November 5, 2021

Andrew Levinson
Acting Director
Directorate of Standards and Guidance
Occupational Safety and Health Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20010

Dear Director Levinson:

Thank you and your staff for taking time to meet with representatives of our organizations on August 6, 2021. We share a common interest in increasing access to and ensuring the quality of mental health and addiction treatment and support the Occupational Safety and Health Administration's (OSHA's) goal of ensuring the safety of personnel in all healthcare settings including those focused on behavioral health.

As we discussed, our organizations represent those providing or receiving treatment in the many levels and environments of care where people access mental health or substance use disorder treatment [e.g., acute inpatient, ambulatory, residential, and outpatient settings]. Providers of care in these settings are uniquely and highly experienced in both anticipating and preventing agitated behavior. Mental health and substance use disorders can sometimes cause aggressive acts— often out of fear and/or misunderstanding. These conditions can result in confusion, impulse control challenges, delusions, and outright hallucinations. Individuals who receive treatment in psychiatric hospitals have very serious, medically-diagnosed conditions that can cause behaviors that pose a risk of danger to self or others resulting in involuntary commitment to these settings. This can further heighten the risk of aggressive behavior due to confusion, anger, or fear. Providers in other behavioral healthcare settings including outpatient and residential settings also have extensive, direct experience addressing agitated and aggressive behavior. We recognize that the potential for such behavior can pose risks to other patients and staff nearby.

Drawing upon this extensive experience and numerous research studies, behavioral healthcare providers have developed and implemented evidence-based practices proven to reduce the risk of violence in treatment settings. The following summary highlights these techniques and includes citations to research that demonstrates their effectiveness in behavioral healthcare settings.

Administering evidence-based risk assessments upon admission:

- Research has informed development of valid and reliable risk-assessment tools that can be used "to implement preventive safety measures, reduce the incidence of inpatient aggression and improve quality of care."[i]

- Risk management and risk assessment are founded on peer-reviewed published literature focusing on predictive factors associated with violent behavior among individuals in treatment settings.[ii]
- A recent review of related research concluded that "[risk] assessment of violence by patients appeared to be the way to effectively minimize the occurrence of WPV [workplace violence] and, consequently, to better protect mental HCWs [health care workers]."[iii]

Using risk assessments to develop and implement individualized care plans as well as psychiatric advance directives that address any issues related to violence:

- Studies on risk assessment demonstrate that by "looking at history of violence, in addition to clinical and other historical factors, clinicians can identify which patients present the most risk of exhibiting violent behavior and whether the violence would most likely flow from psychosis, impulsivity, or predatory characteristics. With that information, clinicians can provide environmental and treatment modifications to lessen the likelihood of violence."[iv]
- Behavioral treatment plans and contingency management programs have been demonstrated to reduce violence and associated use of seclusion and restraint.[v]
- Psychiatric advance directives (PADs) are legal tools that allow a person with mental illness to express their preferences for treatment, who to contact in their support network, and how to best support the person in advance of a crisis. "PADs can also enhance the therapeutic alliance by helping people feel more connected to their clinicians and service providers."[vi]
- Research studies have found that people with PADs experience significant improvement in their relationship with their clinicians and fewer coercive crisis interventions as well as increased perception that their mental health needs are being met.[vii]

Implementing risk assessment and management to avoid the use of seclusion, restraint, and psychotropic medication:

- "The literature on reducing patient aggression on adult inpatient units emphasizes two factors: first, the importance of early assessment and identification of patient characteristics that may be indicative of aggression and, second, strategies to reduce the use of seclusion and restraint on these units using systems measures or protocols."[viii]
- There is substantial evidence that use of seclusion and restraint results in injuries among staff and patients.[ix]
- Agitation or disorientation are often the reason for use of restraints and seclusion.[x]

Using behavioral management techniques and promoting staff engagement with patients:

- Behavioral management techniques have been shown to help manage challenging behaviors and encourage the acquisition of skills critical for successful transition to outpatient environments. [xi]
- Safe environments in behavioral health treatment settings require staff members to be proactive and intervene quickly.[xii]
- To improve safety, patients need to feel that they have a connection to staff who are available and recognize their needs as legitimate.[xiii]

Establishing a therapeutic milieu reflecting research on how physical and interpersonal environments affect mood and interactions between providers and patients:

- Environmental modifications, structuring activities, establishing effective interactions with patients, and teaching caregivers to manage conflict behavior have been shown to reduce aggressive behavior by patients.[xiv]
- Evidence suggests that use of color in a facility can influence mood and behavior.[xv]
- Use of sensory rooms or strategies have been shown to reduce distress in individuals with serious mental health conditions and may reduce the use of seclusion and restraint which is often associated with increased risk of injury.[xvi]

Incorporating trauma-informed care to inform both environmental interventions and settings:

- "Understanding and applying neuroscience and implementing a cultural change of trauma-informed care" can help reduce workplace violence in treatment settings.[xvii]
- Trauma-informed care has resulted in an array of environmental, interpersonal, and patient-centered strategies that prevent violence behavior in treatment settings.[xviii]
- "Many studies identified attention to the physical environment as a significant, positive (and relatively inexpensive) trauma-informed care strategy [including through the] refurbishment of units to provide a welcoming physical environment including using comfortable home-like furniture; warm and inviting colour schemes; art and craft hangings; soothing soft furnishing . . ."[xix]

Conducting debriefing sessions when incidents do occur including the patient's perspective to inform additional prevention measures:

- Studies of post-incident reviews indicate that care providers find them useful in offering other perspectives and solutions for avoiding future incidents and empowering patients to develop new coping strategies.[xx]

Providing clinician and staff development/training on de-escalation techniques:

- Research studies demonstrate the link between staff de-escalation and aggression management training and reductions in violence.[xxi]
- For example, implementation of an aggression management program that was comprised of staff training, staff support program, risk assessment tools, and an incident monitoring system resulted in "a significant decrease in the number of staff injuries reported in the [following] 3-year period". This decrease occurred despite increasing acuity of the clients at the study facility.[xxii]
- Another study found that training programs focused on improving risk assessment, de-escalation, emotional intelligence, and communication skills for nurses are effective at reducing patient violence in mental health settings.[xxiii]

Implementing an organizational structure that supports staff:

- An organizational culture that defines critical elements of treatment and safety policies while maintaining an environment and working conditions that support staff is key to safe treatment settings.[xxiv]
- Acknowledging the stressfulness of these environments and supporting staff are critical for ensuring staff and patient safety.[xxv]

Offering resiliency training for clinicians and staff:

- Research studies have shown resiliency training can improve mental well-being and decrease traumatic stress among healthcare workers.[xxvi]

Guiding Principles

Evidence (including the research referenced above), experience in implementing these approaches, and expertise in addressing underlying conditions that can trigger aggressive behavior all inform the following set of principles that we hope OSHA will consider when developing workplace violence standards and/or any operational guidelines for surveyors of mental health or addiction treatment settings:

- Support the use of valid and reliable risk assessment tools and PADs to develop individual care plans including behavior management techniques to prevent violence;
- Support increased provision of trauma-informed care;
- Support continued reductions in the use of seclusion and restraint;
- Avoid the use of uniformed security guards or law enforcement for behavioral management in instead use highly trained behavioral healthcare staff;

- Ensuring the content and frequency of training is adequate for the level of acuity of your patient population;
- Encourage the use of peers to improve engagement and de-escalation;
- Support provision of a therapeutic milieu for individuals in need of mental health and addiction treatment, including:
    - Ongoing staff involvement in setting policies that designate preventive techniques;
    - Minimizing physical barriers in favor of open spaces to encourage interactions with between patients and staff;
    - Providing areas where staff can self-seclude when necessary in violent situations;
    - Offering comfort rooms and sensory modulation rooms designed to reduce distress among people in inpatient psychiatric settings and reduce the use of seclusion, restraint, and pharmacological interventions;[xxvii] as well as
    - Providing communications systems, locking devices, and alarms for emergencies;
- Encourage implementation of a quality improvement approach including data tracking and trending, video review, as well as an injury reduction committee including management and front line staff; and
- Incorporate flexibility in any standards to account for the individualized needs and issues among diverse populations who receive care in behavioral health treatment settings including children and youth, older individuals, and forensic populations.

We urge you to convene a group of leading experts including representatives from our organizations to work with you to incorporate the evidence and corresponding guiding principles outlined above into any workplace violence prevention standards. We hope to continue to collaborate with you to ensure that implementation of additional safety requirements does not inadvertently result in increased risk of violence in these settings and/or lower quality of care for a very vulnerable patient population.

Please contact Kirsten Beronio at kirsten@nabh.org or 202-680-3095 if we can provide additional information or assistance.

Thank you for your consideration.

Sincerely,

American Nurses Association

American Psychiatric Association

National Alliance on Mental Illness

National Association for Behavioral Healthcare

National Association of State Mental Health Program Directors

National Council for Mental Wellbeing

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[i] Neufeld E, Perlman CM, Hirdes JP. Predicting inpatient aggression using the InterRAI risk of harm to others clinical assessment protocol: a tool for risk assessment and care planning. J Behav Health Serv Res. 2012 Oct;39(4):472-80. doi: 10.1007/s11414-011-9271-x.

[ii] Flannery RB, Flannery GJ. International review of precipitants to patient assaults on staff, 2013-2017. Psychiatr Q. 2018 Jun;89(2):497-503. doi: 10.1007/s11126-017-9552-5; Goldberg BR, Serper MR, Sheets M, et al. Predictors of

aggression on the psychiatric inpatient service: self-esteem, narcissism, and theory of mind deficits. J Nerv Ment Dis. 2007 May;195(5):436-42. doi: 10.1097/01.nmd.0000253748.47641.99; Berman BA, Duffy K, Serper MR. Beliefs about voices and aggressive behavior in inpatients in an acute psychiatric setting. J Clin Psychiatry. 2010 Apr;71(4):497-501. doi: 10.4088/JCP.08m04753yel.

[iii] d'Ettorre G, Pellicani V. Workplace Violence Toward Mental Healthcare Workers Employed in Psychiatric Wards. Saf Health Work. 2017 Dec;8(4):337-342. doi: 10.1016/j.shaw.2017.01.004.

[iv] Fisher K. Inpatient violence. Psychiatr Clin North Am. 2016 Dec;39(4):567-577. doi: 10.1016/j.psc.2016.07.005.

[v] Donat DC. An analysis of successful efforts to reduce the use of seclusion and restraint at a public psychiatric hospital. Psychiatr Serv. 2003 Aug;54(8):1119-23. doi: 10.1176/appi.ps.54.8.1119.

[vi] Substance Abuse and Mental Health Services Administration: A Practical Guide to Psychiatric Advance Directives. Rockville, MD: Center for Mental Health Services. Substance Abuse and Mental Health Services Administration, 2019.

[vii] Swanson JW, Swartz MS, Elbogen EB, et al. Psychiatric advance directives and reduction of coercive crisis interventions. Journal of Mental Health. 2008 Jan 1; 17(3):255-267. doi: 10.1080/09638230802052195 ; Wilder CM, Swanson JW, Bonnie RJ, et al. A survey of stakeholder knowledge, experience, and opinions of advance directives for mental health in Virginia. Adm Policy Mental Health. 2013 May; 40(3):232-239. doi: 10.1007/s10488-011-0401-9. PMID: 22240937.

[viii] Jayaram G. Aggression and prevention of use of seclusion and restraint in inpatient psychiatry. Focus (Am Psychiatr Publ). 2016 Jul;14(3):354-357. doi: 10.1176/appi.focus.20160016. Epub 2016 Jul 8.

[ix] Chieze M, Hurst S, Kaiser S, Sentissi O. Effects of seclusion and restraint in adult psychiatry: a systematic review. Front Psychiatry. 2019 Jul 16;10:491. doi: 10.3389/fpsyt.2019.00491; Substance Abuse and Mental Health Services Administration. Promoting alternatives to the use of seclusion and restraint, Issue Brief # 1, March 2010; The Joint Commission, Quick Safety: De-escalation in health care, Issue 47, January 2019.

[x] Keski-Valkama A, Sailas E, Eronen M, et al. The reasons for using restraint and seclusion in psychiatric inpatient care: A nationwide 15-year study. Nord J Psychiatry. 2010 Apr;64(2):136-44. doi: 10.3109/08039480903274449.

[xi] Donat DC. Encouraging alternatives to seclusion, restraint, and reliance on PRN drugs in a public psychiatric hospital. Psychiatr Serv. 2005 Sep;56(9):1105-8. doi: 10.1176/appi.ps.56.9.1105.

[xii] Polacek MJ, Allen DE, Damin-Moss RS, et al. Engagement as an element of safe inpatient psychiatric environments. J Am Psychiatr Nurses Assoc. 2015;21(3):181–90. doi: 10.1177/1078390315593107

[xiii] Berg SH, Rørtveit K, Aase K. Suicidal patients' experiences regarding their safety during psychiatric in-patient care: a systematic review of qualitative studies. BMC Health Serv Res. 2017;17(1):73. doi: 10.1186/s12913-017-2023-8

[xiv] Bhat S, Rentala S, BN Raveesh, et al. Effectiveness of milieu therapy in reducing conflicts and containment rates among schizophrenia patients. Invest. Educ. Enferm. 2020; 38(1).doi: https://doi.org/10.17533/udea.iee.v38n1e06; Hamrin V, Iennaco J, Olsen D. A review of ecological factors affecting inpatient psychiatric unit violence: implications for relational and unit cultural improvements. Issues Ment Health Nurs. 2009 Apr;30(4):214-26. doi:10.1080/01612840802701083.

[xv] Elliot AJ, Maier MA. Color Psychology: effects of perceiving color on psychological functioning in humans. Annual Review of Psychology. 2014; 65:1, 95-120. doi.org/10.1146/annurev-psych-010213-115035

[xvi] Scanlan JN, Novak T. Sensory approaches in mental health: a scoping review. Australian Occupational Therapy Journal. 2015 Sept 11; 62(5) : 277-285. doi: 10.1111/1440-1630.12224

[xvii] Beattie J, Griffiths D, Innes K, et al. Workplace violence perpetrated by clients of health care: A need for safety and trauma-informed care. J Clin Nurs. 2019 Jan; 28(1-2):116-124. doi: 10.1111/jocn.14683.

[xviii] Muskett C. Trauma-informed care in inpatient mental health settings: a review of the literature. Int J Ment Health

Nurs. 2014;23(1):51–9. doi: 10.1111/inm.12012.

[xix] Muskett C. Trauma-informed care in inpatient mental health settings: a review of the literature. Int J Ment Health Nurs. 2014;23(1):51–9. doi: 10.1111/inm.12012.

[xx] Hammervold UE, Norvoll R, Sagvaag H. Post-incident reviews after restraints potential and pitfalls: patients' experiences and considerations. J Psychiatr Ment Health Nurs. 2021 Jun 1. doi: 10.1111/jpm.12776; Hammervold UE, Norvoll R, Vevatne K, et al. Post-incident reviews-a gift to the ward or just another procedure? care providers' experiences and considerations regarding post-incident reviews after restraint in mental health services: a qualitative study. BMC Health Serv Res. 2020 Jun 3;20(1):499. doi: 10.1186/s12913-020-05370-8.

[xxi] Tishler CL, Reiss NS, Dudas J. The Assessment and Management of the Violent Patient in Critical Hospital Settings. General Hospital Psychiatry Journal. 2013 ; 35: 181-185. doi: 10.1016/j.genhosppsych.2012.10.012; Ye J, Xiao A, Yu L, et al. Staff training reduces the use of physical restraint in mental health service, evidence-based reflection for China. Arch Psychiatirc Nurs. 2017; 32:488–494. doi: 10.1016/j.apnu.2017.11.028; The Joint Commission, Quick Safety: De-escalation in Health Care, Issue 47, January 2019.

[xxii] Meehan T, Fjeldsoe K, Stedman T, et al. Reducing aggressive behaviour and staff injuries: a multi-strategy approach. Aust Health Rev. 2006 May;30(2):203-10. doi: 10.1071/ah060203.

[xxiii] Guay S, Goncalves J, Boyer R. Evaluation of an education and training program to prevent and manage patients' violence in a mental health setting: a pretest-posttest intervention study. Healthcare. 2016 August; 4 (3): 49. DOI: 10.3390/healthcare4030049.

[xxiv] Kanerva A, Lammintakanen J, Kivinen T. Patient safety in psychiatric inpatient care: a literature review. J Psychiatr Ment Health Nurs. 2013;20(6):541–8. doi: 10.1111/j.1365-2850.2012.01949.x

[xxv] Kristensen S, Christensen KB, Jaquet A, et al. Strengthening leadership as a catalyst for enhanced patient safety culture: a repeated cross-sectional experimental study. BMJ Open. 2016;6(5):e010180. doi: 10.1136/bmjopen-2015-010180.

[xxvi] Grabbe L, Higgins MK, Baird M, et al. Impact of a resiliency training to support the mental well-being of front-line workers: brief report of a quasi-experimental study of the community resiliency model. Med Care. 2021;59(7):616-621. doi:10.1097/MLR.0000000000001535; Grabbe L, Higgins MK, Baird M, et al. The community resiliency model® to promote nurse well-being. Nurs Outlook. 2020 May-Jun;68(3):324-336. doi: 10.1016/j.outlook.2019.11.002.

[xxvii] Barbic SP, Chan N, Rangi A, et al. Health provider and service-user experiences of sensory modulation rooms in an acute inpatient psychiatry setting. PLoS One. 2019;14(11):e0225238. doi:10.1371/journal.pone.0225238.