Emergency Mental Health and Substance Abuse Numbers:

Aetna HMO	(800) 755-2422
Cigna HealthCare	(800) 554-6931
DC37 Med-Team	(888) 447-2526
Empire EPO	(800) 767-8672
EMPIRE HMO	(800) 767-8672
GHI/CBP	(800) 692-2492
GHI HMO	(888) 447-2526
HIP Prime HMO	(888) 447-2526
HIP Prime POS	(888) 447-2526
Metro Plus Gold	(888) 475-6387
Vytra Health	(888) 447-2526

HHC NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

NYC Health and Hospitals Corp.

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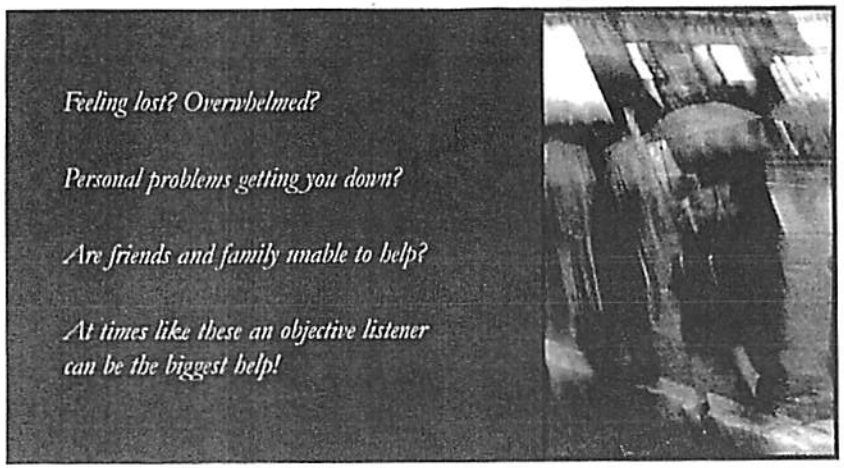

The New York City Health and Hospitals Corp offers its employees a helping hand through the concerned mental health professionals of the New York City Employee Assistance Program (NYC EAP).

What is the NYC EAP?

A confidential problem solving program available to employees of the New York City Health and Hospitals Corporation as well as spouses and dependents.

When should you call the EAP?

When there is something you've been wanting to talk about with an objective person who can help you think it through.

How can the EAP help?

An EAP counselor will speak with you in person or on the phone to help you sort through your difficulties and decide what steps to take to resolve the problem.

What does it cost?

Services are free to employees of the New York City Health and Hospitals Corporation and members of their immediate families.

What sort of problems can the EAP address?

Personal, family and job difficulties; alcohol and drug abuse; mental health problems including stress, anxiety and depression; and social service needs.

What resources can the EAP offer you?

The EAP can help you to get in touch with resources in your community such as childcare, eldercare and financial counseling, etc. Working with your health plan, we can help with treatment for alcohol or drug dependence, emotional and relationship problems. In all cases the EAP will work with you until you have help that is affordable and effective.

How can you get EAP services?

Just call the EAP and ask to speak to a counselor. The number is (212) 306-7660. After hours, leave a message and an EAP counselor will return your call as soon as possible.

Is EAP consultation confidential?

The personal information that may be discussed with the EAP is protected by confidentiality laws and regulations. Except in certain extreme situations, no information may be released without your written permission.

What if you don't want your job to know?

The EAP can arrange a meeting on your time (i.e. during lunch or on personal time).

Can your supervisor send you to the EAP?

Sometimes employees are referred to the EAP by supervisors, union representatives or disciplinary officers because their problems are interfering with work performance. As in all cases, participation is voluntary and the employee's rights to privacy and confidentiality are respected.

Can the EAP help when there is a traumatic event or loss on the job?

Often the EAP responds to workplace events by visiting the site and speaking to the employees involved to help them manage the emotional effects of trauma and loss.

Where is the EAP located?

Our office is located in downtown Manhattan at 250 Broadway, 28th Floor. Please call first to arrange an appointment.

You can reach NYC EAP at 212.306.7660.
or email us at eap@olr.nyc.gov

For further information, visit our website at **www.nyc.gov/eap**

Compliance Standards Pave the Way for Reducing Suicide in Health Care Systems

Julie Goldstein Grumet / Michael F. Hogan / Adam Chu / David W. Covington / Karen E. Johnson

Suicide is the tenth leading cause of death in the United States[1] and is increasing in almost every state, despite rates falling globally.[2] Often overlooked, health care systems and providers play an important and necessary role in reducing suicides. The myth has been that health care is not in a position to make a difference because most suicides do not occur within its scope, but emerging data paints a far different picture: 83 percent of those who die by suicide have seen a health care provider in the year before their death and 40–50 percent of suicide deaths have been within a month of a primary care visit.[3]

Almost 40 percent of individuals who died by suicide had an emergency department (ED) visit in the year before their death but did not receive a mental health diagnosis. In another study of over 1,600 individuals with low acuity chief complaint visits to the ED, of the 48 percent who agreed to take part in a mental health assessment, 11 percent were at high risk for suicide behavior with 5 percent having had no diagnosis of depression or bipolar disorder.[4] The health care landscape is ripe with the opportunity to identify, treat, and save people from suicide; however, most providers never ask people about their risk, most health care systems are poorly prepared to care for people at risk, and most individuals at risk often go undetected. These gaps in care are unnecessary based on current knowledge, and often fatal.

Recognizing the critical role of health care in preventing suicide, in 2012, the U.S. Surgeon General and the National Action Alliance for Suicide Prevention (Action Alliance) published a revised national strategy[5] with new goals 8 and 9, calling for suicide prevention to become a "core component" of health care, and for improved professional and clinical practices. The emphasis called out health care explicitly as a setting to reduce suicides. Suicide prevention had not previously

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been a priority. Most health care systems operated on the mistaken belief that suicide is an unfortunate but inevitable part of caring for persons with mental illness. Clinicians report being told, "If you haven't experienced the suicide of a patient, you haven't treated enough patients."

While health care seems to be an obvious setting to identify and reduce suicides, current research suggests that no single approach will reduce suicide among individuals who are in care. Comprehensive, multi-component, system-wide approaches to suicide prevention have been shown to be effective in broad and diverse settings and likely are the keys to reducing suicide.[6,7,8,9] Notably, training, protocols, practice guidelines, and quality assurance for fidelity to these practices must accompany any systemwide changes. Working closely with a health care system's researchers and information technology staff, compliance officers and risk management staff are critical to adopting and sustaining practice changes.

One of the earliest examples that an innovative approach to suicide care within a health care system could be highly effective was at the Henry Ford Health System (HFHS). Following the 2001 Institute of Medicine's *Crossing the Quality Chasm* report,[10] HFHS, located in Detroit, Michigan, began a robust quality improvement program that initially was designed to reduce depression among patients. The goal of its Perfect Depression Care initiative was "zero defect" mental health care.[11]

Stimulated by the call for fundamental changes to improve patient safety and aggressively pursuing zero defects, HFHS used deaths by suicide as one measure. Perfect Depression Care relied on suicide assessment for all behavioral health patients, means restriction for patients at acute risk for suicide, provider education, follow-up via phone calls, and peer support services. The HFHS Perfect Depression Care program reduced the suicide rate among patients receiving behavioral health care from an average of 96 people per 100,000 in 1999–2000 to an average of 24 per 100,000 in 2001–2010—a reduction of about 75 percent[12]—signaling that sustained and robust health care improvements could affect suicide rates and setting a new bar for health care leaders.

Based on the impressive HFHS results, evidence from other organizations demonstrating that reducing suicide among behavioral health patients is possible, and the emerging evidence for specific interventions, the Action Alliance Clinical Care and Intervention Task Force recommended a seismic shift in values and culture along with a set of practices for optimal suicide care in health care, called Zero Suicide. Zero Suicide embraces the conviction that a radical and systematic approach to perfection is the only way to create dramatic change. In short, preventing suicide for those in care is possible.

Zero Suicide is both a *concept*—the unrelenting commitment to eliminate suicide deaths in health care—and a set of practices—implemented within a sustained practice change effort. The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through multiple cracks in a fragmented and sometimes distracted health care system, and on the premise that a systematic approach to quality improvement is as necessary as it would be to reduce any systematic harm.[13] Zero Suicide fills the gaps that suicidal individuals fall through using training and evidence-based practices embedded in workflows to reduce harmful variation and increase patient safety. It bundles specific, evidence-based interventions shown to reduce suicide behaviors including:

- **LEAD**—A leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care that includes suicide attempt and loss survivors in leadership and planning roles.
- **TRAIN**—A competent, confident, and caring workforce.

- **IDENTIFY**—Systematic identification and assessment of suicide risk among people receiving care.
- **ENGAGE**—Compulsory suicide care management plans, or pathways to care, for those at risk that is both timely and adequate to meet the individual's needs and includes collaborative safety planning and restriction of lethal means.
- **TREAT**—Use of effective, evidence-based treatments that directly target suicidality.
- **TRANSITION**—Continuous contact and support, especially following acute care admissions.
- **IMPROVE**—A data-driven quality improvement approach that informs system changes that will lead to improved patient outcomes and better care for those at risk.

Since its earliest inception in 2012, the Zero Suicide framework has been implemented, refined, and tested by a broad range of health and behavioral health systems demonstrating both feasibility and improved outcomes. Benefits have included a spectrum of care improvements such as those related to changes to screening or safety planning practices and also longer-term outcome measures such as decreasing rehospitalizations, cost savings, and especially reductions in suicide attempts and deaths.

Though still early on in adoption, several large health and behavioral health systems have obtained reductions in suicide deaths and attempts with sustained Zero Suicide implementation over the past several years. Avera Health, an integrated Catholic health system spanning five states in the upper Midwest, began implementing Zero Suicide in 2016 and approximately a year later observed a 97-percent decrease in suicide attempts among patients who had previously been hospitalized in the behavioral health inpatient units.[14] At Centerstone, a large outpatient behavioral health nonprofit in Tennessee, the baseline rate for suicide before Zero Suicide implementation was 31/100,000. The suicide rate approximately three years into implementation dropped to as low as 11/100,000, a reduction of about 65 percent.[15]

While Centerstone implemented the model broadly, a central innovation was creating a standard care pathway for individuals with acutely elevated risk, including immediate and persistent follow-up with any individual at risk missing a scheduled appointment. The Institute for Family Health (IFH), a network of 31 community health centers in New York State, saw a downward trend in its annualized suicide death rate, which began at an already low level of 6.15/100,000 to a remarkable level of 0.98/100,000, or less than 10 percent of the current national rate.[16] Community Behavioral Health Centers (CBHCs) implementing Zero Suicide in Missouri saw a 32-percent reduction in suicide deaths over a two-year period during which the statewide rate was increasing.[17]

Metrics related to reductions in rehospitalization and diversions from inpatient care are critical in evaluating the impact of Zero Suicide implementation on patient outcomes. In addition to the reduction in suicide attempts mentioned above, Avera Health saw a 52-percent reduction in emergency psychiatric assessments, a 32-percent reduction in ED readmissions among patients who had received inpatient behavioral health services previously, and a 45-percent decrease in rehospitalization (emergency department or inpatient setting) among patients with suicidal ideation (based on question 9 of the PHQ-9).[18] Several inpatient psychiatric hospitals within the Universal Health Services (UHS) system, the largest inpatient psychiatric hospital system in the United States, also demonstrated drops in readmissions following suicide care improvements grounded in Zero Suicide and specifically focused on discharge planning and follow-up care. Notably, there was a nine percent decrease in 90-day readmissions and a 21-percent decrease in 30-day readmissions compared to previous year baselines in two separate

hospital locations where there was fidelity in implementation of new discharge planning and follow-up practices.[19,20] At The Chickasaw Nation Departments of Health and Family Services, compared to a yearly average of 120-150 inpatient treatment admissions, an average of 200 diversions from inpatient treatment was observed after Zero Suicide implementation.[21] A baseline comparison of mental health clinics in New York on dimensions of Zero Suicide fidelity and suicide deaths in the prior six months found fewer suicide deaths in clinics with better fidelity.[22]

While implementing all of the components of the Zero Suicide framework outlined earlier are judged necessary to achieve optimal change, indicators of progress should also be context-specific and tailored to the organization's mission (*e.g.*, behavioral health/primary care, acute/continuing care) and its priorities for Zero Suicide adoption. Measuring the faithfulness to implementation of each specific clinical intervention as well as the bundle of interventions ensures fidelity in implementation, a key ingredient of success. For example, after embedding the Stanley/Brown safety planning template in their electronic health record, providing training, and closely monitoring adherence to this practice over two years, safety plan use at IFH by primary care providers for their patients who screened positive for suicide increased from 38 to 84 percent.[23] In addition, AtlantiCare Health System, a large health system in New Jersey, increased the follow-up appointment show rate after discharge from inpatient psychiatric care from 50 to 100 percent among patients engaged in a new suicide prevention protocol consisting of a bundle of interventions that aligned with the Zero Suicide framework.[24] Within each of these successful agencies, their relentless commitment to continuous quality improvement unearthed discrepancies in fidelity, areas for training, and opportunities to improve care.

Even with policy and protocol changes, compliance with suicide safe care practices can take years to successfully install and demonstrate change. For example, in The Netherlands, on average, 40 percent of all suicides were by patients treated by mental healthcare institutions (MHIs).[25] Suicide researchers in The Netherlands observed a marked degree of practice variation in the care for patients at risk of suicide in The Netherlands with two out of three MHIs lacking well-defined suicide prevention standards. Essentially, whether suicidal patients received safe quality care was luck in getting to the right institution. As a result, in 2012, the Dutch practice guidelines for diagnosis and treatment of suicidal behavior were published alongside a train-the-trainer program. Evidence in The Netherlands indicated that implementing guideline recommendations for the diagnosis and treatment of suicidal behaviors significantly reduced the odds for patients to die by suicide. Marked practice variation, however, existed among the 24 specialist MHIs that were part of this study. Performance on six out of the 10 recommendations did not improve in three years, speaking to the need for a rigorous approach to quality improvement and compliance monitoring to achieve reliable safety and quality.

The evidence base for elements of safe and reliable suicide care has expanded dramatically in the past decade. Today, evidence exists for each of the individual components that are part of the Zero Suicide framework: standardized and routine screening and assessment,[26,27] collaborative safety planning,[28] reducing access to lethal means,[29,30] treatment that targets suicidal thoughts and feelings directly,[31] and follow-up during acute care transitions to reduce suicide,[32] as well as for fidelity to the bundle of interventions.

Despite the evidence for each of these practices, they are still underutilized. Health professionals should use these

effective approaches, but few providers received training on these practices in graduate programs or have them as required CEUs or CMEs. Additionally, only a small percentage of health care systems in the United States to date have adopted, trained staff on, and embedded these best practices.[33] Health professionals report difficulties in the clinical work with suicidal patients including a lack of knowledge about suicidality and effective interventions. Alarmingly, many health care providers still use outdated, even detrimental, practices such as no-suicide contracts.[34,35,36]

Even health care providers who are seemingly aware of best practices do not always employ them. A self-report study from Roush *et al*[37] identified that over 30 percent of mental health professionals did not ask every patient about suicidal thoughts or behaviors in first visits. While the majority of mental health professionals conducted a suicide risk assessment with suicidal patients (between 68 and 77 percent), the fact that 23 to 32 percent did not receive a suicide risk assessment despite known suicide risk is astonishing. Furthermore, this study did not address how suicide risk was assessed, meaning that it is not clear whether providers used a standardized tool or clinical judgment alone.

This study examined other suicide care practices and found that asking about lethal means was reported by only 34 percent of the clinicians. Removing access to lethal means is one of the single best practices to reduce suicide; however, it is significantly underutilized by health care providers. With suicide rates rising in the United States and the availability of interventions that work, the expectation that these best practices are "installed" by health systems and used reliably by the health care providers who work in them is essential. Needless to say, this will require professionals and payers to raise the bar on expectations, and health systems to assure quality improvement and compliance with these expectations.

As a harbinger that suicide care and expectations of providers are changing, the American Medical Association recently adopted resolution 312. It states that the AMA will "engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach." This is a clear signal to providers that using what works in suicide care is equally as important as would be expected for any other medical diagnosis.

Similarly, Resolution 71: *Creation of a Suicide Prevention Task Force and Resources for Pediatricians, Healthcare Organizations, Schools and Community Organizations Who Serve Children and Adolescents* was one of the top 10 American Academy of Pediatrics (AAP) Board of Directors resolutions adopted in March 2018. The AAP has released resources for pediatricians and is creating a centralized location on the AAP website for suicide care. In addition, the AAP is partnering with national organizations to enhance training and educational efforts for pediatricians and to advocate at the community, state, and federal levels for access to evidence-based mental health services.

To support health care organizations seeking to adopt a Zero Suicide framework, there is an online evolving toolkit available at www.ZeroSuicide.SPRC.org that includes tools, resources, and the research behind the interventions, developed and managed by the SAMHSA-funded Suicide Prevention Resource Center (SPRC). Recognizing that the workforce is ill prepared, SPRC offers an online workforce survey for health care systems who are adopting Zero Suicide and want to assess the self-reported comfort, competence, and skill of their workforce. Of over 15,000 health care providers who have taken the survey, results reveal that

less than one-third report feeling knowledgeable about warning signs for suicide, understand their organizational procedures for those at increased risk, and are confident in their ability to respond.[38] Only 35.5 percent report using a standard tool, instrument, or rubric for screening or assessment despite the availability of these resources. Among those responsible for delivering treatment (n = 4,101), only one-third strongly agree that they are confident or comfortable providing treatment to patients with suicide risk. These results present opportunities for local and national organizations and health care systems to create a set of expectations, offer tools, and educate staff.

There is a groundswell of evidence now that focusing on health care systems and the education of providers is a realistic, achievable, and necessary target for reducing suicide. Compliance responsibilities for health care organizations treating patients with elevated suicide risk are evolving rapidly, but until recently, there were few explicit expectations. The Joint Commission's 1998 Sentinel Event Alert[39] established the first "bright line" accountability for suicide in health care by defining suicide of a patient in a hospital (originally, only applied to psychiatric units or facilities) as a sentinel or "never event." Hospital accountabilities included a recommendation—not a requirement—for reporting to The Joint Commission, a requirement to conduct a Root Cause Analysis of the event, and to make indicated improvements. The Sentinel Event Alert was modified to apply to all areas within hospitals and to include suicides within 72 hours of discharge. More recently, under pressure from the Centers for Medicare & Medicaid Services (CMS), The Joint Commission has been focused in its surveys on eliminating "loopable" objects (anything that a patient could use with clothes or sheets to asphyxiate themselves) in psychiatric units.

The Joint Commission also established a related National Patient Safety Goal (NPSG) for hospitals with a focus on reducing or eliminating inpatient suicides. NPSG 15.01.01 was just updated in 2018 and was designed "to improve the quality and safety of care for those who are being treated for behavioral health conditions and those who are identified as high risk for suicide." A suite of suicide prevention resources to support Joint Commission Accredited organizations implementation of NPSG 15.01.01 was released November 2018.[40]

A recent systematic analysis of suicide deaths in hospitals revealed that the number of inpatient suicide deaths is substantially less than had been conjectured. Williams *et al*[41] used data from the Centers for Disease Control and The Joint Commission's own database to show that the number of inpatient suicides in the United States is only about 70 per year. This data, combined with studies[42] showing many more suicide deaths occur for patients being treated in outpatient settings, suggest that treatment efforts and the focus of compliance protocols should shift toward outpatient and emergency care settings. Given the still-inadequate supply of alcohol and drug treatment facilities, recent data are not available on suicide deaths among patients receiving substance misuse treatment; however, suicide rates are known to be extremely high for individuals with opioid use disorders.[43]

There is a paradox and challenge, however, that will have to be overcome for suicide care in outpatient settings to be successful. Expectations for safe and effective suicide care are not yet broadly established, and providers lack training in working with suicidal individuals. In an environment marked by fear of liability and constrained resources, hospitalization may be used for people who could be managed in community settings. While suicide deaths on inpatient units are

extremely rare, the rate of suicide deaths in the days and weeks following an inpatient admission is extremely high.[44] This high incidence of suicide deaths following inpatient admissions reveals a severe fissure in care and an opportunity for better collaboration and continuity of care. It is incumbent that health care leaders, and those who accredit their institutions, find solutions to these challenges through innovation and accountability. Further, medication treatment alone for underlying behavioral health diagnoses is often the norm, rather than integrated care addressing both underlying behavioral health concerns with psychosocial interventions for suicidality.[45]

The emerging compliance focus on preventing suicide must move beyond a focus on inpatient settings to improve safety and quality in ambulatory care settings and emergency departments. This emerging focus has been driven by the rise in and public concern about suicide rates, by the increased awareness of suicide's nexus to health care, and by development of effective ways to detect and manage suicidality. These trends are shaping an increased focus on "suicide care" beyond inpatient psychiatric care and increasing the need for managing compliance with adequate "suicide care" practices.

In just the last few years, a cascade of effective suicide care practices have led to explicit increases in compliance-ready expectations and a roadmap for the future. In 2012, the updated U.S. National Strategy for Suicide Prevention[46] signaled the emerging nature of this direction by adding goals specific to health care as an important setting for reducing suicide; galvanized by the work of a task force on clinical care and intervention, the Action Alliance made improved efforts in health care one of its major priorities; and successful demonstration that suicide could be reduced for those in care using a bundle of interventions was achieved.

In 2016, The Joint Commission issued Sentinel Event Alert 56,[47] urging "all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicidal ideation" (The Joint Commission, 2016). While such alerts do not have the force of accreditation standards, they signal attention to developing expectations. Other accrediting bodies (Council on Accreditation—COA and Commission on Accreditation of Rehabilitation Facilities—CARF[48,49]) made changes to their standards. These developments indicate that improved opportunities for suicide care are becoming explicit compliance expectations, and health care systems should be prepared to adapt to these expectations.

A final and recent development signaling increased compliance expectations for health care settings was the release of the report "Recommended standard care for people with suicide risk: Making health care suicide safe."[50] This 2018 report by the Action Alliance synthesized research (on effective identification of people with near-term risk of suicide, and on effective, mostly brief interventions) with an assessment of the feasibility and practicality of implementing these actions in typical health care settings. It is expected to help define acceptable care in ordinary settings, and thus to identify a framework for compliance and risk management.

Conclusion

Every minute of every day suicide is impacting the lives of hundreds of people across the nation. It robs us of our family, friends, colleagues, and our community's most valuable resource, our people. Perhaps surprisingly, health systems and settings are both a part of this problem and likely a central part of the solution. Medical and clinical professionals have always saved lives, but Zero Suicide shows they can have a far deeper impact.

Addressing care of suicidal patients is both a quality and safety imperative. Evolving accreditation requirements along with an improved understanding of the dynamics inside health care organizations has resulted in a singular focus on raising the questions and solving problems that at one time were deemed to be too time consuming or difficult to solve. The evidence now exists for the effectiveness of both the elements of suicide safe care and for the comprehensive, bundled approach known as Zero Suicide; however, much work must be done. It is clear that systematic and measurement-based approaches to implementation—in other words embedding compliance into care—are essential. These multi-layered approaches assure that no one slips through the cracks.

Insightful leaders committed to the pursuit of Zero Suicide will help us make significant strides toward eliminating these tragic and avoidable deaths. For health care organizations, in addition to training and implementing suicide care pathways, this will require extending compliance activities to assure implementation steps are adequate, and to minimize risk exposure. Payers and regulators will need to consider whether to embed expectations about standard suicide care practices in contracts, accreditation, and licensure requirements. Turning back the tide of rising suicide deaths is possible. Health care organizations around the world are becoming central players in solving this complex problem. This cannot occur successfully without building suicide care expectations into the clinical and compliance fabric of the health system.

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De-escalation in health care

Issue:
The need for using de-escalation techniques has become more prevalent as violence in health care settings increases. De-escalation is a first-line response to potential violence and aggression in health care settings.[1] The Centers for Disease Control and Prevention (CDC) has noted a rise in workplace violence, with the greatest increases of violence occurring against nurses and nursing assistants.[2] A three-year study in the *American Journal of Nursing* noted that 25 percent of nurses reported being assaulted by patients or the patient's family members. Statistically, higher rates of health care violence are reported to occur in the emergency department (ED), geriatric and psychiatric settings.[2]

The purpose of this Quick Safety is to present some de-escalation models[1] and interventions for managing aggressive and agitated patients in the ED and inpatient settings. There are many different de-escalation techniques; this Quick Safety is intended to guide health care professionals to resources for more information and training.

It should be noted that there is little research about the efficacy of de-escalation, and there is no guidance of what constitutes the gold standard for practice.[1] A Cochrane review acknowledges that this leaves nurses to contend with conflicting advice and theories regarding de-escalation.[3] However, some de-escalation studies have concluded that the positive consequences of de-escalation include:[1]

- Preventing violent behavior
- Avoiding the use of restraint
- Reducing patient anger and frustration
- Maintaining the safety of staff and patients
- Improving staff-patient connections
- Enabling patients to manage their own emotions and to regain personal control
- Helping patients to develop feelings of hope, security and self-acceptance

What is de-escalation and what is its purpose?
The literature has several definitions of de-escalation[1,3] and uses other terms for de-escalation, including conflict resolution, conflict management, crisis resolution, talk down, and defusing.[1] For the purposes of this Quick Safety, we describe de-escalation as a combination of strategies, techniques, and methods intended to reduce a patient's agitation and aggression. These can include communication, self-regulation, assessment, actions, and safety maintenance in order to reduce the risk of harm to patients and caregivers as well as the use of restraints or seclusion. (See the sidebar for an example of using de-escalation.)

Injuries to patients and staff can occur during the use of restraints. Data from the Cochrane Library reveals that in the United States, 40 percent of restraint-related deaths were caused by unintended asphyxiation during restraint.[3] The use of restraint and seclusion creates a negative response to the situation that can be humiliating to the patient, and physically and emotionally traumatizing to staff involved.[3] Also, it impacts the trust between the patient and health care professionals. Restraint and seclusion should be a last resort, used after other interventions have been unsuccessful, and done to protect the patient, staff and other patients in the area from physical injury.

Example of using de-escalation

A psychiatric unit nurse recounts how he intervened in a power struggle between a patient and an inexperienced nurse and elicited the story from the patient:[5]

"I went into the patient's room and he was very agitated. I asked him if I could sit down and talk to him a few minutes, just to see what was going on with him. I found out during the interaction with the patient that one of the things that had escalated him was that he was threatened. He was told that he would get an intramuscular (IM) injection of medication. And I found out that he was very afraid of needles and so that upset him even more. And, if we had attempted to give him an IM, he was going to fight us tooth-and-nail."

Abridged from: Johnson ME & Hauser PM. "The practices of expert psychiatric nurses: Accompanying the patient to a calmer personal space." *Issues Ment Health Nurs* 22, no. 7 (2001): 651-668.

The Joint Commission

Recognizing the aggressive patient

In the mental health setting, dealing with aggressive patients can be an everyday occurrence.[3] Acute inpatient psychiatric settings may have patients who exhibit risk-prone behaviors, such as verbal aggression, attempts to elope, self-harming behaviors, refusing to eat or drink, and displaying aggression to objects or people.[4] The ED has its own set of challenges. Patients come to the ED with hallucinations, hearing voices, or they may be under the influence of unknown substances. Upon entry, a triage nurse must assess the patient.

A number of assessment tools are available to help health care professionals recognize the aggressive patient, including:

- STAMP (Staring, Tone and volume of voice, Anxiety, Mumbling, and Pacing) is a validated tool for use in the ED.[5]
- Overt Aggression Scale (OAS) is a reliable tool for use in the inpatient setting for children and adults.[6]
- Broset Violence Checklist (BVC) has been validated for use in the adult inpatient psychiatric unit.[5]
- Brief Rating of Aggression by Children and Adolescents (BRACHA) has been found to be a valid tool for use in the ED to determine the best placement on an inpatient psychiatric unit.[6]

De-escalation models

The following cyclical de-escalation models from the literature advocate considerable flexibility in the use of different skills and interventions:

- The ***Dix and Page*** model consists of three interdependent components: assessment, communication and tactics (ACT). Each should be continuously revisited by the de-escalator during the incident.[1]
- Similar to Dix and Page, the ***Turnbull, et al.*** model additionally describes how the de-escalator evaluates the aggressor's response to their use of de-escalation skills by constantly monitoring and evaluating feedback from the aggressor. The authors stress that flexibility in individual cases is more important than basing de-escalation on a few well practiced skills, or using those skills in a pre-determined order, since what may be de-escalatory for one person may be inflammatory for another.[1]
- A linear model is the ***Safewards Model***, which begins with delimiting the situation by moving the patient or other patients to a safe area, and maintaining a safe distance; clarifying the reasons for the anger using effective communication; and resolving the problem by finding a mutually agreeable solution. The model stems from a randomized control trial conducted in the United Kingdom to look at actions that threaten safety and how staff can act to avoid or minimize harm. The trial concluded that simplistic interventions that improve staff relationships with patients increase safety and reduce harm to both patients and staff.[4]

Interventions for defusing aggression

The following interventions can be used to defuse an aggressive situation in both the ED and inpatient psychiatric setting:[3,5]

- Utilize verbal communication techniques that are clear and calm. Staff attitudes must be non-confrontational in use of verbiage. Avoid using abbreviations or health care terms.
- Use non-threatening body language when approaching the patient.
- Approach the patient with respect, being supportive of their issues and problems.
- Use risk assessment tools for early detection and intervention.
- Staff attitudes, knowledge and skill in using de-escalation techniques must be practiced and discussed in an educational format.
- Respond to the patient's expressed problems or conditions. This will help create a sense of trust with the health care professional.
- Set clear limits for patients to follow.
- Implement environmental controls, such as minimizing lighting, noise and loud conversations.

On inpatient behavioral health units, there are three approaches that can be used to decrease aggression throughout the unit, using a multidimensional aggression assessment process:[7]

- ***Patient-centered care approach:*** Each patient should undergo a medical exam to rule out any underlying disease or condition; a nursing history and social history should be obtained; an aggression assessment should be conducted using a valid or reliable tool; and a psychiatric evaluation should be completed, including observation for cues or signals of approaching anxiety or aggression.

- ***Staffing-centered approach:*** Therapists and staff have training, skills, knowledge and competencies in appropriate areas, including de-escalation. Staff and therapist approach patients with respect, and are non-controlling, unprovocative, non-confrontational, and non-coercive. Staff have very good interpersonal skills.
- ***Environmental-centered approach:*** Diversionary activities should be available at all times. The physical layout should allow patients to move about freely, without feeling cramped, and provide for personal space. Apply consistent unit rules to every patient. Avoid loud conversations and additional noise whenever possible. Maintain a small census and shorter length of stay whenever possible.

The 10 interventions to reduce conflict and minimize harm of the Safewards Model are:

1. Mutually agreed upon and publicized standards of behavior by and for patients and staff. Patients and staff meet as a group to discuss these expectations for behaviors while on the unit.
2. Short advisory statements (called soft words) to be used during flashpoints, hung in the nursing office and changed every few days.
3. A de-escalation model used by best de-escalator on the staff (as elected by the ward concerned) to increase the skills of others on the ward.
4. A requirement to say something good about each patient at nursing shift handover.
5. Scanning for potential bad news a patient might receive from friends, relatives or staff, and intervening promptly to talk it through.
6. Structured, shared innocuous personal information between staff and patients (such as, music preferences, favorite films, and sports) via a 'know each other' folder kept in the day room.
7. A regular patient meeting to bolster, formalize and intensify interpatient support.
8. A crate of distraction and sensory tools to use with agitated patients (for example, stress toys, mp3 players with soothing music, light displays, textured blankets).
9. Reassuring explanations to all patients following potentially frightening incidents.
10. A display of positive messages about the ward from discharged patients.

In addition, the Crisis Prevention Institute (CPI) published a list of Top 10 De-Escalation Tips that can be used in health care, human services, business, or any field where workers might deal with angry, hostile, or noncompliant behavior. The tips are designed to help workers respond to difficult behavior in the safest, most effective way possible.

Safety actions to consider:

There are a number of actions that health care organizations can take to make sure that staff is prepared to intervene and de-escalate a potentially dangerous or harmful situation should a patient become aggressive or agitated. The following strategies are derived from the Safewards Model:[4]

- Commitment by senior management to change. Leadership must endorse resources needed to educate staff, and allow time to audit the interventions and environmental changes needed to create the most therapeutic unit possible.
- Use audits to inform practice. The Patient Staff Conflict Checklist (PCC)[4] is an example of a reliable and valid tool. At the end of each shift, the charge nurse records the number of times conflicts (actions that threaten safety) and containments (restraint, seclusion or observation) occurred — not the number of patients involved.
- Implement workforce training on new techniques and interventions.
- Incorporate the use of assessment tools.
- Involve patients.
- Use debriefing techniques.

Should violence occur despite efforts to de-escalate the situation, organizations should be prepared to address workplace violence issues, as described in Sentinel Event Alert 59, "Physical and verbal violence against health care workers."[9] The alert provides suggested actions, including:

- Clearly defining workplace violence and putting systems in place across the organization that enable staff to report workplace violence instances, including verbal abuse.
- Recognizing that data come from several sources, capture, track and trend all reports of workplace violence—including verbal abuse and attempted assaults when no harm occurred, but in which the health care worker feels unsafe.
- Providing appropriate follow-up and support to victims, witnesses and others affected by workplace violence, including psychological counseling and trauma-informed care if necessary.

- Reviewing each case of workplace violence to determine contributing factors. Analyzing data related to workplace violence, and worksite conditions, to determine priority situations for interventions.
- Developing quality improvement initiatives to reduce incidents of workplace violence.
- Training all staff, including security, in de-escalation, self-defense and response to emergency codes.
- Evaluating workplace violence reduction initiatives.

Resources:

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2. Brous E. "Workplace Violence: How It Affects Health Care, Which Providers Are Most Affected, and What Management and Staff Can Do About It." *AJN* 118, no. 10 (Oct 2018):51-55.
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Note: This is not an all-inclusive list.

Other resources:

"**Safewards: An Introduction**." London UK: Society of Mental Health Nursing, Institute of Psychiatry Health Service and Population Research, 2018. The website includes full descriptions of interventions, training videos, downloadable document templates, planning and implementation guidance, and a web-based forum offering support.

Hallet N and Dickens GL. "De-escalation of Aggressive Behaviour in Healthcare Settings: Concept Analysis." *IJNS* 75 (2017):10-20. Article includes a table of the attributes of de-escalation in the five areas of communication, self-regulation, assessment, actions, and maintaining safety.

Johnson ME & Hauser PM. "The practices of expert psychiatric nurses: Accompanying the patient to a calmer personal space." *Issues Ment Health Nurs* 22, no. 7 (2001): 651-668. This interpretive phenomenological study includes several real-life examples of using de-escalation techniques.

Mavandadi V, et al. "Effective Ingredients of Verbal De-escalation: Validating an English Modified Version of the 'De-escalating Aggressive Behaviour Scale.'" *J Psychiatr Nurs Ment Health Serv* 23 (2016): 357-368.

Gaynes BN, et al. "Preventing and De-escalating Aggressive Behavior Among Adult Psychiatric Patients: A Systematic Review of the Evidence." *Psychiatr Serv* 68 (2017): 819-831.

Workplace Violence Resources:

The Joint Commission

- "Physical and verbal violence against health care workers." Sentinel Event Alert 57 (2018)[9]
- Workplace Violence Prevention Resources
- Questions & Answers: Hospital Accreditation Standards & Workplace Violence
- Improving Patient and Worker Safety (Pages 95-108)[27]

Occupational Safety and Health Administration (OSHA)

- Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers
- Preventing Workplace Violence in Healthcare

The Joint Commission.