Emergency Involuntary Procedures Committee:

Report Department of Mental Health, July 1, 2019- June 30, 2020

Introduction

This report is submitted on behalf of the Emergency Involuntary Procedures Committee in accordance with Vermont Regulation for Establishing Standards for Involuntary Procedures, which outlines expectations as follows:

> *The Review Committee shall prepare an annual report summarizing its advisory work, providing suggestions and recommendations regarding adherence to these standards, including trends in the frequency in the use of emergency involuntary procedures, findings relative to compliance with the requirements for the use of such procedures, the need for staff training, and other related matters.*

This report reflects the fourth year of the Committee's work. The Vermont Cooperative for Practice Improvement and Innovation (VCPI) continued in the role of facilitating the Procedures Committee and the VCPI Executive Director is submitting this report on the Committee's behalf. The Committee meets on a quarterly basis. Meetings are open to the public, but only Committee members serve in an official role. Committee members may represent the voices of their constituencies for this report, but public comment is not directly included.

DMH maintains a section of their website that includes meeting agendas and minutes, data and any handouts used during the site presentations.

The EIP regulation is also available at the website and provides more information about the charge and structure of the Committee

https://mentalhealth.vermont.gov/about-us/boards-and-committees/emergency-involuntary-procedures-review-committee

Definitions

The Administrative rule defines the terms as follows:

Emergency Involuntary Procedures (EIPs) Include instances of restraint, seclusion or emergency involuntary medication.

Restraint: A restraint includes any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely (CMS 482.13(e)(1)(i)(A)).

Seclusion: Seclusion means the involuntary confinement of a patient alone in a room or an area from which the patient is physically or otherwise prevented from leaving. Seclusion shall be used only for the management of violent or self-destructive behavior that poses an

imminent risk of serious bodily harm to the patient, staff member, or others. (CMS 482.13(e)(1)(ii).

Emergency Involuntary Medication: A restraint is also defined as a drug or medicine used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement, and is not standard treatment or dosage for the patient's condition (CMS 482.13(e)(1)(i)(B)).

Episodes of Emergency Involuntary Procedures: When clinically indicated, emergency involuntary procedures may be used in combination when a single procedure has not been effective in protecting the safety of the patient, staff, or others. When the simultaneous use of emergency involuntary procedures is used, there must be adequate documentation that justifies the decision for combined use. (CMS 482.13(e)(15)).

In the following report, the use of emergency involuntary procedures in combination is referred to as an episode. Episodes can include any combination of seclusion, restraint, or emergency involuntary medication.

Report Development

The approach to the development of this report has been consistent.

- Time is set aside at EIP meetings to explain the report's purpose and solicit input.
- VCPI requests input from all Committee members both at meetings and via e-mail. A timeline is established for submitting input.
- VCPI provides the previous year's report to the Committee as a reference.
- At the deadline for receiving input, VCPI drafts the report and sends it to all Committee members for continued comment, input and approval.
- Responses received are integrated into the report and a final version is submitted to the DMH Commissioner. The Committee members also receive a copy and the reports are posted on the DMH website.

Data

Quarterly meetings include a report that presents aggregate de-identified data as specified by legislation. The Research and Statistics Unit of DMH publishes the quarterly's reports on the

DMH website and provides the report to the committee members prior to each meeting. Committee members review and discuss the report and there is an opportunity to ask questions of a DMH data analyst. The committee considers differences between quarterly data and works to understand the possible explanations. The committee regularly considers whether the amount and type of data collected provides sufficient information. A comparative of current data with the same quarter from the previous year was added this fiscal year, at the request of the committee.

Data reports can be found at https://mentalhealth.vermont.gov/about-us/boards-and-committees/emergency-involuntary-procedures-review-committee

The following is a summary of fiscal year '20 in its entirety.

- During FY20, there were **1,069 total EIPs** for an a**verage of 89 EIPs per month** for involuntary patients.
    - 12% of these EIPs were for youth patients (125 procedures for 13 individuals).

    - For all involuntary patients- inclusive of youth, the total number of 1069 EIPs were recorded as follows:
        - 11% of EIPs were Mechanical Restraints (115 procedures),
        - 22% were Emergency Medication (234 procedures),
        - 21% were Seclusion (227 procedures),
        - and 46% were Manual Restraint (493 procedures).

        - There were 644 total Episodes across all involuntary patients, with an average of 1.84 EIPs per Episode. As previously defined, an "episode" is when there is simultaneous use of emergency involuntary procedures.

    - The table below provides a comparative view of youth numbers of EIPs performed' experience in FY '19.

Fiscal Year	Total EIPs for all involuntary pts	% for youth	# Procedures	# Individuals
FY '19	1277	3%	42	11
FY '20	1069	12%	125	13

- The table below provides a comparative view of the number of all involuntary patients (inclusive of youths) in FY 19 and FY20

Fiscal Year	Total EIPS	Mechanical Restraint	Emergency Medication	Seclusion	Manual Restraint
FY '19	1277	5% / 68 procedures	21% / 262 procedures	28% / 352 procedures	47% / 595 procedures
FY '20	1069	11% / 115 procedures	22% / 234 procedures	21% / 227 procedures	46% / 493 procedures

The most recent reporting reflects on the final quarter of FY 20 (April- June)
https://mentalhealth.vermont.gov/sites/mhnew/files/documents/AboutUs/Committees/EIP/EIP_Report_2020-AprJun_final.pdf

The reader is encouraged to review the complete data report for context and clarity.

- Reviewing that data brings up several points for consideration. The table found on p. 9 of Q 4 data illustrates *Aggregate Emergency Involuntary Procedures for Involuntary Patients - Procedures Per Patient/ Adult Psychiatric Units* It provides information on number of episodes per patient and it is important to note that 78% of patients experienced no EIP's during the final quarter of the year. Of those who did experience an EIP, most had only one.

  - This data has been quite stable over time and reflects not only that most patients do not experience an EIP, but also that it is generally a single patient, or perhaps two, that experiences a high number of seclusion/restraints.
    - Some Committee members wondered if this suggests that, overall, the environment and programming on the units are successfully managing the majority of patients.
    - These Committee members recommend considering a more in-depth analysis of the set of patients that experience a greater number of EIPs and, **i**f indicated, recommend that technical assistance should be sought specific to how to work with the particular issues present in this sub-population.

- It's imperative to note that the Covid-19 pandemic broke out during this fiscal year. Any analysis of FY '20 data should consider the significant effect on all aspects of hospital operations beginning in March and continuing through the conclusion of the fiscal year. Although other factors may be relevant, viewing data through this lens is critical when we consider Q 4 data within the full year.

    - Overall, the combined rate of Seclusion and Restraint for Level 1 units rose across FY20, from a rate of 1.29 in quarter 1 (July-September), to 2.43 in quarter 4 (April-June).

        - As noted,this trend was largely driven by data from the Brattleboro Retreat, which saw an increase from 1.65 in quarter 1 to 5.04 in quarter 4.

        - The rate of Seclusion per 1,000 patient hours also increased from 0.48 in quarter 1 to 0.70 in quarter 4, with the highest value in the fiscal year occurring in quarter 4.

        - However, the rate of Restraint per 1,000 patient hours **decreased** from 0.58 in quarter 1 to 0.40 in quarter 4 and, in fact, remained below the national average (0.53) for all but quarter 1.

- In review of the fiscal year in sum, the trend of these rates was mixed, with the rate of Seclusion increasing, the rate of Restraint decreasing, and the combined rate of Seclusion and Restraint remaining similar in Quarters 1 and 4 with a pronounced drop in quarters 2 and 3.

- For a fiscal year comparison, across all units, the annual rate of Seclusion and Restraint per 1,000 patient hours was 0.80 for FY20, an increase of 0.13 from FY19 (0.67).

Presentations

In addition to the data review, each quarterly meeting includes site presentations. Hospital units named in the regulation provide a detailed overview of their recent data and experiences. Presenters rotate across the sites. Each meeting schedule includes two presentations and is a chance to tell the "story behind the data".

This allows the committee members to put the data they review into context and more easily see trends in data over time.

The Committee noted some concerns in the last report that attendance was inconsistent by some sites and that sites have not always attended when they are on the calendar to present. The Committee recommends that there be clear expectations relayed regarding attendance and a quarterly review of which sites are and aren't present. This is especially important since it becomes harder to be aware of participants in virtual meetings. The presentations are an important component of the meetings since they often generate significant discussion as sites have an opportunity to describe the strategies being are implementing to meet the goal of reducing seclusion and restraint.

Last year's Annual Report noted that although the discussions continue to offer an opportunity for *the committee members in the room with lived experience to be able to participate meaningfully in these conversations, there were also* times of obvious tension. It was suggested that tension may result from the inherent challenge of ensuring the Committee member's comments are given and received in the spirit of collaboration and a shared investment in providing the best outcomes possible.

Tension increased significantly during this fiscal year. Peer representation has been limited and it has been challenging to find people with lived experience to serve on the Committee. Certainly, the topic alone can be a challenge from an emotional perspective, but there has been concerns expressed repeatedly by peers and advocates on the Committee that it often does not seem that there is any response evident when program specific concerns are raised and that concerning trends continue to be consistent in quarterly data.

The final quarterly meeting of this year was attended by many public voices in advocacy roles who participated specifically to share concern about the Retreat's most recent EIP data as rates are higher than is being experienced at other Vermont sites. The comment was made that it is not new for the Retreat S/R data to be higher than other Vermont sites. The Brattleboro Retreat representative at the meeting informed the group that a large contingency of staff at BR took recent the 6CS © training and are starting to implement some of these things. She went on to say that the organization is always trying to utilize the data behind the numbers, and now there is a greater push with getting senior leadership involved. Now when there is a code, senior leadership has to be part of this.

To provide further information about Brattleboro's Retreats efforts related to specific T2 numbers, the representative informed the Committee that the organization closed T1 and made it a COVID-19 unit with negative pressure. The Representative also stated that there are frequent CMS visits and CMS has not expressed any concerns. She

stated that they want to reduce the number of procedures and that is why they are working with 6CS and took advanced CPI trainings. She advised the group that the Retreat has significant concerns for patients who are slamming their heads on doors or putting hands on staff and that they are doing S/R mindfully, and only when things like this happen.

Minutes from this meeting, along with all meetings, are posted on the website referenced earlier and provide a unique opportunity to review the concerns and the general tenor of the group discussion.

Recommendations for Consideration-

A. Committee Process and Function

1. Clarifying membership and increasing community involvement-
   Some Committee members acknowledged they recognize initial efforts in this area were made, but recommend a refocus to gain further progress as ground has been lost this fiscal year.

2. Participation and Attendance
   This area remains a concern for the Committee which asks that the suggestions below from the previous report, be implemented.

   a. It is essential that the committee continue to have regular participation by persons with lived experience. It is equally imperative that the designated sites consistently attend and participate in the quarterly meetings.
   b. Membership of the Committee, inclusive of name and role on the Committee, should be consistently up to date on the DMH website
   c. Take attendance at each meeting using a format that makes clear not only the participation, but also the absences. This information should be reported as part of the meeting notes.
   d. Establish a protocol to address attendance concerns that arise and are within the scope of the committee's advisory responsibilities. The protocol should be developed with input from the entire committee and result in considering options to address the concerns.

3. Role of the Committee -
   Last year's recommendation regarding committee role stated:

   Meeting notes reflect continued discussion regarding clarifying the role of the Committee.

   The Rule describes the role of the Committee as follows:

   The Review Committee shall meet quarterly to review the aggregate data submitted by the designated hospitals and the state-operated facilities. The Review Committee shall prepare an annual report

summarizing its advisory work, providing suggestions and recommendations regarding adherence to these standards, including trends in the frequency in the use of emergency involuntary procedures, findings relative to compliance with the requirements for the use of such procedures, the need for staff training, and other related matters.

Some members have expressed frustration that the activities assigned to the group (reviewing, summarizing, providing suggestions and recommendations regarding any concerns)do not lead to any way for them to know whether changes were considered, or made, as a result of their work and, if so, if the changes had any impact. Put simply, there is no feedback loop built into the system and some Committee members have expressed that they have no way to know if their input is valued. It has been suggested that perhaps this derives from challenges with the regulation itself.

The update from some members of the Committee is that they have experienced no visible progress in this area and they have asked that their recommendation be repeated. To add further specificity to the recommendation, some Committee members would like to know what the process is for addressing and/or reporting concerns when they are uncertain that their input is being considered. An essential element of that process is to determine who the correct recipients are for this information.

As noted, the frustrations in this area may be more attributable to the actual regulations and not a recommendation for DMH. However, the continued challenges in this area are stated because they call attention to the fact that some members have a general dissatisfaction with the process and do not find it valuable. It may be important to explore whether that is a factor in the difficulties of retaining peers on the Committee.

4. Benchmarks for EIP incidents –

Some Committee members stated they continue to believe that new measures should be determined to provide additional ways to recognize if efforts to reduce EIPs are meeting with progress. These Committee members would like the meetings to allow for a focused exploration of this idea that allows for an informed, collaborative approach to considering the options. No Committee members have come forward to suggest they feel that determining additional appropriate measures is within their purview. The recommendation is for the Committee, as a whole, consider options.

Some of these recommendations would require more time for the Committee meetings as the current structure provides only for the data

review and presentations. This does not allow for setting aside time to consider and/or implement changes in the Committee's approach.

Some members of the Committee continue to share concerns that the process is currently not functioning at an optimal level, and are asking fo**r** a thorough exploration of how the Committee is both structured and facilitated. It is hoped that this would result in an objective and informed listing of recommendations to increase the effectiveness of the Committee's work. Returning to the legislative body for additional guidance may be warranted.

B. Training Recommendations

1. Six Core Strategies © training – A revitalization of this evidence based initiative has consistently been a strong recommendation of the Committee who is confident that the implementation of the practice positively influences outcomes. VCPI worked with DMH and the Committee to develop a training plan further described below.

The Six Core Strategies is an Evidence-Based Practice developed specifically to reduce seclusion and restraint in in-patient psychiatric unit. Drs. Kevin Huckshorn and Janice LeBel are the developers and they train internationally. They have worked with Vermont several times in the last few years to support improvements.

During this round of funding:

- Designated hospital sites, as well as EIP Committee members, had the opportunity to participate in 4 half-day virtual training sessions.
  - Participants attended from Brattleboro Retreat, Windham Center and Rutland Regional Medical Center.

- The hospitals also had the opportunity to request individualized technical assistance regarding their programs implementation of the practice.
  - UVMMC, Rutland Regional and Brattleboro Retreat took advantage of these opportunities.

- More intensive technical assistance was provided to two sites
  - Brattleboro Retreat and VPCH applied for, and were rewarded those two slots.
  - This work would have historically been done via site visits, but due to the Covid- 19 pandemic were instead focused on a

comprehensive document review of policies, procedures, training plans, etc.
    - The review resulted in written reports to each program providing feedback related to practices known to reduce seclusion and restraint incidents.
        - They noted areas of both challenge and strengths and included specific recommendations for improvements
    - Written reports were followed by extensive TA opportunities to review recommendations and begin to develop an action plan for implementing

VCPI has submitted the grant report to DMH and it included points relevant to work of the EIP Committee. Understandably, due to the severe impacts from Covid-19 outbreak across all settings and situations, it proved difficult for sites to dedicate their attention and significant staff to this initiative. Those who were able to participate rated the training highly for teaching strategies to improve practice.
Based on this some Committee members recommend

- Offering additional opportunities

- On-going implementation support and expectations are also recommended.

Note: The trainers noted an excellent response to these opportunities from Brattleboro Retreat. They dedicated high level leadership and considerable staff time, remained open to feedback throughout and have a clear commitment to more fully implementing the Six Core Strategies ©. Since sites across Vermont and the nation have described the approach as extremely effective in meeting the goal of reducing seclusion and restraint, this would give them a solid foundation for significantly improving practice.

- Supporting an on-going learning collaborative where the sites are able to continue to learn together and support one another's progress is a strategy used to increase the rate of sustainment of practice changes. This would provide an opportunity to focus on Six Core Strategies © as well as other promising practices.

2. All sites continue to provide internal training to staff at their sites. Some members of the Committee would like to have reports on training be included in the site presentations.

3. Previously, interest was expressed in a collaborative training on Sensory Integration. The Committee recommended that this, and other topics, that multiple sites are (or want to be) addressing, should be explored to determine if there are opportunities for collaborating.

This has not been done to date due to COVID-19 and other considerations, but the recommendation is still applicable.

In conclusion, some Committee members reported that having regular reports back on recommendations provided is important. We recommend regularly reviewing for status updates.

On behalf of the Emergency Involuntary Procedures Committee, thank you for the opportunity to share our thoughts with you in the interest of continued reduction of EIPs in our in-patient settings.

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