ESSAYS AND DEBATES IN MENTAL HEALTH

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# Silver linings: Observed reductions in aggression and use of restraints and seclusion in psychiatric inpatient care during COVID-19

Krystle Martin[1,2] ⬤  |  Simone Arbour[1]  |  Carolyn McGregor[1,2]  |  Mark Rice[1]

[1]Ontario Shores Centre for Mental Health Sciences, Whitby, ON, Canada

[2]Ontario Tech University, Oshawa, ON, Canada

**Correspondence**
Krystle Martin, Ontario Shores Centre for Mental Health Sciences, 700 Gordon Street, Whitby, ON L1R 0J3, Canada.
Email: martink@ontarioshores.ca

**Accessible Summary**

**What is known about the subject?**

- In a survey conducted by the World Health Organization (WHO) in the summer of 2020, 93% of countries worldwide acknowledged negative impacts on their mental health services.
- Previous research during the H1N1 pandemic in 2009 established an increase of patient aggression in psychiatric facilities.

**What the paper adds to existing knowledge?**

- Despite expected worsening of mental health, our hospital observed reductions in aggressive behaviour among inpatients and subsequent use of coercive interventions by staff in the months following Covid-19 pandemic restrictions being implemented.
- The downward trend in incidents observed during the pandemic has suggested that aggression in mental health hospitals may be more situation-specific and less so a factor of mental illness.

**What are the implications for practice?**

- We believe that the reduction in aggressive behaviour observed during the pandemic is related to changes in our organization that occurred in response to concerns about patient well-being; our co-design approach shifted trust, choice and power. Therefore, practices that support these constructs are needed to maintain the outcomes we experienced.
- Rather than return to normal in the wake of the pandemic, we are strongly encouraged to sustain the changes we made and continue to find better ways to support and work with the individuals who rely on or use our services.

**Abstract**

The global COVID-19 pandemic has dramatically changed the operation of health care such that many services were put on hold as patients were triaged differently, people delayed seeking care, and transition to virtual care was enacted, including in psychiatric facilities. Most of the media dialogue has been negative; however, there have been some silver linings observed. Coinciding with the pandemic has been a reduction in aggressive

incidents at our psychiatric hospital, along with the decreased need to use restraints and seclusion to manage behaviour. In this paper, we are taking stock of the changes that have occurred in response to the pandemic in an attempt to share our learnings and offer suggestions so that health care does not necessarily return to "normal".

# 1 | INTRODUCTION

It has been suggested that the mental health impacts of the COVID-19 pandemic will pose a severe challenge for governments and results from a survey conducted by the World Health Organization (WHO) in the summer of 2020 found that 93% of countries worldwide experienced negative impacts on their mental health services (WHO, 2020). Here in Canada, a Canadian Angus Reid poll in April 2020 found that half of all respondents indicated that their mental health has worsened during this time (Angus Reid Institute, 2020). As we and others anticipated that this phenomenon would also apply to psychiatric inpatients (Yao et al., 2020), many drastic changes were implemented within our hospital to proactively prevent further negative impact. Somewhat surprisingly, however, we observed that our patients were tolerating the unusual situation, and in fact, demonstrated fewer incidents of aggression leading to a significant reduction in our use of restraints and seclusion (R/S). This finding follows several years of concerted efforts by our healthcare teams to address the use of coercive interventions with some success, but not nearly to the extent currently observed. As such, we have reflected on this naturally occurring phenomenon during this pandemic to ascertain its potential causes. As governments attempt to restore life as usual, we are writing this position paper to inform others of our observations, with the recommendation that perhaps mental health care does not necessarily return to "normal".

Previous research during the H1N1 pandemic in 2009 established an increase of patient aggression, for example in Australian emergency departments (Fitzgerald et al., 2012). Recent research has proposed that lack of freedom and movement may cause mental health patients to become irritable and upset amid the COVID crisis (De Sousa et al., 2020). Specifically, it is posited that relapse or exacerbation of illness during this period is probable, with some patients even generating delusions around themes of the pandemic. If some individuals experience increased delusions and paranoia, it would seem likely that individuals hospitalized with schizophrenia could develop aggressive and violent behaviour as a result (Mazza et al., 2020). However, literature to date has not reported on actual incidences of aggression in mental health facilities during the COVID-19 pandemic or previous pandemics.

# 2 | RECENT CHANGES WE MADE IN RESPONSE TO THE CURRENT PANDEMIC

Ontario Shores Centre for Mental Health Sciences is a tertiary mental health hospital with approximately 340 inpatients beds devoted to the treatment of adult, adolescent, geriatric and forensic mental health issues. In response to the declaration of a global pandemic by the World Health Organization in March, our hospital introduced strategies to counter the public health and social distancing measures that were implemented. Specifically, we made the following changes:

March 2020

- Scaled down and suspended outpatient and non-essential services in order to streamline resources and support inpatients, including redeployment of outpatient staff to inpatient units to deliver activities
- Sequestration of inpatients to their units (i.e. no off-unit privileges for inpatients)
- Opening of outdoor courtyards for scheduled cigarette breaks
- Visitor restriction and eventual suspension
- Established patient engagement steering group designed to centralize decision making around engagement on inpatient units; tasks included weekly engagement with patients and families in identifying meaningful activities and corresponding resources, plus identification of processes and barriers to delivery of such services

April 2020

- Combined two adolescent units into one (eating disorders and general adolescents) to create a new unit dedicated to individuals at high risk for COVID-19
- Organized ongoing patient and family engagement to refine and customize unit activities
- Celebrated patient successes

# 3 | RECENT STATISTICS FOR AGGRESSION AND THE USE OF RESTRAINTS AND SECLUSION

Our hospital monitors the incidence of aggression and use of R/S and produces weekly reports: for this paper, we requested the entire data from our decision support team retrospectively after the time period of interest. The incidences of use of R/S are reported separately by patient population and divided into three periods, namely pre-COVID (Pre; 1 January–10 March), during COVID transition (Transition; 11 March–15 March) and post-transition (Post; 15

March–30 April). This resulted in 70, 5 and 46 days, respectively. Discharges remained fairly consistent over the duration of the three study periods and admissions fell slightly during the Post period.

While the rate of incidences of mechanical restraints increased during the 5-day transition, the average daily rate of the number of mechanical restraints in the Post period relative to the Pre period reduced in our Adolescents, Forensics and Geriatrics programs by 56%, 49% and 100%, respectively. The rate of incidences of mechanical restraints did increase for our General Adult Psychiatry program during the Post period by 36%; however, a third of all instances for the Post Period were within the first few days.

For seclusions, the rate of incidences increased during the 5-day transition; however, during the Post period relative to the Pre period the rates reduced for the General Adult Psychiatry, Adolescents, Forensics, and Geriatrics programs by 54%, 76%, 35% and 19%, respectively.

## 4 | DISCUSSION

Traditionally mental health care is associated with a power imbalance between service providers and users which can lead to violence and aggression and ultimately coercive practices. The hospital has traditionally made concerted efforts to minimize the use of coercive practices. For example, it introduced Safewards (Bowers, 2014) in 2015 as a means of minimizing conflict on the units by having staff and patients come together to create a therapeutic recovery-oriented environment. And while these evidence-based interventions are associated with a reduction of conflict on units, we observed during the COVID-19 crisis that it is possible to further and drastically reduce the use of coercive practices in tertiary mental health care.

The downward trend in incidents observed during the pandemic has suggested that aggression in mental health hospitals may be more situation-specific and less so a factor of mental illness. This is not a new concept however: previous scholars have argued that there are other—non-pathological—reasons why aggressive incidents are observed on inpatient psychiatric units such as it being a form of resistance (see McKeown, 2016). McKeown and others (e.g. Holmes et al., 2012) have noted that we tend to legitimize forms of aggression enacted by staff (e.g. use of restraints) and by organizations (e.g. working environments, funding decisions, etc.) but fail to acknowledge that this form of violence begets violence in patients.

Patient engagement has always been addressed within our hospital. However, prior to the COVID-19 outbreak, this operated in a very reactive way: patients make complaints, and these complaints are investigated and remedied. When the outbreak occurred, this department, and its corresponding family and patient engagement committees, proactively identified potential issues, gaps in service delivery and factors related to self-directed day-to-day behaviour. This resulted in the localized and customized creation of activities that were meaningful to patients. For example, the dual diagnosis unit wanted to have more 1:1 engagement and smaller group activity

with staff for support. On the other hand, forensic patients wanted access to phones and Amazon purchasing opportunities. As a result, Amazon gift cards were purchased for these units. The fact that co-design was used to identify the activities may also have had a positive impact on inpatients. Oftentimes, service delivery is a top-down process whereby professionals determine what is best for patients. When using co-design recently, patients were brought in with equal decision-making power to determine the implementation of programmes and activities and participated in co-delivery. As a result, this shifted power from the service provider to the service user. This is congruent with previous research that demonstrates that trust, choice and power are perceived as important for those receiving mental health services (Laugharne et al., 2011). Researchers found that factors influencing trust are caring attitudes and acts of kindness. In their research, participants also reported the need for a shift in power, with more power being afforded patients in their own care and self-determination.

Amid the COVID-19 crisis, it may be that the lack of perceived control over the course of the pandemic by both service users and providers lessens the power imbalance between these two groups—the pandemic has put both groups on the same side to work together with the common goal of meeting the challenges presented to the healthcare system. So not only has the pandemic lessened the power imbalance between clinician and patient, but it requires that both groups trust one another to adhere to their respective responsibilities amid this health crisis. As such, service users and providers *cooperated* to respond to the pandemic. As such, a bond was fostered: "[o]nly through cooperation [can] a sense of solidarity be established" (Maravelias, 2012). While typically assigned to internal motivations, we would also suggest that our organization shifted its usual relationship with service providers, and these environmental and institutional changes facilitated cooperation and prosocial interactions between these two groups (Simpson & Willer, 2015).

Where choice is concerned; however, the COVID-19 crisis may have demonstrated that the lack of choice (namely the lack of off-unit privileges) or more importantly the uniformity of choice (i.e. that *all* patients were faced with the same restrictions) may have alleviated patient-to-patient comparisons: if no one is afforded off-unit privileges, then there are no complaints regarding patients' own access relative to others' access. The concept of procedural justice stipulates that when people believe that a process is fair—even if they do not like the outcome —they will have respect for the process, thereby reducing any disputes. This possibility has important implications for the perceived subjective nature in which patients are afforded or denied access to privileges, leading to feelings of frustration.

Lastly, the tremendous effort to reduce the negative impact of the pandemic restrictions on our inpatients resulted in more programming, easier access to these activities (as they were offered on the units) and enhanced 1–1 engagement of staff with patients. We hypothesize that this increase in services also contributed to the reduction of aggression observed. Previous research has indicated that boredom is a risk factor for aggressive behaviour (Bowers et al.,

2011) and other undesirable actions such as unauthorized leaves of absence (ULOA; Martin et al., 2018).

In order to fully understand the factors associated with these observations, future research should continue to focus on issues related to trust, choice and power. In this case, it was speculated that the use of co-design contributed to sharing of power between service users and providers. Co-design posits that all individuals have assets and strengths (Lewis et al., 2017) and establishes reciprocal and meaningful relationships between service users and providers; therefore, actively embedding co-design within mental health care must become a priority.

In addition, while the lack of choice regarding off-unit privileges may have be associated with a probable decrease in patient frustration given that everyone was equally restricted, it is likely that uniformity, rather than lack of options, contributed to this reduced sense of frustration. If this is the case, what if there was no subjectivity in allocating privilege access? What if (within reason and ensuring safety) all patients had access to all privileges? This also raises the question —why does mental health care use the word privilege to denote what are often basic citizenship entitlements (i.e. go outside, access to own money, access to food, etc.)? There is an element of positive risk taking in this suggestion, but perhaps worth research investigation.

Finally, the events of the past few months have also demonstrated that flexibility is crucial in dealing with events that are out of one's control. Oftentimes the mental health system can be risk averse and rigid in its policies and practices. The COVID-19 crisis essentially forced the hospital to listen to and engage its patients and celebrate their successes. When the pandemic finally does come to pass and things go back to "normal" perhaps, this would be a step back. To echo Brown and colleagues (Brown et al., 2020) who state that there is "an opportunity now to find better ways of working with patients which we hope will outlive the COVID-19 pandemic" (p. 12), mental health care should learn from the lessons of what is possible in terms of patient engagement, flexibility, sharing power and trust amid the pandemic and as such, not go back to "normal". The phrase "new normal" has often been used to speculate life after COVID-19 and it would seem mental health care can establish a "new normal".

## 5 | RELEVANCE TO CLINICAL PRACTICE

We believe that our observations of a reduction in incidents of aggression and use of coercive interventions during the pandemic are related to changes in our organization that occurred in response to concerns about patient well-being; our co-design approach shifted trust, choice and power. Rather than return to normal in the wake of the pandemic, we are strongly encouraged to maintain this new approach and continue to find better ways to support and work with the individuals who rely on or use our services.

In theory, recovery-oriented practices guide mental health service delivery in Canada (WHO, 2020). Many organizations, including our own, have invested considerable resources to advance recovery-oriented practice to not only enhance mental health outcomes but also minimize custodial practices including those that are coercive. The experiences noted during the pandemic have demonstrated very simple and practical ways that the relationship between service provider and user can be enhanced. By amplifying the service user's role in his/ her own care and working cooperatively together, recovery principles are attained. Oftentimes organizations implement complex interventions and initiatives designed to direct behaviour and practice, when perhaps an attitudinal shift is necessary—namely recognizing the value of co-produced, strength-based care interventions as well as the belief that aggression is not inherently part of one's mental illness.

## AUTHOR CONTRIBUTIONS

C.M. first made comment about the observation we had which lead to the idea for this paper, as well as performed the data analysis. M.R. provided contextual and policy information which informed the ideas in this paper, and S.A. provided theoretical and other research information. K.M. contributed some theoretical material and was responsible for the organization, structuring and overall draft of the manuscript, as well as managed the revised version. Together, all the authors took responsibility for reviewing, editing and finalizing the manuscript and therefore are accountable to the accuracy and integrity of this work.

## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

## ORCID

*Krystle Martin* https://orcid.org/0000-0003-0419-8328

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