxbury said her answer was media coverage, because criticism gets the attention of senior leadership, without which meaningful change cannot occur. Staffing decisions need to be made on the basis of shared principles, to ensure that everyone has the same vision of the hospital's work.

Dr. Klassen commented on the need for transparency in dealings between caregivers and patients. Duxbury agreed, saying that caregivers must be honest about how difficult it is to do their job well, and to admit when they have become burnt out. Staff should not be afraid to admit when they need help. "Sometimes you're not the right person to deal with aggression at that particular time," she said. "You might not have the right relationship with the patient. Stand down; let someone else step in."

Collective and Vicarious Trauma: Effect on Professionals and their Organizations

SPEAKER

Cheryl Regehr, Vice President & Provost, University of Toronto

Professor Cheryl Regehr described the outcomes of studies she has conducted over 15 years of research into trauma experienced by frontline care providers.

People whose jobs involve either witnessing or hearing about traumatic events can develop vicarious or "secondary" trauma. In the research on this subject, there are two hypotheses about how trauma can develop: one is a "dosage model," in which many minor episodes have a cumulative effect, and the other is that a particular event with high salience can trigger trauma.

Regehr said her studies took into account how organizational and societal factors contribute to an individual's trauma reaction. A frontline worker's ordinary caseload might become too much when experiencing trauma, and the culture of an organization—whether or not it is supportive during a trauma response—might have a significant impact on the individual's recovery. "Witch hunts," or looking for someone to blame when something goes wrong, whether coming from the organization itself or from outside media sources, can lead to secondary trauma.

In a study Regehr conducted of 175 Children's Aid Services (CAS) workers, 70% were found to have symptoms of post-traumatic stress disorder (PTSD), compared to around 25% for firefighters and paramedics polled in a separate study. Working conditions might help explain the higher incidence rate among CAS workers, since these are mostly women, working alone, going into high-risk neighbourhoods, and frequently being threatened with violence. Using follow-up questionnaires, this study showed that the only significant support measure for helping the caseworkers cope with PTSD was organizational support, particularly from management.

With the knowledge that a significant percentage of frontline workers are struggling with PTSD, Regehr, as part of a broader research effort, asked what the implications were for the health and safety of the public. She and a colleague looked at the effect of PTSD on performance in emergency occupations to find out whether "trauma symptoms contribute to performance impairments on work-related tasks during acutely stressful events."

Four occupations were studied: police officers, child welfare workers working with child abuse, paramedics, and police communicators (911 operators). Subjects in each study were put through highly stressful simulated scenarios, monitored to determine their anxiety level throughout, and judged on their performance by outside evaluators. Regehr provided a synopsis of the studies' findings:

- For the police officers, there was no correlation between prior trauma and performance, or between PTSD and performance. Subjective distress and heart rate were not correlated with performance; however, cortisol levels 20 minutes after the event were significantly correlated with performance. Conclusion: the public is not at risk.
- For the child welfare workers, those workers who had a higher number of exposures to critical events in their career were less likely to determine that a child was at risk of abuse. Those with higher levels of symptoms of traumatic stress were less likely to determine that a child was at risk of abuse or neglect. Higher acute stress was associated with higher perceived risk for the child.
- For the paramedics, high-stress scenarios resulted in lower performance, but this showed up on a standardized performance checklist, rather than on their global rating from the judges. Performance on very routine tasks was not affected. More errors of commission rather than omission were made following high-stress scenarios. Overall, presence of PTSD was not associated with quality of performance.
- For the police communicators, the speed of their response decreased during high stress calls; errors increased on complex tasks, but errors on spelling did not increase. PTSD was associated with performance on complex cognitive tests.

An overall finding from these studies is that PTSD and trauma exposure did not impair performance on "over-trained activities," but performance on complex tasks was affected.

Regehr then shared findings from her research into the effectiveness of various strategies for reducing secondary traumatic stress. Her team of researchers developed a coping strategies inventory, including such things as

- Leisure time (family, vacation, hobbies, exercise)
- Self-care (stress management training, self-care plans)
- Supervision (case discussions, regular supervision)
- Research and teaching

The inventory was shown to 259 mental health workers who were asked whether they felt these strategies were effective. In general, these social workers, psychologists, and nurses believed the strategies worked, and supervisors tended to believe that supervision worked.

However, the research has shown no association between time allotted to any of these activities and post-traumatic stress scores. The "only variable related to secondary trauma was time spent counselling traumatized individuals," in other words, what a person does to cope with secondary trauma does not matter as much as the organizational support for employees who are experiencing burn out. "We do too much blaming of the worker. We tell them, 'You don't have the right work-life balance.'"

The last study Regehr described examined whether crisis debriefing groups help or hinder a person's ability to cope with PTSD. In satisfaction surveys, participants have consistently responded that they find such groups to be helpful. However, studies have shown that there is either no difference for participants, or that people who attended actually had higher levels of PTSD.

"If you put traumatized people in these groups, their PTSD rates go up." The positive aspects of these groups are that they can normalize PTSD symptoms, can give participants increased control over their symptoms by teaching them cognitive-behavioural techniques, and can mobilize social supports in the organization. The negatives include, an inability to reduce PTSD symptoms, the possibility of vicarious traumatization, and limited opportunities to assess a participant's vulnerabilities and risk of PTSD.

Regehr said people do indeed suffer secondary trauma as a result of exposure to workplace traumatic events. Unavoidably, things will go wrong when workers have to make a difficult decision about risk in a highly stressful situation. Organizations must find ways to support workers when this happens, rather than trying to determine blame. Workers involved in traumatic situations benefit from having the tools to help them modulate an acute stress reaction.

Ethics, Insights, and Lessons Learned from a Sustained Restraint and Seclusion Initiative

SPEAKER

Barbara Russell, Bioethicist, Toronto General Hospital & Women's College Hospital

Barbara Russell said when faced with the task of distilling her four years' experience on a hospital initiative to reduce and prevent restraint and seclusion into a single presentation, she chose three paradigms:

- Dignity
- Ethical crucible
- Moral repair

Dignity

Using Nora Jacobson's taxonomy of dignity, Russell conducted research on the topic with a focus group composed of people with mental health difficulties, healthcare workers, and human rights workers. The group defined human dignity as "part and parcel of being human."

More relevant to the topic of restraint and seclusion was social dignity, which the group defined as dignity-of-self and dignity-in-relation. Encounters with patients or clients can involve either dignity promotion or dignity erosion or violation. Russell then asked participants to work in groups to reflect on their own experience of when seclusion or physical/mechanical/environmental restraints were used against the person's will. She asked them to watch for examples of:

- Dignity-promoting actions, behaviours, responses, communications
- Dignity-eroding actions, behaviours, responses, communications

After participants shared some of their examples, Russell said that the results of interviews conducted by Jacobson in 2005 with individuals who had undergone the use of restraints highlighted many of the dignity-eroding and promoting factors. Russell said hospitals need to train their staff on how to read situations, because how people interpret events determines their response.

"They're professionals, but they're humans too," she said. Work should be done to develop practical strategies for how staff can avoid eroding dignity; otherwise all the talk about promoting dignity is "just intentions."

Ethical Crucible

Russell referred to an article she'd read, "Feeling Trapped and Being Torn," that described physicians who sought to avoid conflicts with their patients, and felt burdened when they had to use their authority. This was when the idea of a crucible occurred to Russell to describe her four years on the initiative.

Restraint and seclusion is a "highly contested concept," involving many competing and clashing interests. Such complexity requires a complex approach. A reductionist approach will bring about "ethical diminishment." A good place to start this journey is to ask, "What is integral to a person's dignity, and what is each party's responsibility to the relationship?" Over the course of this initiative, there was a big debate about whether the rationale for the use of restraints was safety or therapeutic benefit.

Russell came across writers and clinicians who viewed the use of restraint and seclusion as a sign of the healthcare unit's failure. This became a hot button issue for many of the staff, who took this criticism to heart. According to Russell, staff heard the word failure as meaning "I have acted unwisely. Our practice has been unsound, our team's work has been unacceptable." This would typically lead to a shutting down of engagement, with staff becoming worried about possible discipline and repercussions.

Many proponents of eliminating restraint and seclusion put the onus on organizational leadership to effect change. To start with, leadership needed to understand the experience of being on the front line. At the hospital undertaking this initiative, all management and leadership took a two-day retreat together. This included personnel from housekeeping, billing services, information technology, and administrative services.

The rationale was that it was easy for someone not involved in direct care to judge a member of staff for using restraint and seclusion. The retreat was part of an effort to build solidarity within the hospital and to assuage staff's concerns about being judged.

Working toward the elimination of restraint and seclusion also involves extending invitations to family and partners of patients, and advocacy groups to provide input and to help shape policy. Hospitals must decide whether "stakeholders are going to be included piecemeal, or all the way through the journey." Resources must be dedicated to this effort, because it is complicated.

Russell introduced the idea of "interventional creep" to describe the common problem of caregivers blurring the line between consent agreements, contingency management, and forced restraint. "We have to pay attention to these differences," she said.

When interviewed, staff described the use of restraints as a "necessary evil" to prevent harm, but the question remains, "harm to whom?" The moment a staff member lays hands on a client, it becomes a "battleground for control," with one saying "Calm down," and the other saying, "I will when you get off me."

When looking at the evidence about whether restraint and seclusion actually work, Russell found what she considered a "phenomenal way of differentiating between evidence." In addition to measuring a given intervention's practical validity, one can also look at its psycho-political validity.

The latter takes into account the power inequities that always exist in mental health settings. Clients and advocacy groups are interested in the way evidence is collected because they want

to ensure that staff are being tracked; staff is interested in the evidence because they are accountable to their clients. Power differentials were at the heart of a larger effort during the initiative to sort out who had what rights, duties, responsibilities and accountabilities for what and to whom. Often staff would say, "Patients have rights, why don't they have responsibilities?" Russell's response to that was, "If someone has no self-worth or rank, or has very little power, ascribing responsibilities to that person is not right." Respecting the rights of patients imposes serious duties on the staff.

There was considerable discussion about the difference between responsibilities and accountabilities. "Responsibility means I own my reactions, like how I will use my body. Accountability means to whom do I owe an account to explain what I have done, and to make myself understood?"

Moral Repair

This third paradigm comes from Margaret Urban Walker's work and has to do with stabilizing and repairing relationships in the aftermath of a dignity-violating or eroding event.

Restraint and seclusion are traumatizing and re-traumatizing events for patients. When staff does not acknowledge that this is so, it can damage their relationship with the patient. Repairing relationship requires the wrongdoer to take responsibility and make amends.

Staff can come to feel isolated when they must constantly take responsibility for their actions. To make matters worse, when a caregiver does take responsibility, they become a player in a process over which they do not have control. When it comes to restraints, there are no ready ways to make amends, which is also the case when the staff is harmed or wronged.

Russell asked participants to work in groups to write down examples from their own experience of times when they needed to make amends. They were asked to describe the challenges in doing this, and how it worked out in terms of stabilizing and restoring the relationship with the client.

Asked to share some of their discussion with the whole group, a participant said that her facility employs a dialectical behavioural therapy approach, in which clinicians seek to talk with "radical genuineness" about the part they played in the escalation to restraint or seclusion. Clients are often surprised to hear such honesty coming from the clinicians.

Russell said that the hospital at which the initiative took place had client debriefs built into the process, instead of having staff fill out a form and hand it in. The process raised questions, though, about the right way to restore the relationship, whether staff should apologize, and what such apologies mean.

Russell concluded by quoting Stephen Carter's work on integrity, in which he outlined three important steps:

"Discerning [your] deepest understanding of right and wrong"

Acting openly and "consistently with what [you've] learned," sometimes at risk to [your] own self-interests/welfare

"Being willing to say that [you're] acting consistently with what [you've] decided is right"

The third step is particularly difficult since staff often "don't want to give an account because they might be punished." Leadership understanding of staff is key, as is paying attention to what clients are saying. Healthcare organizations need to be fully committed to transparency, and to clarifying everyone's rights and responsibilities. Moral repair is not just about individuals, it is about the community.

Discussion

Asked by a participant how staff can address the power imbalance between them and their patients, Russell said one possibility is to empower peer support workers so that nurses do not have to shoulder the entire burden for patient care. Leadership at healthcare organizations should think about employing others who have relevant experience that they use to improve communications with clients.

A participant said that she was concerned about the notion of "dignified restraint," because staff might use this to justify using restraint again. Emphasizing that she herself is not a clinician, Russell said, "Restraint and seclusion always involve harming the person. That's why we should prevent or minimize it." At the hospital where she worked there was disagreement about eradicating versus minimizing restraint and seclusion. Eventually agreement was reached on setting realistic aspirations, and not having to decide the matter of which approach was best.

Likening the use of restraint to other interventions that can cause harm, such as giving a diabetic an insulin shot, a participant asked why there would not be negotiation at those times as well. Just as some patients consent to insulin shots, some patients want to be in restraints. Russell said that in emergency situations consent is not required. However, an insulin shot should be part of a patient's care plan that has been consented to. The point is, dignity should always be considered, regardless of whether the intervention is by consent or unilateral.

Panel
Restraint and Seclusion around the World

PANELLISTS

Sabine Hahn, Head of Nursing Discipline, Berne University of Applied Sciences

Marie Gerdtz, Associate Professor, Department of Nursing, The University of Melbourne

Gill Thomson, Senior Research Fellow, Maternal and Infant Nutrition & Nurture, University of Central Lancashire

Teshome Shibra Kelkile, Clinical Fellow, Ontario Shores Centre for Mental Health Sciences

MODERATOR

Dr. Phil Klassen

Switzerland

Sabine Hahn said that in Switzerland general hospitals do not provide mental health services, so her comments about restraint and seclusion do not apply to psychiatric settings. The terminology used is a bit different as well: for example, "freedom of movement" is used instead of "restraint."

As background, Hahn explained that these issues are very rarely discussed in the general health or senior care setting, and most staff consider restraint to be a normal intervention. Because of the prevalence of three languages in Berne (Italian, French, and Swiss-German), staff must work hard to make sure they are understood by their patients. For the most part, doctors and nurses are viewed as experts who know what is best for the patient.

In 2011, for the first time Swiss hospitals became responsible for reporting any use of restraints on patients. Of the 10,000 patients included in the sample, almost 20% had experienced restraints in the previous seven days. The most prevalent reason (32.8%) cited for the use of restraint was to prevent falls.

Patients seemed to have many different definitions of restraint, so it is important to ensure everyone means the same thing when talking about restriction of free movement. A piece of legislation just passed this year, called the *Adult Protection Law*, seeks to give patients as much self-determination as possible, to increase levels of co-determination, to ensure restriction of freedom of movement is used as a last resort, to provide patients with a right to information, to make documentation mandatory, and to furnish patients with the right to appeal.

Hahn said more research is needed to establish the basis for the restriction of freedom of movement. For example, there is no evidence to support the idea that restraints make patients more secure and prevent falls. The new legislation supports hospitals' quality improvement processes through the implementation of evidence-based standards. Better training is needed to teach staff how to intervene without resorting to the use of restraints.

Australia

Marie Gerdtz, from Melbourne, Australia, said the city's population is 4.5 million people, and the emergency room in the hospital she is reporting on treats approximately 60,000 patients per year. She provided a definition of some terms:

- "Clinical aggression" refers to an incident of aggression directed towards staff.
- "Code grey" and "code black" refer to responses for which policies are in place. Code black is an armed threat dealt with by police officers, and code grey is an in-house, clinical response.
- "Security officer" refers to personnel hired by the hospital to provide security. These people have a license, the same as those who provide security at nightclubs. Security officers do not have to be credentialed. Many hospitals provide additional training. The officers are predominantly male.

For added context, Gerdtz explained that a 2004 government report looking at occupational violence issued 29 recommendations that were eventually enacted by government. In 2010, the newly elected federal government, which had made an election promise to address the issue of violence in hospitals, proposed having armed guards in hospitals. This garnered a lot of protest, and, as a result, an inquiry was conducted. So far, the government has responded to the backlash and has not gone ahead with the proposal.

The healthcare workers union, "a militant union," has taken an "industrial perspective" in lobbying for armed guards. The *Mental Health Act*, passed in 1986, along with several others, puts the onus for preventing restraint and seclusion on hospitals, but no standardized training programs are offered in this area.

Prior to reviewing the hospital's statistics on code grey events, Gerdtz explained that this category is divided into two parts: planned and unplanned. A planned code grey event is when a patient with a history of aggression is known to be arriving to the hospital with police, and an unplanned event means that there is actual violence. In almost 50% of code grey events, restraints were used. Only a third of the patients in these events had a mental health complaint, and most events involved patients who had consumed drugs and/or alcohol.

For the years 2010–12, the number of unplanned code grey events decreased, while the number of planned events increased. However, the number of events where no restraints were used decreased.

"It would seem we are seeing more restraints," Gerdtz said. To counter this trend, the hospital is implementing new strategies, including triage procedures that identify people who might erupt into violence if they are made to wait too long, and the use of "behavioural assessment rooms," which are seclusion rooms by another name, as well as more training for staff on how to de-escalate potentially harmful situations.

United Kingdom

Gill Thomson said practices around restraint and seclusion in the UK are "in a huge state of flux right now," due in part to the recently released findings of the Francis Report. The government ordered an inquiry, headed by Robert Francis, QC, after an investigation into a hospital with an unusually high mortality rate showed serious shortcomings in its oversight. The inquiry looked at all incidents from 2005–09 that caused concern, and was directed to investigate why these cases were not acted upon.

The Francis Report found that "a toxic culture was allowed to develop unchecked which fostered the normalisation of cruelty and the victimisation of those brave enough to speak up." Despite numerous reports alerting officials to disturbing conditions at the hospital, nothing was done to address these problems. Headlines in the papers described an organizational culture more focused on doing the system's business than helping people in distress, and a lack of openness and transparency. The Francis Report issued 290 recommendations in total, aiming to:

- Foster a common culture of putting the patient first
- Develop fundamental standards of care
- Make those who provide care properly accountable for what they do
- Enhance recruitment/education/training and support

As a consequence, the Department of Health has developed a set of guidelines called "Patients First and Foremost," aimed at improving reporting procedures and accountability. Forthcoming changes include a new inspection regime that will include hospital assessment conducted by independent agencies and publication of the results; patient-led assessment of care environment (PLACE); government focus on timely response to complaints; and instituting meaningful training experiences for all staff.

Ethiopia

Teshome Shibra Kelkile said that in Ethiopia the focus for those in the mental health sector is on coverage, not on the use of restraints. There is only one psychiatric hospital (and five admitting facilities) for the entire country, which has a population of 58 million and is five times the size of France.

Over 85% of Ethiopians live in remote villages and have very limited access to physicians. If someone is experiencing mental health difficulties, their first step is to seek help in the "informal" health sector, which offers traditional and religious healing practices. In 2012, a national mental health strategy was approved that integrated mental health into the primary health care system, but offered no specific guidelines relating to:

- Protection of basic rights
- Regulation of compulsory admissions

- Appeal procedure
- Restraint management
- Seclusion

Friends and family will often put people with mental health difficulties in chains, and traumatic injuries and deaths resulting from the use of restraints are common. It is not unusual for someone to arrive at a hospital in chains, having made the long trip to the facility in this condition.

Shibra Kelkile told the story of one child who had been restrained at home by his family for eight months. During that time, nobody in his family looked at him or believed him when he told them he was not dangerous. The country struggles with a scarcity of trained health practitioners, with only 53 psychiatrists and 375 nurses serving the entire country.

Since 2003, some positive changes have been made, including the development of guidelines for the use of restraint and seclusion; a psychiatric centre within the prison system; training family members, police, and religious leaders about safety; and referral pathways to psychiatric care. Shibra Kelkile described these as small changes in an area of overwhelming need.

Discussion

A participant asked Thomson about the data she presented on the hospital's avoidance of the use of restraint as a measure of quality and safety. She likened this to a "near-miss," and asked how the hospital tracked those.

Thomson said those numbers came from reports on code grey events, which captured what type of restraints, if any, were used. Prior to this method of data gathering, the hospital only looked at the type of code, whether it was planned or unplanned. The thinking was that if there were more planned events that meant the hospital was being proactive in avoiding the use of restraints; but in fact, the number of restraints used in the code is the only valid measure.

In response to a participant's question regarding what is the most useful indicator of quality of care across all patient populations in hospitals when it comes to restraints and seclusion, Joy Duxbury, the day's keynote speaker, replied, "Given that we have talked about this being a multi-modal problem, I would be looking at patient satisfaction surveys in the therapeutic milieu."

A participant asked the panel whether any of their data showed a difference in the frequency of restraint use based on time of day or day of the week. Gerdtz said that, looking at emergency room data from Australia, there is almost no difference. The hypothesis was that more problems would occur on the weekend, but that did not come through in the data. Duxbury added that there might be more restraint use on Monday and Tuesday when you have a full of complement of staff imposing more rules.

Summary of the Day

SPEAKER
Barb Mildon

Barb Mildon thanked the day's speakers and participants for making a compelling case to continue work to eliminate the use of restraint and seclusion. She said she was pleased to see the interactive component of Barbara Russell's presentation continue a forum tradition of using powerful teaching practices. Throughout the day, a commitment to dignity, care, and respect of patients and clients was palpable. She said eliminating the use of restraints "enriches our professional experience and makes us safer."

Appendix
Small Group Discussions

Examples of Dignity-Preserving and Dignity-Eroding Actions

What could help patients preserve their own dignity? (How can clinicians support clients in these activities?)

Please note: Examples from workshop participants are in italics.

- **Contribution** ("giving something back" to others, as through volunteering)
- **Discipline** (performing routine activities like cleaning and exercising that are seen as responsible and "normal")
- **Independence** (being self-sufficient)
- **Accomplishment** ("doing the job right" or completing an undertaking in a way that meets or exceeds expectations)
- **Authenticity** ("being myself" or honouring one's own individuality)
- **Creativity** (making or sharing art)
- **Enrichment** (making consumption choices that are seen as self-improving)
- **Transcendence** ("rising above" provocation or temptation)
- **Restraint** (demonstrating emotional or behavioural control)
- **Control** (taking charge of a situation)
- **Perseverance** ("just surviving" in difficult circumstances or "making the best of it" after a tragedy or severe disappointment)
- **Preparation** (steeling oneself by reducing expectations, to revisit settings that in the past have seen violations of dignity)
- **Avoidance** (steering clear of associates or activities that have in the past led to dignity violation)
- **Concealment** ("covering up" embarrassing markers or situations)
- **Resistance** (i.e., asserting oneself in the face of threats to dignity)

What helps preserve the dignity of others? (How can clinicians "do" these towards clients?)

- **Recognition** (acknowledging the humanity of others by paying attention and showing appreciation)
  - *Use their names, privacy, eye contact, active listening, know the patient's history, see the person not the behaviour*
- **Acceptance** (being non-judgmental of difference)
  - *Non-reactive, non-judgmental, accept patient's values, validate patient's concerns/strengths, involve family as patient wishes, involve SDM on behalf of incapable patient, accept patient's cultural and religious values, accept patient's feelings, know patient's history*
- **Presence** (keeping others company in difficult situations)
  - *Calm/reassuring voice, increase time spent with patient*

- **Leveling** (minimizing asymmetry)
  - *Explain step x step, use language that promotes cooperation, communicate honestly, reduce power, help patient know their plan of tx/care, mutual problem solving, respect patient's space, least amount of restraints, be flexible, avoid over-reliance on rules, plan de-escalation techniques with patient, try to understand patient's perspective/words, debriefing of patient*
- **Advocacy** (standing up for or beside those who are oppressed)
  - *Tell patient that you are there for them, realize patients can be afraid*
- **Empowerment** (working with others to enhance their capacities, capabilities, and competencies)
  - *Ask permission, give choices, give back control, "what works best for you?" give patient opportunities to calm themselves down, offer alternatives to restraints, seek patient input on their triggers/stressors*
- **Courtesy** (demonstrating common respect)
  - *Politeness*
- **Love** (honouring and esteeming others)
  - *Empathy, offer measures to comfort/soothe*

What can erode or violate others" dignity? (How can clinicians avoid doing these unintentionally?)

- **Rudeness** (being nasty or showing general disrespect)
  - *Speaking disrespectfully about patient*
- **Indifference** (demonstrating a lack of consideration, care)
- **Condescension** (treating or talking to an adult as if a child)
  - *Talking down to patient*
- **Dismissal** (ignoring or discounting patient's knowledge, experience, views)
  - *Reducing patient's autonomy, being dismissive, not listening*
- **Diminishment** (making patient feel smaller or lessened)
  - *Restraints used in presence of co-patients/family members, being paternalistic towards patients*
- **Disregard** (rendering an actor invisible or voiceless)
  - *Ignore patient's basic needs, not following through with promises or plan of care*
- **Contempt** (i.e., treating a person in a way that suggests he or she has no value)
  - *Ignore patient's basic needs*
- **Dependence** (being forced to rely on others for basic needs)
  - *Reinforcing patient's helplessness*
- **Intrusion** (transgressing a person's bodily or personal boundaries)
  - *Disrobing patient without patient's consent, not attending to male/female concerns*
- **Objectification** (treating a person like a thing, not a person)
- **Restriction** (limiting a person's ability to direct his or her own life)

– *Prison-like environment*

- **Trickery** (taunting, lying, or manipulating for material gain or psychological advantage)
  – *Deceit*
- **Grouping** (seeing a person not as a unique individual, but only as a member of a collective)
- **Labeling** (tagging a person with a descriptive term that carries a connotation of moral deficiency or social inferiority)
- **Vilification** (making a person appear threatening or dangerous)
- **Suspicion** (distrusting or treating a person as though he or she has committed bad acts)
- **Discrimination** (treating a person poorly based on achieved or ascribed status or apparent membership in a low-status group)
- **Exclusion** (making a person feel unwelcome or left out of physical or social settings)
  – *Excluding patient from tx/care plan development*
- **Exploitation** (using a person or viewing him or her only as a means to an end)
- **Deprivation** (lacking absolute or relative access to the necessities of life)
  – *Limiting patient's private/person time or space*
- **Revulsion** (treating a person as though he or she is disgusting or tainted)
- **Bullying** (threatening or intimidating a person)
  – *Intimidation, premature involvement of security, abuse of power*
- **Assault** (using physical force to damage or demean a person's body and the spirit)
  – *Use of force, punitive use of restraints*
- **Abjection** (forcing a person to humble him or herself by compromising closely held beliefs or by forced associations with material or practices considered unclean)

Source: Categories from Jacobson's A Taxonomy of Dignity: a grounded theory study (2009); terms and most of the parenthesized explanations are quoted from Jacobson.

Examples of "Making Amends"

Examples from workshop participants are in italics.

- Accept responsibility
- Take time to reflect on own actions/role in restraint event
- Make a plan as to how to make situation/relationship with patient better
- Debrief with the patient about the restraint event
- Return respect to the patient
- Journal or write about own perspectives regarding restraint event
- Acknowledge patient's struggle/experience
- Allow patient to tell their story
- Be honest
- Provide care and comfort to patient

- Work to reduce or avoid transference and counter-transference
- Avoid being punitive
- Use dialogue with patient which means true 2-way conversation
- Acknowledge breakdown in communications and therapeutic relationship
- Ask for genuine forgiveness
- Requires "radical genuine-ness" (as per DBT)
- Give the patient real options
- Communicate with the family
- Tailor discussions to patient's actual circumstances/state of mind
- Ask patient for their perspective/views
- Be accountable in terms of explaining own actions/decisions

Source: "Making Amends" concept from Margaret Urban Walker's Moral Repair (2006)