Encouraging Alternatives to Seclusion, Restraint, and Reliance on PRN Drugs in a Public Psychiatric Hospital

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Reliance on seclusion, restraint, and psychotropic PRN (as needed) medication for behavior management has been tied to a variety of untoward outcomes that detract from the quality of care in public psychiatric hospitals. A large body of evidence has accumulated to demonstrate that behavioral approaches to care can provide useful alternatives to reliance on seclusion, restraint, and psychotropic PRN medications. This article draws from the research to outline how behavioral approaches to psychiatric care can assist in realizing alternatives to these restrictive interventions. Strategies to assess the behavioral competence of direct care staff, improve it, and establish ward programmatic structures that facilitate competent behavioral applications are discussed as well as methods to enable expert consultation and demonstrate clinical and administrative support. These steps have had a positive impact in reducing reliance on seclusion, restraint and psychotropic PRN medication in the inpatient psychiatric setting. Given the wealth of supportive data to confirm the value of behavioral applications, there is no excuse for failing to aggressively pursue these options. (*Psychiatric Services* 56:1105–1108, 2005)

Public-sector providers of inpatient psychiatric care effectively become the setting of last resort for persons with severe, persistent, and frequently dangerous impairments who have not adequately responded to services available in the community or private sector (1). Because such care is often provided within a context of significant resource limitations, there is sometimes an unnecessarily high reliance on restrictive intervention measures—such as seclusion, mechanical restraints, or the use of psychotropic PRN (pro re nata, or as needed) medication to achieve sedation—under conditions that jeopardize safety (2).

The reliance on seclusion or mechanical restraints to manage problem behavior contributes to negative opinions among consumers about the quality of inpatient care received (3,4) and to conflicts with advocates about the right to receive active rehabilitative treatment without unnecessarily restricting freedom of movement (5). For example, the unnecessary reliance on seclusion, restraint, and psychotropic PRN medication for behavior management has been a primary focus of human rights litigation generated by the U.S. Department of Justice (DOJ) against state psychiatric inpatient facilities.

Similar observations can be made about the reliance on psychotropic PRN medication to minimize challenging behaviors. Relying on psychotropic medication for its sedative effect can make it less likely that individuals will develop the daily living and coping skills needed to function outside the inpatient setting (1,6). Furthermore, the use of benzodiazepines, a common class of psychotropic PRN medication, is contraindicated for a large proportion of public-sector inpatients who have a history of comorbid alcohol or substance use disorder (7).

Issues such as these make it prudent for inpatient care facilities to seek alternatives to seclusion, restraint, and PRN medication for managing challenging behaviors. One promising alternative is to promote the clinical application of interventions grounded in behavioral science and technology. Despite the confirmed value of these evidence-based approaches for managing challenging behaviors and encouraging the acquisition of skills critical for successful transition to outpatient environments (8), these approaches are underused or employed ineffectively in many inpatient psychiatric settings (9–11).

This finding becomes more salient in light of the growing body of evidence that directly supports the value of behavioral intervention methods specifically for reducing reliance on seclusion, restraint, and psychotropic PRN medications (12–14). This article reviews several factors that emerge from these studies as important for optimizing behavioral competence and reducing such reliance within an inpatient psychiatric facility.

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Assess behavioral competence

Although the increasing expectation among oversight agencies is that direct care staff members will implement rehabilitative treatment plans that capitalize on existing technology that focuses on changing behavior, critics note that these staff and their supervisors seldom have an adequate understanding of the concepts and procedures involved in actively providing behavioral rehabilitation (15). However, studies demonstrate that competence in behavioral rehabilitation—or behavioral competence—among psychiatric direct care staff can be assessed in a cost-effective manner that directly addresses quality indicators of measurement, such as internal consistency, temporal stability, content validity, construct validity, and, most important, criterion-related validity (16–18). These methods directly assess situations that direct care staff encounter in their daily practice.

Among a variety of other focal competencies, these measures demonstrate that staff members who practice behavioral competence recognize how the environment, including their own behavior, can influence the behavior of others; proactively identify and reinforce behaviors relevant to the transition to an outpatient setting, regardless of whether these behaviors are related to problems; and differentially reinforce preferred alternatives upon recognition of early problem behaviors that may escalate. Such measures can be used by clinical administrators to establish staffing patterns and plan programming to facilitate active behavioral rehabilitation.

The value of direct care staff who are behaviorally competent is highlighted in the following case. Mr. J, who had a severe deficit in expressive speech, suddenly began experiencing agitation, during which he would grunt loudly and push at others in his vicinity. The increased reliance on seclusion influenced the psychiatrist to establish a PRN option, and the dosage of Jerry's standing medication was increased. A psychiatric aide informed the consulting psychologist that these episodes seemed to be associated with the administration of liquid dietary supplements to other patients in the room. On the basis of this observation, the staff began giving Mr. J fruit punch whenever others received their supplements. The agitation and associated reliance on seclusion and PRN medication were immediately eliminated.

Improve behavioral competence

Research demonstrates that with proper training behavioral knowledge and competence can be improved among all direct care providers (17,19). A variety of corollary benefits will accrue from realizing improved levels of behavioral competence. For example, among psychiatric aides, the most prevalent class of direct care providers, higher levels of behavioral knowledge and competence translate to lower levels of occupational stress. Psychiatric aids who have higher levels of behavioral knowledge and competence are also less likely to be frustrated and dissuaded by common organizational system impediments, such as poor staffing and inadequate programming resources. Furthermore, they report that they are more active in attempts to apply lessons learned in behavioral training during their interactions with patients and experience more success in their attempts to facilitate desired changes in patient behavior (20–22). Such results are consistent with self-efficacy theory (23).

Improved behavioral competence enhances the likelihood of contributions by direct care staff, such as the contribution described above in Mr. J's case. The following example emphasizes the importance of being able to gauge the quality of training that is offered. A state's mental health department sponsored systemwide training to "improve behavior interaction and management techniques" used by direct care staff. However, pre-post assessment of this training with the hospital's behavioral competence measure demonstrated that the training did not improve the staff's knowledge or competence of how to address the common challenges faced in their everyday practice. Consequently, a program that had been previously developed by behavioral staff within this hospital and that had been demonstrated to significantly improve knowledge and competence scores (19) was retained as required training for all direct care staff.

Create an environment that facilitates application of skills

Although proper training can increase the behavioral competence of all direct care staff, it is clear that preexisting differences among different classes of staff will remain (24). Thus there remains a need for administrative structure that not only encourages the competent application of behavioral skills by staff but also ensures effective oversight by those who are relatively more competent in this area of practice.

Such structures have been developed and studied. More than a half century of research has confirmed the value of models of psychiatric inpatient programs that are based on behavioral science, such as token economies and other contingency management programming (25–27). These organizational models can be adapted in a variety of ways to address the specific needs of patients. For example, traditional token economies can be established in long-term care settings, such as forensic psychiatric wards (28), whereas rehabilitative settings, which have a greater likelihood of active transition to the community, can emphasize the interpersonal behavior of staff as antecedents and consequences for fostering more adaptive self-regulation (29,30).

The following case highlights how such models can be adapted to facilitate a transition toward improved self-reliance. Ms. A had required multiple hospitalizations over several years. In frustration, many staff had labeled her as a "world-class borderline" because of persistent "attention-seeking" complaints about physical ailments and a variety of other problems. Their past efforts to reason with her or ignore her complaints had frequently resulted in exacerbations of the behavior, which led to a reliance on PRN medication and restraint for behavior management.

The behavioral consultant developed a check system for each hour without specified disruptive behaviors. Desired snacks and several other incentives were available in the

ward's token store for consecutive hours of success. Staff proactively engaged in incidental conversation as long as checks were being earned. With success, Ms. A began attending classes off the ward. She earned points for attendance and participation, which were exchanged on the ward for money that could be spent in a canteen off of the ward and later at stores such as Wal-Mart during off-grounds trips. In addition, staff would compliment Ms. A to reinforce positive behavior. The point system was replicated in her community placement after discharge. The system was later scaled back and eventually terminated after Ms. A obtained supported employment.

Facilitate access to expert consultants

However, even within the structure of a sound behavioral program, exceptionally challenging cases will inevitably be encountered. Such cases will require attention from individuals who have expert-level training and experience in the application of behavioral methods (31).

Such expert-level preparation and competence are rarely included in the clinical privileging of psychiatric hospitals. Despite this lack of recognition, the prioritization of reducing seclusion and restraint by review agencies, such as the Joint Commission on Accreditation of Healthcare Organizations and the DOJ, has stimulated interest. The establishment or enhancement of a behavioral consultation capability is a frequent outcome of human rights litigation pursued by the DOJ.

Individuals with exceptional qualifications in the area of behavioral applications can be identified. Such expertise has been specifically delineated as a postdoctoral specialty within clinical psychology (32) and procedures exist for the certification of expert preparation for the application of behavioral methods (33).

By realizing such a capability for consultation, the hospital facilitates needed guidance and oversight for exceptionally challenging cases, such as the one illustrated by the following example. Concerned about data that showed a reliance on seclusion and restraint, a hospital's psychology department began a program to review all cases exceeding a criterion level of three PRN administrations of psychotropic medication within a week and instigated a behavioral consultation and plan when indicated. A 60 percent reduction in reliance on seclusion and restraint was realized after the implementation of such plans (12). The reductions were realized despite the fact that this review procedure was administered within a single clinical department and was not formally part of the hospital's interdisciplinary quality management efforts.

Maximize the impact through clear administrative support

Despite evidence of the positive impact of the efforts reviewed above, their impact can be strengthened through clear support by clinical administrators within the facility. The departmental review procedure that was described above was expanded beyond the bounds of the clinical department in which it was developed to ensure that key clinical administrators were involved in the review process. By involving these clinical administrators and systematically lowering the threshold for case reviews, overall reliance on seclusion and restraint was further reduced within this facility (13,14). When this specific innovation was compared with a variety of other organizational efforts to reduce seclusion and restraint, the innovation was found to be the single most potent factor that was responsible for the reduction of seclusion and restraint (14).

Studies also demonstrated that when the review procedure was expanded to include reliance on psychotropic PRN medication, this type of medication was significantly reduced as well (13). The review found that weekly psychotropic PRN administrations, about 85 percent of which were benzodiazepines, were reduced by about 33 percent. This reduction in PRN reliance was realized concurrently with reductions in reliance on seclusion and restraint through application of the same procedure, which provided evidence that reduced reliance on seclusion and restraint does not have to result in increased reliance on psychotropic PRN use for behavior management.

The importance of administrative support is illustrated by the following information from the facility discussed above. As this hospital's reliance on psychotropic PRN medication decreased, it became apparent that an individual ward was relatively highly reliant on psychotropic PRN medication. The psychiatrist argued that it would be disruptive and dangerous to minimize the use of lorazepam as a PRN medication for managing problem behaviors on this ward. A review by the committee, which included the hospital's director and medical director (both psychiatrists), was able to encourage the implementation of several behavior plans. The number of individuals who were given PRN medication three or more times a week was reduced from five or six patients a week during the ten weeks before the review to one or two patients a week within several weeks after the review. This reduction was realized without an increase in dangerous incidents.

Furthermore, the implementation of such a procedure does not have to involve a significant amount of time from clinicians or administrators. For example, the project outlined above (13) later initiated a self-review option for the treatment team, in which leaders of the treatment team initially assessed their own management of threshold cases according to criteria used by the review committee. Through implementation of this option, steps to reduce reliance were facilitated and fewer formal reviews by clinical and administrative committees were required.

Discussion and conclusions

Unnecessary reliance on seclusion, restraint, and psychotropic PRN medication for behavior management can provoke a variety of untoward effects that detract from the quality of care. These interventions often lead to negative evaluations of the quality of care provided. The process of applying seclusion and restraint can stimulate further aggression. The reliance on psychotropic PRN medication can promote conditions such as

drowsiness that interfere with the ability to acquire new knowledge and skills. Furthermore, the reliance on benzodiazepines as a PRN option can maintain a physical addiction. Clearly, alternatives to these interventions should be seriously considered.

A large body of evidence has accumulated to demonstrate that behavioral approaches to care can provide useful alternatives to reliance on seclusion, restraint, and psychotropic PRN medications. The research outlined above confirms that behavioral competencies among all levels of direct care staff can be measured and improved. The application of these competencies can be enhanced through the ward's program structure. The positive impact can be further enhanced through the administrative support of clinical leaders. Beyond these steps, the availability of experts in the area of behavior consultation has been demonstrated as useful for exceptionally challenging cases.

Thus psychiatric care facilities can capitalize on these results by developing training programs, ward management practices, and clinical and administrative structures that make more adequate use of behavioral science and technology. Given the wealth of supportive data to confirm the value of behavioral applications, there is no excuse for failing to aggressively pursue these options. ♦

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