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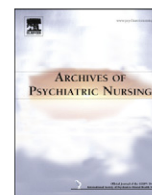

Milieu Improvement in Psychiatry Using Evidence-Based Practices: The Long and Winding Road of Culture Change

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ABSTRACT

Background: Shorter inpatient stays have resulted in greater patient acuity, making it difficult for patients to heal and challenging for staff to manage.
Objective: To improve the milieu for psychiatric inpatients using evidence-based practices.
Design: A thorough literature review suggested 18 basic principles to improve patient outcomes while reducing violence, seclusion, restraint, and 1:1 observation. Interventions were multiple, including intensive multi-modal staff education based on the literature review and starting in orientation, introduction of comfort rooms, changes in debriefing practices, careful review of all seclusion and restraint episodes, introduction of integrative modalities, and careful review of all 1:1 observation and review of unit structure.
Results: Multiple interventions resulted in favorable outcomes in the following: rates of seclusion and restraints; time devoted to 1:1 observation, patient and staff satisfaction; violent incidents; and staff and patient injury.
Conclusions: Long-term culture change toward a more therapeutic milieu can occur as a result implementing evidence-based practices.

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There are enormous challenges in today's psychiatric inpatient care: shortages of nurses and physicians, pressure to reduce cost and length of stay from private, regulatory and governmental sources; budget limitations, declines in reimbursement rates; and progressive tightening of budgets in health care. During the same time, psychiatric hospitals are receiving pressure from state and federal government agencies and professional organizations to reduce our most coercive interventions: seclusion and restraint (American Psychiatric Association, American Psychiatric Nurses Association, National Association of Psychiatric Health Systems, 2003; New York State Office of Mental Health, 2005; U.S. Department of Health and Human Services/SAMHSA, 2006). Although these forces (decreased length of stay, physician and nurse shortages, cost reduction efforts and pressure to reduce seclusion and restraint) were in play in psychiatric inpatient care throughout the country, little concrete guidance was available to mitigate the difficulties associated with them. These forces seemed to reach crisis level for us toward the end of 2005. Rates of seclusion, restraint and 1 on 1 observation were at all-time highs at our facility. There were more assaults on staff resulting in significant injury, accompanied by declines in both patient and staff satisfaction. Length of stay had been reduced to all-time lows and as a result, shorter lengths of stay and higher acuity became obstacles that seemed insurmountable. The inpatient units felt tense and chaotic, and the staff were overwhelmed by patient acuity and increasingly rapid admission and discharge rates.

Our facility is a large multi-site urban/suburban medical center with inpatient psychiatric services at four of our sites treating children, adolescents and adults with a wide variety of psychiatric diagnoses on 15 separate inpatient units with a total of nearly 350 patients. Of our 15 units, one specializes in treating children and one in treating adolescents. There is one specialty unit for eating disorders, one for substance use disorders and two for the treatment of psychotic disorders, particularly schizophrenia and schizoaffective disorder. The remaining units are general psychiatric units. On all our units patients most often have multiple diagnoses with one or more comorbid conditions.

In an attempt to regain a sense that our inpatient units were restorative places where people could come to heal from acute episodes of mental illness, our leadership initiated a far-reaching project to improve the inpatient milieu. What came to be known as the milieu improvement council began as a relatively small interdisciplinary group which spent its first few meetings defining terms and creating a clear statement of purpose.

The definition of milieu we settled on is "a healing environment which is adaptive, responsive: one that provides a safe, caring environment for personal growth and development." Our purpose statement then was to develop and implement a safe, effective and evidence-based foundation for therapeutic milieu management given the resources and constraints of the current (new) reality.

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Table 1
Milieu Improvement Project Workgroups.

Literature review—Use the Stetler Model for Research Utilization to conduct a broad and thorough review of the literature on the subject of milieu improvement in inpatient psychiatry
Comfort room—Search the existing literature on the use of comfort rooms to determine where and how to create one
Data/Metrics—Determine which metrics could be used to measure outcomes and create methods to collect and trend the data
Model unit—Select one or two units to work intensively with and operationalize the research findings on, preferably ones with high rates of seclusion, restraint, 1:1 observation and staff injuries
Restraint/Seclusion review—Review each instance of seclusion and restraint to determine if alternative measures could have been tried, to detect patterns of occurrence, and to create a clinically useful way to give feedback to the staff involved
Falls reduction—Review the literature on falls in inpatient psychiatry to determine ways to reduce the current fall rate using predictive and preventive measures
Research—Work with the metrics subgroup to develop protocols to study outcomes

Determining where to proceed and how to measure the success of our efforts occupied us for our first 6 months. In those early months we determined the following:

- Something or some things had to change in the way we provided care.
- A wide swath of research had to be reviewed to give us direction in what changes needed to be made.
- The evidence-based practices we implemented would need to be adopted by all members of our staff at all levels on a consistent basis which would require extensive training and supervision.
- Ways to measure success might include:
  - Number and length of episodes of seclusion and restraint
  - Patient and staff satisfaction
  - Number and severity of violent episodes with and without injury
  - Number of patients on 1:1 observation status

METHODS

We foresaw that there would be obstacles. Our psychiatry services have a long history of a traditional psychoanalytic approach with lengthy inpatient stays and a belief that patient improvement was most strongly influenced by individual psychotherapy with a psychiatrist and psychotropic medication. Frontline staff were not seen as contributing significantly to a patient's healing: rather their job was to maintain safety and order. Rules were followed with little flexibility, and staff opinions and decisions were seen as being superior to those of patients. Although much about the field had changed, remnants of those traditional attitudes and beliefs continued to exert influence. We knew that changes would occur to those beliefs and practices only slowly. Rather than impose a change toward person-centered and recovery-oriented care, we were determined to involve staff in the discussions about the current problems and their potential solutions. Rather than see these changes as imposed by leadership who only wanted to improve their statistical reports, we wanted to work together to understand that whatever changes we made in our everyday work were necessary and primarily for the benefit of patients and staff. To accomplish this, we expanded our workgroups to include staff at all levels and in all disciplines and organized a full-day brainstorming sessions that included the full membership of all workgroups and additional frontline staff. Despite these efforts, many of our nursing staff expressed anger and fear about making changes they felt might lead to increased violence and danger for front-line workers.

In discussing the broad scope of our task, we decided to continue monthly meetings of the total membership while dividing into subgroups which would meet separately to advance the work in specific areas. The early tasks of each subgroup are summarized in Table 1.

Over time, we found that the work of our various subgroups overlapped considerably, emphasizing the importance of the full milieu improvement council meetings at which we could share progress, integrate our findings and continue to chart our course. Those monthly meetings occurred consistently throughout the project and continue to this day. In addition, a steering group was formed to meet the week prior to each general meetings to establish priorities, prevent overlap of subgroup tasks, discuss future directions and prepare an agenda for the next meeting.

The data/metrics workgroup recommended that we track the following quality measures to determine the success of our work.

- Satisfaction scores for staff and patients
- Rates of seclusion and restraints—both number of episode and total time
- Episodes of violence with or without injuries

In some of these areas we were able to gather past quality data to create trend lines.

Eventually we decided to track other data that might have a bearing on whatever changes we found in the data. We created a single dashboard to track all the data, including the data mentioned above as well as:

- length of stay and numbers of admissions and discharges as indicators of acuity
- number of psychiatric emergencies
- percentage of staff up to date in training on milieu improvement and violence prevention and intervention

With the help of our quality department, all data were tracked on Excel spreadsheets by month and by unit with the derived graphs as a means of visually tracking progress at each of our monthly meetings of the combined workgroups.

As the literature review progressed and word spread of this new council, change began to occur despite the fact that the only intervention so far was to announce our formation and purpose. There was a dramatic drop in restraint use—presumably a tribute to the Hawthorne effect. The use of this coercive measure plummeted simply by calling attention to restraint use and telling staff that each instance would be carefully reviewed in the near future by an interdisciplinary team who would provide feedback and recommendations about alternative measures that might have been successfully used to prevent the episode. Clearly our first intervention, calling attention to the need to reduce seclusion and restraint rates had a robust effect.

As time went on, the overlaps in workgroup goals became so great that several of our subgroups combined and a few additional ones were formed. As the literature review progressed, we decided to combine the literature review group with the education and training group to make a smooth transition from research findings to staff education designed to help staff translate the findings into practice. The research subgroup was put on hold until it was clearer what the sum total of our interventions would be. The idea of beginning intensive work on one or two units was disbanded because of the dramatic improvements that were already being seen across the board. Initially our model units were going to be ones with the greatest challenges in reducing seclusion and restraint, but the units that had been selected were showing such rapid improvement that it no longer seemed necessary to focus only on them.

The milieu improvement council showed enough progress that it was decided to expand the efforts to all four of our hospital's psychiatric sites. Over the course of the first year both the overall milieu improvement council, the steering group and each of the subgroups had members at each site. Monthly council meetings were held by videoconference with periodic in-person meetings.

The seclusion and restraint reduction workgroup recruited at least one staff member from each inpatient unit. They developed a written protocol for reviewing each incident by medical record review and interviews with the staff involved as soon as possible following the event. Feedback was given to the patient care director verbally and in writing about any recommendations about alternative interventions.

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