Avoiding the Chill Pill: Verbal De-escalation training for psychiatric residents in a Simulated Lab setting

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Introduction

- Simulated training has been shown to improve outcomes in acute psychiatric settings through **promoting risk reduction and safety, strengthening of staff collaboration**, especially psychiatric trainees by bringing about improvement in confidence and competence.
- Prevention-based models recommended by the United States Preventive Task Force (USPTF) are the current standard of care (1) at most institutions and these guidelines lend reason to **actively ensure the creation of a safe clinical and working environment designed to preemptively intervene, anticipate and alleviate the greatest risk for adverse outcomes**.
- Recognizing the gap in trainee curricula at our Community Mental Health Center and promising results from simulation-based training studies, the Department of Psychiatry deemed it beneficial to develop a standardized training course aimed at training residents in **de-escalating agitated patients and appropriately deploying more restrictive measures when needed**.

OBJECTIVES

- Understand the existing knowledge and skill gap when working with agitated patients
- Discover advantages of using simulation-based learning over didactics only, to improve resident competence, preparedness, skill, and confidence
- Identify appropriate measures and techniques to foster resident and patient safety through simulation
- Develop solutions to implement verbal de-escalation training among residents/staff in various settings

Methods

- IRB exempt study, grant funded $4000, by the Committee of Interns and Residents

The study consisted of a **two-part intervention:**

1. **Online module-** all residents (N=36) viewed a 4 hour JCAHO and OMH accredited verbal de-escalation training, based on “Crisis Prevention and Intervention”
2. **Simulation training-** all residents did the simulation training with standardized patients (trained actors) depicting 3 clinical scenarios: psychosis, intoxication and cognitive impairment, followed by individual debriefing with faculty and SP, and small group debriefing with the other residents in the same session

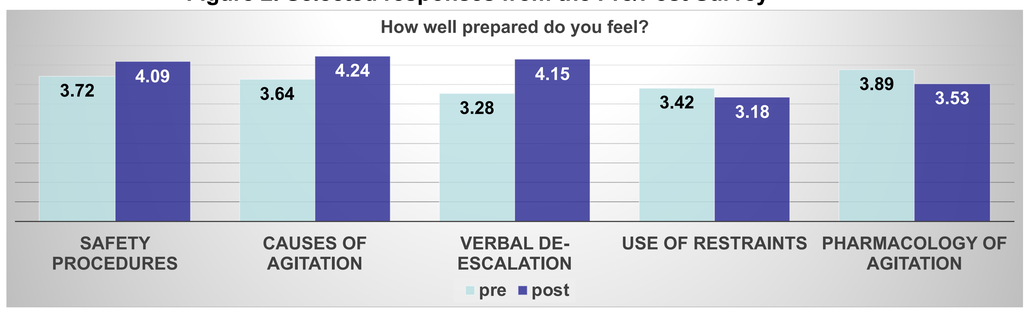
Pre and post intervention surveys including the **Management of Aggression and Violence Attitude Scale (MAVAS)** were administered.
Calming and triggering behaviors during the simulation were rated by 3 faculty members.

Study Results

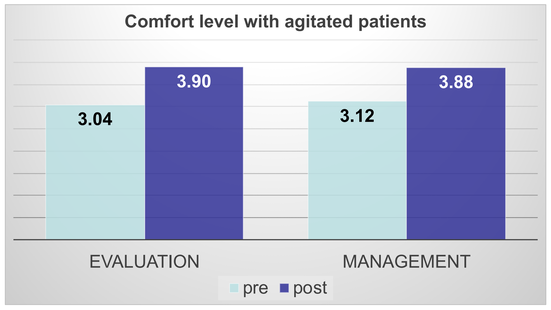
Figure 1. Residents’ responses to MAVAS Questions

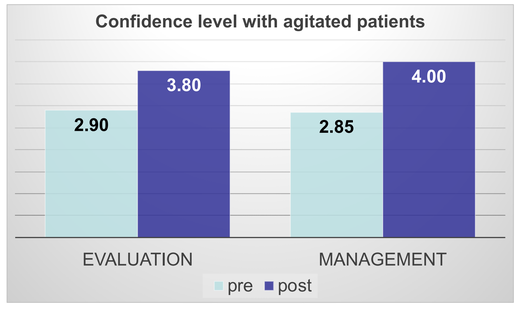
	MAVAS QUESTIONS	Mean (pre-intervention)	SD	Mean (post-intervention)	SD	S	P
A	**INTERNAL CAUSATIVE FACTORS**	**Wilcoxon signed-rank test**				**S=556.5**	**0.052**
4	Gender mix on the wards is important in the management of aggression	2.515	0.508	2.441	0.746	15	0.518
5	It is difficult to prevent patients from becoming violent or aggressive	2.765	0.606	2.794	0.592	-4	0.747
7	Patients are aggressive because they are ill	2.242	0.708	2.324	0.589	-11.5	0.701
9	There appear to be types of patients who frequently become aggressive towards staff	2.088	0.514	2.353	0.734	-42	0.098
14	**Patients who are violent are often restrained for their own safety**	**2.088**	**0.621**	**2.412**	**0.557**	**-60.5**	**0.024**
17	Aggressive patients will calm down automatically if left alone	2.871	0.619	3.000	0.661	-10.5	0.452
B	**EXTERNAL CAUSATIVE FACTORS**	**Wilcoxon signed-rank test**				**S=296.5**	**0.074**
1	**Patients are aggressive because of the environment they are in**	**2.091**	**0.384**	**1.824**	**0.521**	**36**	**0.035**
16	Restrictive environments can contribute towards aggression	1.839	0.454	1.939	0.429	-9	0.289
27	Seclusion is sometimes used more than necessary	2.367	0.615	2.219	0.608	11	0.484
24	Patient aggression could be handled more effectively on this ward	1.839	0.523	1.545	0.564	24.5	0.092
25	Prescribed medication can sometimes lead to patient aggression and violence	1.968	0.482	2.121	0.600	-16.5	0.183
26	It is largely situations that contribute towards the expression of aggression by patients	2.100	0.481	1.844	0.767	24.5	0.192
C	**SITUATIONAL/INTERACTIONAL CAUSATIVE FACTORS**	**Wilcoxon signed-rank test**				**S=744.0**	**0.046**
2	Other people make patients aggressive or violent	2.091	0.459	2.000	0.492	11	0.432
3	**Patients commonly become aggressive because staff do not listen to them**	**1.879**	**0.485**	**1.559**	**0.561**	**57**	**0.008**
6	Patients from particular cultural groups are more prone to aggression	3.176	0.626	3.162	0.660	3.5	1.000
15	**The practice of secluding violent patients should be discontinued.**	**2.971**	**0.521**	**2.647**	**0.646**	**50**	**0.037**
20	Expressions of aggression do not always require staff intervention	2.613	0.715	2.667	0.692	-9.5	0.736
21	Physical restraint is sometimes used more than necessary	2.000	0.577	1.909	0.522	7.5	0.791
22	Alternatives to the use of containment and sedation to manage patient violence could be used more frequently	1.903	0.473	2.061	0.747	-15	0.485
23	Improved one to one relationships between staff and patients can reduce the incidence of patient aggression and violence	1.645	0.661	1.545	0.564	4	1.000
D	**MANAGEMENT FACTORS**	**Wilcoxon signed-rank test**				**S=275.5**	**0.490**
8	Poor communication between staff and patients leads to patient aggression	1.588	0.500	1.324	0.475	54	0.059
10	Cultural misunderstandings between patients and staff can lead to aggression	1.794	0.479	1.559	0.561	46	0.088
11	Different approaches are used on this ward to manage patient aggression and violence	1.971	0.521	1.912	0.570	8.5	0.825
12	Patients who are aggressive towards staff should try to control their feelings	2.412	0.609	2.485	0.619	-10.5	0.693
13	**When a patient is violent, seclusion is one of the most effective approaches**	**2.559**	**0.705**	**3.029**	**0.627**	**-55.5**	**0.006**
18	Negotiation could be used more effectively when managing aggression/violence	2.000	0.643	1.667	0.692	40.5	0.108
19	Restrictive care environments can contribute towards patient aggression and violence	1.806	0.477	1.848	0.566	-7.5	0.791

Figure 2. Selected responses from the Pre/Post Survey



Of note: restraints and pharmacology were not addressed in our study, and were used as “control questions”





Qualitative Analysis

All 3 faculty members rated the calming and triggering behaviors based on a preset checklist, as well as additional comments on the evaluation sheet:

- **The most commonly used calming interventions:**
  - ❖ Explaining the situation and process
  - ❖ Summarizing the content
  - ❖ Identifying patient’s feelings, wants and needs
- **The most common triggering behaviors:**
  - ❖ Interrupting/ talking over the patient
  - ❖ Not prioritizing patient’s needs
  - ❖ Using long/ convoluted explanations
  - ❖ Insisting on using medications (of note, the standardized patients (SPs) were instructed to react negatively to being offered medications, as the purpose of the simulation was to train verbal de-escalation skills)

In 3 situations the faculty had to end the scenario as the resident was not able to de-escalate the SP.

In more than 10 situations the scenarios ended early as the residents were extremely skilled in putting the SPs at ease.

Qualitative comments which had the most impact on SPs and were reviewed with the residents in the debriefing session were related to:

- **Body language**: too far/ close, concealed hands, in pockets, fiddling with hair/ ID)
- **Choice of words**: which might be considered derogatory, or which are emphasizing the doctor is in control, and the patient needs to comply like “my priority is to…”, “you have to/ need to calm down”,
- **Punishment-like statements**: “if you don’t … then…”

Conclusion

This project successfully **addressed an important practice and knowledge gap and lent structure to the tailored protocol-based approach for managing agitated patients**, especially in busy ER settings. This approach utilizing a combination of online and simulation training can be replicated in programs across the country as a means to standardize verbal de-escalation training. There are multiple limitations that could prevent programs from utilizing a similar training such as funding for simulation actors, as well as a lack of experienced actors, and possibly a lack of simulation space. However this is a **proof of concept that reflects significant benefits reported through pre and post surveys by residents**.

References

1. Advancing the U.S. Preventive Services Task Force Methods: Important Considerations in Making Evidence-Based Guidelines. Edited by Alex H. Krist, Tracy Wolff, Iris R. Mabry-Hernandez, Kirsten Bibbins-Domingo. Volume 54, Issue 1, Supplement 1,Pages A1-A8, S1-S104 (January 2018).