Guide, Standards, Benchmarks & Literature Review:

Standard 1: Physical Safety

March 2, 2020 Edition

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STANDARD 1: PHYSICAL SAFETY

The unit assures the physical safety of patients, visitors, and staff.

QUESTIONS OF INTEREST

- How safe is inpatient care?
- What are the most common and serious inpatient risks?
- To what extent should patients, parents/caregivers, and involved mental health workers and teachers be involved in the process of identifying risks and assuring inpatient safety?
- What are some mechanisms to promote better communication and collaboration?
- Should all patients have an individualized safety plan?
- What are some common and important inpatient safety practices?
- Are most safety practices similar for general crisis, treatment, and subspecialty units?
- How important are staff? Does safety depend upon having experienced staff with enough staff time and staff numbers to manage different levels of risk? Are staff supervision and training important? What about the safety of staff?
- Do staff need specialized knowledge and interventions for the most common risks such as suicidal and aggressive behaviours? What about rarer but very concerning behaviours such as sexual assaults and fire setting?
- Should crisis and treatment units be backed-up by more secure alternatives including psychiatric intensive care units if required?
- Can some non-admissions and early discharges result in safer care? Is access to psychiatric intensive care and secure settings important?
- Are coercive safety measures such as involuntary admission, restrictions, and seclusion and restraint used in a consistent manner? Are they safe? Effective? Overused?
- Is some risk important for recovery?
- Should inpatient units have access to national and provincial safety standards and databases that can provide safety performance benchmarks specific for child and adolescent mental health inpatient units?

INTRODUCTION

The focus of this section entitled 'Standard 1: Physical Safety' is on risks arising from suicidal behaviour, non-suicidal self-injury, violence and aggression, sexual assault, and other physical risks including falls, and accidents. Risks stemming from poor environmental design, medication errors, and failures to address psychological and cultural safety are mentioned but are discussed in greater detail in their own sections including 'Standard 2. Psychological Safety, Dignity, & Rights,' 'Standard 3. Physical Environment', and 'Standard 12. Medication'. The present section

reviews literature that focuses on the identification and management of risks of harm to self, to others, and from others, and on ways to prevent and manage these risks. Qualitative and quantitative indicators for safety are included in a self-audit checklist at the end of the section.

This section reviews the role of inpatient services in Ontario in providing safety for youth with mental health problems. It notes that the primary role of inpatient care in Ontario appears to be to provide safety for children and adolescents who present to emergency care with suicidal risk. Such unplanned and typically involuntary crisis admissions provide parents/caregivers and referral and transfer sources with immediate benefits such as reduced worry, reduced liability, ability to rapidly clear emergency departments, as well as a more rapid service response and greater after-hours coverage than is possible for most community services to provide. There are also a few Ontario subspecialty treatment units including several for eating disorders, one for concurrent disorders, and several generic treatment units which provide longer stays for treatment. Regardless of reasons for admission, all of the differing types of inpatient units provide risk management for the risks that precipitated admission as well as for any other co-occurring safety concerns.

Units regardless of type tend to rely on many similar practices to assure safety. These include identifying and analyzing incidents and near misses, assuring sufficient numbers of staff, using involuntary mechanisms, providing reasonable restrictions and surveillance, providing seclusion and restraint, engaging patients, parents/caregivers and community partners in risk management, completing a risk assessment, collaboratively developing safety plans with families and their community mental health supports, and assuring staff have the competencies to manage suicidal, aggressive, sexualized, and other specific risks. Some less common but nevertheless important practices include not admitting or discharging patients whose safety needs exceed what the unit can provide by redirecting or transferring them to safer settings such as more secure forensic settings and psychiatric intensive care units.

Initiatives to improve safety have spawned new and interesting conceptual approaches such as the development of "cultures of safety" on inpatient units (Slemon, Jenkins, & Bungay, 2017), trauma informed care (Boel-Studt, et al., 2017), attachment supportive care (de Decker et al., 2017), mindfulness training for staff (Hallman et al., 2014), increased patient and parent/caregiver involvement in safety planning (Azeem et al., 2011), more integrated safety approaches like Safewards (Bowers et al., 2015; Fletcher et al., 2017; Hottinen et al., 2019), Dialectical Behaviour Therapy (Katz et al., 2004), and patient safety education programs (Emanuel et al., 2013). Increasingly all approaches emphasize the importance of assuring safety for staff as well as patients. Although ONCAIPS surveys have found that units are generally seen to be safe places, the percentage of units with concerns about safety has been increasing. Concerns expressed by units include concerns about the social environment (e.g., contagion and patients learning of unsafe behaviors from co-patients), the patient type and mix (e.g., youth with severe criminogenic behaviours that cannot be managed safely), staffing (e.g., not always sufficient in numbers or specialization to best assure safety; not enough time), and difficulties balancing restrictive control required for safety versus allowing the risks required for learning and recovery. The list of indicators begins with the practice of monitoring, analyzing and reporting incidents, near misses, and potential risks.

INCIDENTS & RISKS

1.1 The unit routinely monitors, analyzes, and reports incidents, near misses, and potential risks.

Incidents and near misses typically occur on the unit, but they can also occur during abscondment, on pass, and shortly after discharge. Inpatient incidents are important to identify and monitor as they are not uncommon and are typically associated with poorer patient outcomes (Barton et al., 2001). Units should routinely identify, report, analyze, and work to prevent occurrence and recurrence of incidents. Units should encourage patients and parents/caregivers to formally report incidents, near misses, and potential risks. Incidents of physical harm, near misses, and potential risks include self-injurious behaviours, assaults, use of seclusion and physical and mechanical restraints, sexual contact, falls, accidents, and use of contraband (e.g., sharps, drugs). Information from identification and analysis can be used to help reduce incidents, protect units from litigation, and identify root causes of problems (Vincent et al., 2000).

The development of provincially and nationally aggregated data specific to child and adolescent inpatient unit incidents and safety measures would be helpful. Such data bases, if they were available and easy to access, would help units understand national trends and their own level of safety. Categories and definitions for inpatient incidents have been proposed but are not widely adopted (e.g., Marcus, Hermann, & Cullen, 2018). Although adoption of common definitions provincially and nationally is some time away, units should nevertheless identify the most common and serious incidents, near misses, and potential risks until provincial and national reporting categories are better developed. Types of incidents, near misses, and potential risks of concern that should be identified, reported, and prevented include incidents of:

- Child Abuse (Harm to patient)
- Risks from Staff (Harm to patient)
- Suicidal behaviour (Harm to self)
- Non-suicidal self-injury (NSSI) (Harm to self)
- Violence & aggression (Harm to others)
- Sexual assault or contact (Harm to and from others)
- Other Less Frequent Incidents, Near Misses and Potential Risks including Absconding, Fire setting, Falls, and Accidents.

Safety issues related to life-threatening weight loss and life-threatening substance abuse, design and condition of the physical environment, medication use, staffing ratios, and psychological harm are beyond the scope of this section but are all discussed in greater detail in later sections. Safety is not the same as treatment. Safe services contribute to better outcomes by providing a base for other activities and interactions. Treatment for suicidal behaviour, aggression, and other problems is discussed in greater detail in other sections.

SAFETY PROCEDURES & PRACTICES

1.2 The unit provides a complete range of safety procedures and practices required to prevent incidents and evaluates their effectiveness.

Hospitals should provide a complete range of safety procedures and practices. Units should have a list of safety procedures and evaluate the effectiveness of these procedures in terms of numbers, severity and types of incidents, and the safety record of the units. The most common practices which will be covered in detail in this section include:

1. Monitoring and reporting incidents, near misses, and potential risks
2. Providing a sufficient range of developmentally informed safety practices
3. Assuring staff time and resources
4. Having the support from psychiatric intensive care and other secure settings
5. Not admitting patients whose safety cannot be assured
6. Discharging patients with risks the unit cannot address
7. Making the best use of involuntary status to assure safety
8. Providing risk assessment
9. Communicating and collaborating with patients, parents/caregivers, and community professionals
10. Implementing reasonable restrictions
11. Implementing reasonable observation and surveillance
12. Monitoring and searching the environment, and when necessary, patients for dangerous items
13. Developing and implementing individualized safety plans
14. Making the best use of seclusion and restraint
15. Assuring staff safety
16. Reducing risks to patients from staff
17. Preventing and reporting child abuse
18. Preventing and managing suicidal behaviour
19. Preventing severe non-suicidal self-injuries
20. Preventing and managing violence and aggression
21. Preventing sexual assault and contact
22. Preventing absconding, falls, accidents, and other risks
23. Promoting healthy risk taking

The practices discussed in this section are not stand-alone practices for physical safety. Physical safety is impacted by the environmental design of the unit, the emotional climate of the unit, the psychological safety of patients, the degree to which patients and parents/caregivers are engaged, the availability of a complete range of more appropriate services, the types of unit activities and treatments available, the quality of assessment, medication and many other factors. There are several other important and promising approaches including patient-centred, family-centred, trauma-informed and attachment-supportive care which are discussed under Standard 2. Psychological Safety, Dignity, & Rights. Contributions to safety from appropriate environmental design, staffing ratios, psychotherapies, and medication are respectively discussed under Standard 3. Physical Environment, Standard 4. Staffing, Standard 9. Milieu & Activities, Standard 10. Assessment, Standard 11. Stabilization & Therapy, and Standard 12. Medication.

STAFF TIME & RESOURCES

1.3 The unit assures that staff have the time and numbers required to assure patient and staff safety.

Staff must have the time and staff numbers required for the provision of safety. A recurring concern of unit staff is that they do not have enough time to allocate to patient care because of the many other task requirements (James & Maude, 2015). Nurses and clinicians are too busy because of paperwork and non-patient hospital demands to keep informed about the details of a patient's history of risk, to detect and prevent periods of group contagion, to develop a working alliance that promotes safety, and to prevent milieu problems before they escalate. Safety depends to a large extent on having enough staff, enough time, and the right kind of consultative resources to properly do the job. Staff time for engaging with patients in the interests of safety needs to be protected, and management and staff both have responsibilities in assuring appropriate levels of staffing (American Nurses Association, 2007; Panagiotou et al., 2019). Needs to monitor and adjust staffing are important when there are unexpected increases and decreases in numbers of patients, risk frequency, and amount of work each patient requires (American Nurses Association, 2007; Weissman et al., 2007). Risks of insufficient staffing and time should be openly identified and addressed whenever patient demands exceed or threaten staff ability to cope. Staff will also need to go on breaks to interrupt stress and fatigue, and have opportunities for increased contacts with peers and managers for support. Units are at increased risk of experiencing patient incidents when staff work over capacity, regardless of whether this is due to excessive paperwork, overly rapid operational changes, or excessive patient load (Weissman et al., 2007). Need for support can be expected when the unit occupancy goes above 100% or when patients with severe behaviours are admitted. O'Herlihy et al. (2004), for example, found that 21% of admitted inpatients in their UK national sample needed resources beyond standard staffing as reflected in the use of some staff for continuous one-to-one observation. Newly graduated nurses and nurses from other units may not be able to cope as well as more experienced staff and may need more time and support. Less experienced staff may need increased support from more experienced and specialized mental health nurses on the unit, more supervision sessions, and more frequent communication with other members of the interdisciplinary team (Ramritu, et al., 2002). Having enough time, breaks, and supports can help maintain staff at a level of performance that protects both staff and patients. The reader is directed to the section Standard 4. Staffing for a more detailed discussion of staff to patient ratios and suggested staffing standards and benchmarks.

PSYCHIATRIC INTENSIVE CARE

1.4 The unit has access to psychiatric intensive care units (PICU) and other more secure services for patients that cannot be safely managed on the unit.

The purpose of psychiatric intensive care units is to provide safe, secure assessment and stabilization for the most risky and disturbed patients that cannot be safely managed in inpatient, residential, and forensic settings (Bowers, 2012; Bowers et al., 2008). Psychiatric intensive care is a useful resource for treating highly disturbed individuals who are at high risk of violence and whose risks would be difficult to manage safely on a less secure inpatient ward (Bass & Ward, 2004). They are nevertheless valued because removal of a highly dangerous patient is typically

seen to have a positive impact on the emotional climate of crisis and treatment inpatient units where they would otherwise have been admitted. In their study, Brown and Bass (2004) reported that patients were predominantly young males with psychotic illness and a history of violence and substance use. In Ontario, some child and adolescent units have no access to PICUs, and a number share psychiatric intensive care resources with adult inpatient units.

NON-ADMISSION

1.5 The unit does not admit children and adolescents that it cannot safely manage and redirects them to safer settings.

Units should only admit children and adolescents that they can safely manage. Ideally and ethically, no patient should be admitted if their medical or behavioural risks exceed the level of safety that the unit can provide. In other words, patients should not be admitted to inpatient care if the risks of harm exceed the benefits of admission. Admitting all transfers and referrals regardless of ability to assure safety of the young person and co-patients puts everyone at extreme risk and, in addition, delays the development of the types of settings that could more safely and effectively manage these levels of risk. Units tend to consistently apply a non-admission practice for children and adolescents with medical problems they cannot safely manage (i.e., they do not admit young people who are not 'medically clear') (Tintinalli, Peacock & Wright, 1994; Williams & Shepherd, 2000). Units have not uniformly adopted a similar non-admission practice for children and adolescents whose level of aggression or self-harm exceeds what a unit can safely manage. This appears to be in part due to a greater range of services to redirect young people for medical needs than behavioural ones. Inpatient admission may be the only option available to Emergency Departments and community resources. Unfortunately, most general crisis units are not designed or resourced to deal with some of the most severe behavioural risks, with ensuing risks of harm to self and others. Ideally, referral and transfer sources, and units, should consider whether children and adolescents may be physically harmed or harm others before admission. Units should be able to redirect or discharge youth to a safer and more secure setting when the likelihood of harm exceeds the benefits of admission. Such situations may include youth whose violence is criminogenic more so than the result of a mental illness and who might be better placed in a juvenile detention or forensic setting. It could also include youth with severe developmental disabilities who require long term 1:1 or 2:1 staffing in a home without other occupants. It could include situations where a perpetrator of assault is being transferred for admission to a unit which has admitted one of his or her victims. This latter situation may require a temporary transfer to a different unit of the same type for one of the young people until one of them is discharged. Providing safety by non-admission is difficult and at times not possible if the unit is not supported by a complete system of care that has more appropriate settings. Problems to safe care caused by service gaps are discussed further in the section on Standard 5. Mental Health System and Standard 7. Access & Admissions. The advantages of a complete system of care include the availability of more secure alternatives but also the availability of earlier and more effective prevention that would reduce need for inpatient admission for many youth. The lack of other available services to prevent risks and provide similar or greater levels of safety often results in the default use of general and inpatient crisis units when longer term individualized treatment units, psychiatric intensive care units, family admissions, more secure forensic units or other alternatives would be more helpful.

EARLY DISCHARGE

1.6 The unit discharges children and adolescents it cannot safely manage to safer settings.

Inpatient admission is not without risk and, while it is beneficial for some patients, it can be harmful for others who may escalate suicidal and violent behaviour in response to admission (McDougall et al., 2020). Sometimes admission processes fail to identify youth who may be unsafe or cause others to be unsafe in ways that the unit cannot manage. Recommendations that repeatedly violent patients be transferred to a more secure setting in order to protect withdrawn and more vulnerable non-violent patients is not new (e.g., Crain & Jordan, 1979). These recommendations stem from studies of adult units but are similarly applicable to children and adolescents. It can be argued that risks of harm posed by recurring physical assaults of co-patients pose an even greater concern on child and adolescent units, where substantial differences in size and capacity to harm or protect oneself can exist (e.g., a six-year old who is targeted by a 17-year old). Admitting children and adolescents whose repeated violent behaviour exceeds what the unit can safely address, who present with medical fragility the unit cannot manage, or who present infection risks to others should be discharged to a safer setting as soon as possible. As with non-admission, difficult debates about which are likely to be the least harmful alternatives arise when the system of care has significant gaps in access to services that would have provided safer outcomes had they been available.

INVOLUNTARY ADMISSION & TREATMENT

1.7 The unit encourages voluntary participation and only uses involuntary admission and treatment when essential to assure safety.

Types of Dispositions. Ontario admissions can occur under one of three dispositions under Ontario's Mental Health Act (1990): 1) voluntary, 2) informal, or 3) involuntary. Involuntary detentions for psychiatric assessment (Form 1) and involuntary admissions for treatment (Form 3) are important mechanisms that are used to assure patient safety. Voluntary admissions are those in which the patient is the consenting person. Voluntary patients can leave the hospital at any time and cannot be detained or restrained or suffer restrictions against their will. Informal admissions are those in which the young person is admitted with the consent of another person (typically a parents/caregiver). The informal category does not distinguish whether youth are willing or unwilling to come to hospital on a voluntary basis. A young person who is admitted under the consent of parents/caregivers can go to hospital willingly.

Involuntary Admissions. Involuntary admission is not intended to be used for the convenience of ensuring an ambulance or to comply with parent/caregiver demands for admission. It is to be used for situations where young people are 1) at imminent severe risk of harm to self and/or others by virtue of a suspected or verified mental illness, and 2) are unwilling, or unable, to take steps to assure their safety on a voluntary basis (Ellila et al., 2008; Gandy, 2004). Imminent severe risk of harm includes risk of suicide, aggressive behaviour that threatens the physical safety of others, impaired judgment that can lead to life-threatening decisions as may be the case during psychotic episodes, severe weight loss as seen in anorexia, severe dangerous substance abuse, and some of the more severe types of non-suicidal self-injury. Not surprisingly, crisis units

tend to receive involuntary admissions more than treatment units do. In addition to reducing opportunities for harm by placing a patient in a safer setting, involuntary processes have additional benefits such as helping to clear emergency departments, assuring ambulance transportation, reassuring concerned parents/caregivers, friends, and teachers, reducing provider liability, and allowing access to mental health services when community services are unavailable. In Ontario, most inpatient admissions occur under the conditions of a Form 1 of the Ontario Mental Health Act (1990) (Greenham & Persi, 2014). The Form 1 is used to detain youth for up to 72 hours for psychiatric assessment in order to determine whether they need to be retained for treatment. In Ontario it is physicians who determine involuntary status. In certain parts of the world the deciding authority may be a non-medical one (Carballedo & Doyle, 2011) and other settings besides hospitals can detain patients (e.g., community-based residential crisis). In certain countries youth can be admitted involuntarily for treatment without need for initial detention for assessment (e.g., Carballedo & Doyle, 2011). Some children and adolescents who are admitted involuntarily may not resist certification or apply to the Consent and Capacity Board for a review. To distinguish admissions of willing patients the World Health Organization (2005) has proposed the use of a clarifying category of "non-protesting" patients. These would be patients who may be incapable by virtue of their mental disorder but are not resisting treatment.

Promotion of Voluntary Admissions. Like many other jurisdictions, Ontario encourages the use of voluntary hospitalization when possible. Involuntary admissions for suicidal behaviour should be used only when all other voluntary avenues which might be likely to be as or more effective have been tried (World Health Organization, 2005). Similarly, involuntary admission and refeeding against the will of a young person should be an intervention of last resort in the care and management of anorexia (National Collaborating Centre for Mental Health, 2004). The use of involuntary admissions raises some difficult ethical dilemmas when parents/caregivers want a young person to be hospitalized and the young person makes arguments as to why they need neither hospital nor involuntary detention (Stoner, 2017). It is generally agreed that hospitalization should not be primarily to meet the needs of parents/caregivers but how best to proceed is less clear when parents/caregivers indicate they are unable to cope with difficult behaviours. Voluntary admissions tend to be less fraught with ethical dilemmas as they are more likely to preserve dignity, rights, and personal freedoms. They are also less likely to lead to discord among family members when parents/caregivers and patients offer opposing points of view and arguments. Voluntary admissions are also without some of the other problems associated with involuntary ones, including their vulnerability to overuse, to be influenced by nonclinical variables, to be highly variable across time, providers, and settings, and to be more likely to result in subsequent seclusion and coercive control, disempowerment, and stigmatization (Cassells, Paterson, Dowding, & Morrison, 2005; Dein, Williams, & Dein, 2007; De Leo & Sveticic, 2010; Ellila et al., 2008; Fryer et al., 2004; Greenham & Persi, 2014; Kaltiaila-Heino, 2004, 2010; Molnar, 1997; Rodrigues et al., 2019; Siponen et al., 2007, 2011; Smith, 2004; Tolmac & Hodes, 2004; World Health Organization, 2005; Xu et al., 2019). Overuse may be reflected in the numbers of false positives that inpatient assessment identifies. Many children and adolescents are hospitalized on an involuntarily basis only to be rapidly discharged after initial inpatient assessment determines they required neither inpatient safety nor treatment (Persi, Bird & DeRoche, 2016). Although involuntary admissions provide immediate reassuring safety for the brief time in hospital, there is little evidence that involuntary admissions provide lasting safety or improved outcomes. Ayton et al. (2014), for example, could find no difference in outcomes after 12 months between involuntary admissions and informal admissions. Similarly, Sant'Anna et al. (2019) found no significant differences between individuals who were admitted involuntarily for severe substance abuse in terms of relapse. Discussion about the relative costs and benefits of involuntary admissions, public education, and greater youth involvement in admission decisions may help reduce the need for involuntary admission and increase the likelihood of voluntary utilization of inpatient care

(Henderson et al., 2004; Hotzy et al., 2018; Sharma & Kommu, 2019; Strand & von Hausswolff-Juhlin, 2015).

Variability. Surveys have identified what appear to be significant variability in the use of involuntary mechanisms geographically. ONCAIPS surveys have identified that patients with similar levels of risk may be admitted involuntarily in some geographic areas and not in others. Greenham, Persi, & Prieto (2016), in the 2016 ONCAIPS survey, for example, found a wide range of involuntary detention. Unit involuntary admission rates ranged from 15% to 96% on general crisis/emergency and extended crisis treatment units admitting for similar level of severity. Variability in use is concerning and difficult to explain but is more common than not internationally (e.g., Kaltiaila-Heino et al., 2004; Siponen et al. 2007; 2011). Differences in use may be the result of differing interpretations of the legislation and its intentions among Emergency Departments that make such referrals and transfers, differences in risk tolerance, and differences in perceptions of how to access units of different types (e.g., admission for crisis versus treatment). Some transfer sources in Ontario have expressed erroneous beliefs that crisis units can only be accessed involuntarily, for example.

Table 1: Sample of Studies of Involuntary Admission Rates

INVOLUTARY ADMISSION RATES					
Age Group	*Unit location*	*Reference*	*% Involuntary*	*%Parent Authority*	*% Voluntary*
Adolescent	*Texas*	*Felkins, Guthrie, & Walch (1991)*	*30*	*22*	*48*
Child & Adolescent	*Finland*	*Ellila (2007)*	*29.5*		
Adol: >15	*Norway*	*Hanssen-Bauer et al.(2011)*	*33*		
Child & Adolescent	*Germany*	*Jendreyschak et al. (2014)*	*29.5*		
Child	*UK*	*Jacobs et al. (2009)*	*0*		
Adolescent			*4.9 – 9.8*		
Natl. Registry *Child <12* *Adol 12-17*	*Finland*	*Kaltiaila-Heino (2004)*	 *4.8* *22*		
Adolescent	*Finland*	*Kaltiaila-Heino (2010)*	*50*		
Adol: >15	*UK*	*Mears et al. (2003)* *LOS – 100 days/ no MHA status* *LOS – 210 days/ MAH status*	*19*		
Child & Adolescent Crisis Units	*ONCAIPS Ontario*	*Greenham, Persi, & Prieto (2016)* *LOS - 9 days*	*68*		
Child & Adolescent Crisis Unit	*NE Ontario*	*Persi, Bird & DeRoche (2016)* *LOS (Median) – 6 days*	*80*		
Child & Adolescent	*Finland*	*Sourander & Turunen*	*14*		
Child & Adolescent	*Japan*	*Setoya et al. (2007)* *LOS - 11 months*	*46.8*		*53.2*

Overuse. Overall the Ontario data appear to be on the high side relative to other parts of the world (see Table 1). Involuntary admissions provincially in the ONCAIPS 2016 survey averaged 65% of total admissions with a median of 68%, and a range from 15 to 96%. Involuntary admission rates were lower for treatment units. The findings indicate that most young people in Ontario do not choose to get help from inpatient units. This raises questions about the possibility that youth are not going voluntarily because of negative perceptions of units. Improved understanding of rates of utilization in Ontario would benefit from further study.

Changes to Disposition. Upon completion of risk and psychiatric assessments, a patient's involuntary stay can be extended by certifying the patient as an involuntary patient under a Form

3 for treatment or discharged as a voluntary patient or to the care of parents/caregivers. Involuntary can be extended with a certificate of renewal (Form 4) or a certificate of continuation (Form 4A). It is important to monitor trends in changes to disposition after inpatient assessment. The degree of change in disposition after admission can help inform performance benchmarks, patterns of risk, and possible undesirable variabilities in use across time and units. Rapid changes in disposition from involuntary to voluntary status followed by immediate discharge after initial inpatient assessment may also help identify possible rates of accuracy of pre-admission risk assessment or the possibility of overly low risk tolerance on the parts of referral and transfer sources. Kaltiala-Heino (2010) reported that about 45% of adolescents in their Finnish sample who were initially admitted involuntarily were subsequently retained as involuntary patients suggesting that rates of false positives may not be overly high. In contrast Persi et al., (2016) found that only 13% of children and adolescents who were initially admitted involuntarily were subsequently retained as involuntary patients suggesting the possibility that Ontario transfer sources make significantly more cautious types referrals for patients. These appear to be admissions caused by what may be excessive concerns that lead to overidentification or misidentification of numbers of youth at risk. Although most changes to disposition occur after initial assessment, changes can be made at any time if level of risk changes.

COMMUNICATION & COLLABORATION

1.8 The unit communicates and collaborates with patients, parents/caregivers, and community partners to identify risks and provide safety.

It would be unthinkable for units not to engage patients, parents/caregivers, and community resources in risk identification and safety planning. The best collaborators are likely to be well-informed ones. The unit needs to do its part to inform patients, parents/caregivers, and community partners about the risks on the unit from co-patients and hospital procedures, about the safety rules and practices, and about the unit's desire to partner. Accurate information about potential safety risks and about how these will be managed should be provided prior to admission by the emergency department or referring community mental health setting. Engagement can begin with handouts and orientation for patients, parents/caregivers and visitors that informs them of unit risks, rules, and safety practices. It is unfortunate that many patients and parents are poorly informed and can consequently develop very unrealistic expectations that lead to frustration and disappointment (Akin et al., 2010). The information provided prior to or shortly after admission should include descriptions of how patients and their parents/caregivers can complain or raise concerns about physical safety beyond the unit staff. This would include contact information for accessing a patient advocate, rights advisor, or ombudsman. The information should promote the view that safety is best assured if patients, parents/caregivers, community supports, and inpatient staff make the time to share information and plan together (Brickell et al., 2009).

Units are becoming increasingly appreciative of the many benefits of engaging young people in identifying risks and determining the best safety practices. Most patients are in a better position to make more powerful and lasting improvements to their safety and the safety of others than their parents/caregivers and staff. Patients can learn to avoid risky individuals and situations, warn other patients when they themselves pose risks, take time out to calm down, help others calm down, ask staff for support, and encourage other patients who may feel hopeless, and be open to receiving encouragement in return (Quirk, Lelliott, & Seale, 2005). Patients should be routinely

invited to participate in case conferences or sessions to address their personal safety. In addition, Lucas (2019) recommended the use of a weekly minuted unit meeting for young people and staff members to jointly identify unit risks and safety needs. Such meetings can improve working alliances, identify issues of safety and quality on the unit, and evaluate the quality of safety with staff members. Such meetings will likely work best when they are facilitated by a staff member who is able to lead and manage the dynamics that arise among young patients and staff (Lucas, 2019).

Parents/caregivers can, and should, be involved in the provision of safety whenever possible (Drapeau, 2019; Lucas, 2019; Mental Health Commission of Canada, 2012). Parents/caregivers with their community professionals can share what they know about children's risks, they can support children across admission and after discharge, and they can help problem-solve safety needs. The focus of unit, patient, and parent/caregiver collaboration should include discussions of how to identify risks and assure safety on the unit and at home. Parents/caregivers are more likely to be assets if engaged as active partners rather than passive ones who are expected to wait for medication and staff programming to work (Hepper, Weaver, & Rose, 2005). When incidents do occur, parents/caregivers should be engaged as soon as possible so they can understand what happened, participate in resolving crises, and contribute to prevention of recurrences (Aazeem et al., 2011; American Psychiatric Nurses Association, 2014; Goulet & Larue, 2016; Hammervold et al., 2019; Huckshorn, 2014; Masters, & Bellonci, 2002; Natta et al., 1990; Sutton, Webster, & Wilson, 2014). Working and learning with inpatient staff can also benefit parents/caregivers to improve post-discharge safety practices that can help prevent needs for readmission. Extending the collaboration to include community service partners can enhance what both know about risks and can help align safety plans and practices.

RISK ASSESSMENT

1.9 The unit provides a risk assessment that considers risk of injury to self, to others, and from others

All units, regardless of type, need to assess risk as early as possible so they can plan and provide safe care. Risk assessment goes beyond understanding the patient and the contributing diagnoses. It also includes considerations of not only risks to self and others, but also risks from others (Lucas, 2019). Risk from others includes assessing risks from co-patients, visitors, and the hospital environment and its procedures. Although risk assessment should focus upon the risk that precipitated the admission (Bruggen, Byng-Hall, & Pitt-Aikens, 1973), it should also assess for other problems that could compromise safety. The range of problems to be considered includes possibility of suicidal behaviour, severe non-suicidal self-injury, violence and aggression, sexual behaviours, absconding, unreported medical fragility and infection risks, risks from hospital environment, the staff and hospital procedures, and other foreseeable risks that could compromise safety. Risk assessment should be one of the first tasks after admission. In an ideal world, a comprehensive risk assessment should be completed by referral and transfer sources prior to admission so the unit can be aware of patient safety needs and prepare for the admission. Risk assessment is always best completed in collaboration with the patient, the community mental health workers, and parents/caregivers and needs not be limited to a single psychiatric assessment session. One of the benefits of more global assessment is that it can better help to determine need to change voluntary, involuntary, or informal status. The opportunity to keep or make a patient involuntary after admission provides units with a powerful mechanism to support continued safety, although it also raises problems like inconsistent application and overuse.

Functional assessment, antecedent and reinforcer analysis, diagnosis, and use of reliable and valid psychometric measures should be integral to all risk assessment. Simply attributing behaviour to a mental illness does not provide details about other contributing factors, antecedents, and sources of reinforcement for the risky behaviour. Risk assessment is not a one-and-done assessment, but a process that should continue from admission to discharge and ideally after that as well. Providing the most recent risk assessment update at discharge is essential. It is an important source of information for the patient, parents/caregivers and community resources. The community mental health services and parents can be informed of the hospital view of current risks and safety needs, and help the patients and their supports to develop the safest post-discharge plans possible (safety issues at discharge are discussed in greater detail in the section under Standard 13. Discharge).

RESTRICTIONS

1.10 The unit restricts access to unsafe items, activities, and social contacts.

The present discussion of restrictions does not address restrictions on items that do not immediately affect safety such as having cigarettes or curfews when patients need to be in their rooms. The subject of this section is on the use of restrictions that are intended to prevent severe physical harm and death on the unit. There are both similarities and significant differences among child and adolescent units in the numbers and types of restrictions used to assure such safety. All units tend to similarly restrict access to certain unsafe items, activities, and social contacts. All units also tend to have restrictions that are in place for all patients, and to have additional restrictions for patients who may be at higher risk. Involuntary patients who are presumed to be at higher risk, are restricted from leaving the unit and can be secluded and restrained. Concerns about voluntary patients tend to be less frequent and consequently such patients can refuse unit rules and restrictions and discharge themselves instead. Variation in the application of restrictions across units is common and should not be unexpected given there is little research on the outcomes of most types of restrictions and little consensus about best practices.

In terms of similarities, most units restrict items that could be used for strangulation and asphyxiation, items that could cut or be used as weapons, items like matches and flammable materials, as well as drugs and toxic substances. Prohibited items that pose risks of strangulation or asphyxiation include neckties, shoelaces, electrical cords, intravenous tubing, pull cords on equipment, panty hose, suspender belts, long socks, scarves, ingestible chemical products, plastic bags, shirts and tops with long sleeves, and hoodies and pants with drawstrings. Most units restrict access to knives, scissors, razors, mirrors, and other objects that could be used to cut or poison oneself or others. Restricted potentially ingestible substances include hand wash, over the counter medications, alcohol, toxic substances, illicit substances, prescription and over the counter medications, herbal or naturopathic products mouthwash, acetone (fingernail polish remover), cleaning chemicals, and alcohol-based hand cleaners. Drug use can occur on inpatient units in the absence of patient intention to harm themselves but nevertheless can lead to unintended overdose. Drug use can include saving one's medication and then taking it all at once with the intent to get 'high" and being offered or taking medication which has been prescribed to others. It is also important that staff be vigilant to the possibility of youth ingesting hand cleaner from stations on the unit. Additional details about safety proofing are discussed under Standard 3. Physical Environment. The section discusses desirable aspects of the environment which help promote assurances of safety.

Units typically also restrict patients from contacts with other patients when those contacts pose serious emotional or physical risk to each other by way of aggression, shared dangerous excitement-seeking, sexual contact, or shared self-injurious and violent behaviors. Child and adolescent units are keenly aware of sexual assaults and contacts that can destabilize patients and strive to protect children and adolescents by preventing unsupervised social contacts when there are any doubts. Restrictions can also be placed on parents/caregivers and other contacts if contacts escalate the risk of suicidality or violence (Allen, Pires, & Brown, 2010). Units may also restrict patients from participating in activities that may be unsafe because of medical fragility, social risks, or other concerns about safety. Patients may be restricted to their room if their behaviour poses recurring risks to other patients. They may be prohibited from leaving the unit until risks of harm to self or others are no longer evident, at which time they may be permitted to leave on pass, and to have greater freedoms and privileges.

Excessive reliance on restrictions and rigid application of rules can raise ethical concerns about the costs to personal rights, relative to patient benefits. For example, an excessive staff fixation on removal of all sharps including plastics and small objects may precipitate patients lying and trying to outwit and frustrate staff by better hiding items. It may be more effective for staff to strive to develop a collaborative focus on more serious risks such as suicide and to work on getting patients to be partners in identifying safety priorities and reasonable restrictions that could help.

OBSERVATION

1.11 The unit provides the least intrusive level of observation that assures the safety of all patients on the unit.

Observation. Staff observation is the most common type of surveillance. Observation intensity and frequency co-vary with assessed risk. Units usually assure a minimal level of observation that is common for all patients. This level of observation requires staff knowing where patients are. When additional concerns arise staff may increase observation to more frequent and occasionally scheduled intermittent observation (e.g., 15-minute checks). When risks further escalate, staff can increase the level of observation by ensuring that patients are always in their line of sight. For the most severe risks staff may follow the patient or stay within arm's length (Chu, 2016). Patients on constant observations receive at least one hour per day being observed by a member of staff who is familiar to them (Lucas, 2019). When risks arise that staff cannot manage, risks of false allegations or significant likelihood of harm or liability, observation may require two staff per patient. Observation can occur naturally during staff-led programming or therapy sessions, or it may be brief and more distant as in nighttime checks from the bedroom door. One of the problems with intermittent nighttime observation is the light and noise and disturbances to sleep that staff visits to bedrooms can cause (Veale, et al., 2019). Although staff intermittent observation in bedrooms across the night is a popular procedure, it has been argued that it does not reduce the risk of suicide or severe self-harm, as suicides between 11 pm and 7 am are rare, and most often occur under conditions of intermittent observation (Veale, et al., 2019). Need for increased surveillance and observation should be informed by an awareness of a) settings where harm is likelier to occur, such as in bathrooms and bedrooms, b) awareness of times when incidents are most likely to occur such as during pass (Bayramzadeh, 2017), and c) awareness of risks stemming from the patient mix and patient vulnerabilities. Staff should be aware that it has been noted that about one-third of suicides occur while the 15-minute intermittent observation procedure is in place (Mills et al., 2008). To some extent this is because death that

results from use of ligatures or asphyxiation can occur within minutes and much before the next check is scheduled. Use and changes of observation should be discussed, and young people, and when appropriate, their parents/caregivers, should be involved in decisions as much as possible.

Video Cameras. As is the case with other types of observations, use of cameras poses ethical dilemmas involving balancing patients' autonomy and privacy versus patient, staff, and institutional security and safety. Video cameras are sometimes used to monitor areas where risks cannot otherwise be monitored because they are not visible from the nursing unit, or patients are spread around the unit and staff are unavailable to monitor all the patients. Video surveillance can provide visible reassurances that a patient is safe, but it does not necessarily save a lot of staff time, as staff still must watch the video in real-time to keep informed. Unsafe things can happen in between the times staff look at the camera. One of the more promising uses of video cameras is at night where its use is less sleep-disruptive than bedroom visits by staff (Appenzeller, Appelbaum, & Trachsel, 2019). Video surveillance can increase patients' choices regarding monitoring options. Young people should be informed and allowed opportunity to engage in discussions about costs and benefits of video use, and young people with capacity to make decisions about cameras in their room need to be provided opportunity for informed consent (Appenzeller et al., 2019).

Security Guards and Paraprofessionals. Some units use security guards and paraprofessionals outside patient rooms to provide less surveillance that follows patients or to sit at the door of the patient's room during room restriction. This is usually less expensive than using nurses or child and youth workers but can reduce the quality of health promoting interchanges. It is also controversial because of its impact on perceptions that the unit is more of an institutional or custodial setting than a recovery one.

Staff training and supervision. All staff should undergo specific training in therapeutic observation (including principles around positive engagement with young people, and when and how to increase or decrease observation levels). Reflective practice, supervision, and clinical team discussions should occur frequently enough to assure that staff are prepared and supported.

Concerns. Use of observation and constant surveillance are grounded in common sense and a very long history of use. Jeremy Bentham's 'panopticon carceral' environment was premised on the idea that individuals under constant observation are less likely to act in dangerous ways (Curtis et al., 2013; Foucault 1975). Chu (2016) noted that there is little evidence in the literature that surveillance such as provided by constant observation increases safety, and that excessive use of constant observation can be counter-therapeutic particularly when conducted by inexperienced and unskilled staff who may drift to custodial watching rather than engaging with patients. Inexperienced and unskilled staff may be placed in risky contexts where they may be held solely accountable. Security guards or new and part time staff who may not be familiar with the unit may not have a relationship with the patient and may lack the clinical knowledge needed for effective observation and collaboration with the patient, and these personnel may be used for situations where the most skilled staff should be used. Regardless of staff experience, keeping a patient under constant observation may be perceived as indicating lack of trust, competence and value, which can erode self-efficacy and the therapeutic relationship. In addition, surveillance puts the onus of control on the nurse or psychiatrist and does little to cultivate the patient's safety skills and self-reliance. Despite the lack of studies on effectiveness and the potential for undermining therapeutic relations, surveillance is likely to continue to be seen to be a helpful practice (Russ, 2016). Rather than stopping the practice, more recent efforts have been directed at making observation less about watching and more of an engagement-focused type of clinical risk management that engages staff and patients in active ways (Harrington et al., 2019). The

shift in focus has been found to reduce incidents and to be preferred by staff (Harrington et al., 2019). Additional research will be required to evaluate the benefits and risks, and to identify best practices of using different restrictions and types of surveillance.

SEARCHES

1.12 The unit utilizes the least intrusive types of searches to prevent serious incidents of harm.

Surveillance on inpatient units includes searches. It is important that patients and parents/caregivers who may be subject to searches be informed about the possibility of unit safety practices including searches. This type of early information should be provided by referral and transfer sources in the community or in the Emergency Department prior to admission. Information about risks and safety procedures that would include searches should then again be provided by inpatient staff upon admission. Transitions are difficult enough for young patients without the additional burden of being surprised by requests to be searched. Reactive behaviours can threaten and not only result in suicidal reactions on the part of the patient but can also result in assaults on staff and co-patients. Patients who have been poorly prepared for a search can overly personalize and find searches invasive. They can experience intense negative emotions and react suicidally, or violently, especially if they have a history of false accusation, past invasive physical experiences, rejection sensitivity, or trauma.

It is important to strive to engage the collaboration of patients and parents/caregivers in searches whenever possible. If a patient is prepared and willing, they can assist with the search (e.g., "If it will help, I can show you what's in the bag"). Staff should promote discussions that can increase likelihood of resolution of safety concerns without need for searches. Such discussion can also help with less stressful transitions for patients who are easily agitated and easily hurt emotionally. It is important that searches are not seen to be completed for custodial and defensive benefits of the institution and that staff are seen to be invested in protecting personal rights, privacy, dignity, and a working alliance to the extent possible. Voluntary patients can exercise their right to be discharged instead of submitting to observation or searches. Giving patients an opportunity to disclose the presence of unsafe items can help to avoid recurrent searches. Collaborative discussions should be collaborative and not accusatory. They should encourage disclosure without resulting in defensiveness and lying. Inpatient units should always consider how their procedures and practices will impact parents/caregivers and schools and what they will be able to do to assure safety. Whenever possible, and certainly as discharge approaches, units should strive to promote the types of searches and surveillance that will be applied in homes and schools after discharge. Searches can include those of the following types:

Searches of the Environment. Searches can include scheduled or incidental safety inspections of the environment such as for loose wires, nails or screws that have come loose, or dangerous or prohibited objects left unattended by patients or staff. Searches can include patient bedrooms as well as common areas. Patients, visitors and staff should be encouraged to notice any sources of risk and to be vigilant in protecting their own safety and that of others. Such searches, if seen to be part of unit safety, are less likely to be viewed as devaluing. Joint patient and staff identification of risks that may require searches and monitoring should include risks that arise on outings or use of other parts of the hospital such as gardens or exercise areas, including threats posed by adults in hospital hallways and areas children and adolescents may visit. The use of

handheld metal detectors has been used by some settings and may be an option for further investigation, but very little is known about its potential impact on incidents.

Searches of the Personal Property of Patients. Searches of personal property can be made a routine and scheduled activity for all patients or be restricted to a single patient when staff have reasonable cause. Searches of the personal property of all or riskier patients can include searches of handbags and backpacks, lockers and drawers, and any packages coming into and out of the unit. Routine searches of all personal belongings of all patients should be completed prior to admission, and again upon admission. As part of routine precautions for all patients, staff should open gifts, packages and other items, before the contents are given to a patient. Voluntary patients should be asked for their consent prior to search of their personal belongings, their bedside area, and/or their person. Searches should never take the form of dramatic controlling rituals that reinforce lying, hiding, self-injury, aggressive acting out and that precipitate need for seclusion or restraint. Involuntary patients should always be advised of the reasons for searches and their privacy protected as much as possible. Unless the risk is an imminent severe one that requires emergency response, the search should not be publicly announced. Instead an opportune time that protects the patient from ridicule or shame should be found for the search (e.g., quiet time). Where a voluntary or informal patient (or substitute decision maker) refuses a search or safety check of their belongings, staff will move belongings to a secure location without patient access until a plan of care can be developed.

Searches of the Patient. Of all types of searches those that search the patient are the most intrusive and require the most preparation and discussion. As with other searches patients should know that searches of the patient can occur, the safety reasons for these, and the conditions under which they are likely occur. Patients should know that searches may occur any time during their stay when there are reasonable and probable grounds to believe that the patient may have acquired lethal means/harmful items/substances. It is important to also acknowledge that searches may occur because the information is believable or cannot be discounted but that it may be based on mistaken assumptions and fueled by inaccurate reports from co-patients or others. Demands that the patient change into a hospital gown can be tempered at times by offering options such as changing into the patient's own pj's or another set of clothes. Searches of the mouth, and searches of other body cavities are rare and the most intrusive of these already intrusive search types. Such searches can occur when individuals may have ingested or inserted objects that pose imminent risk of significant harm or death.

Searches of Visitors. If there is suspicion that family members and other visitors are bringing weapons or illegal drugs to the unit, the visitors should not be admitted. Family members and other visitors may be asked to take harmful or dangerous property out of the hospital or may be permitted to store items in a locker prior to entry. Reasons for restrictions and decision to resume access to certain items and situations should always be discussed with patients, parents/caregivers and visitors who are searched.

Staff Safety. Unlike observation, searches can precipitate severe acting out as well as pose other risks for staff. As repeatedly stated above, the collaboration and support of well-prepared patients can do much to defuse possible reactivity. In addition, staff should not be alone during searches but should be supported by another staff member who provides support to both the searcher and the patient. Nurses and child and youth workers and others who perform searches should wear appropriate protective equipment in case of contact with needles and other items that could cause injury.

SAFETY PLANS

1.13 The patient, parents, community service partners and staff develop and follow a common individualized safety plan.

An Essential Component of Care. An inpatient safety plan is an essential part of inpatient care, and there is some evidence that safety plans can help to reduce post-discharge risk for re-hospitalization and emergency room contact (Wolff et al., 2018). A safety plan should be part of a more comprehensive care plan, and should inform care during inpatient stay, across passes home, and at discharge (O'Brien et al., 2019). It should be completed proactively with those most able to prevent risk and manage crisis which usually includes a collaboration of patient, parents/caregivers, school, and community services (Drapeau, 2019; O'Brien et al., 2019; Schweitzer at al., 2007). A safety plan should not be confused with a safety contract or used as a safety contract where a child promises to be safe as a condition of pass or discharge. In contrast to safety contracts, the development of a common safety plan focuses upon the identification of situations likely to precipitate crises, how these can be prevented, and how they are to be managed and encourages the patient and adult supports to have a greater role in maintaining safety. The safety plan should be a common one among parents/caregivers (including group home and community residential staff). It should be one that parents/caregivers can take home with them and teachers can use. It should lead to more reassuring and well-considered safety strategies during passes home and in preparation for discharge. Safety plans should be individualized and open to change in response to feedback. It is obviously not helpful to blame patients, parents/caregivers and community professionals for "not following the plan" when incidents occur. It is suggested that unit staff work collaboratively with the patient and the patient's supports, to anticipate and problem solve possible problems with the plan, and to use feedback about failures of the plan to create more realistic processes and expectations.

Types of Plans. Plans for managing and reducing suicide risk are the most prevalent on inpatient units. These plans tend to identify warning signs of suicide and ways to manage and reduce suicidal rumination or impulses and their contributing causes (de Kloet et al., 2011; Rudd, Mandrusiak, & Joiner, 2006; Rytilä-Manninen et al., 2018; Stanley & Brown, 2012). Although suicide safety plans are the most common types of plans because of the prevalence of crisis admissions, it is important that inpatient safety also be in place to address physical aggression, sexualized acting-out, absconding, fire-setting, serious non-suicidal self-injury (e.g., severe head banging), severe substance abuse, severe purging and eating disturbances, and risky excitement-seeking.

Passes and Discharge. Prior to going on pass or discharge, the patient and parents/caregivers should discuss with staff the safety and crisis management plan and receive a copy. Because of the differences between hospital and community environments, inpatient safety plans should include consideration of how best to fade the amount of control and restrictions as discharge approaches to better resemble less restrictive home and school environments. After discharge, the monitoring and updating of the safety and crisis management plan becomes the responsibility of the youth, their parents/caregivers, school, and community service supports. It is important that the plan includes follow-up recommendations as continuing mental health support after discharge appears to help reduce suicidal behavior (e.g., Luxton, June, & Comtois, 2013). It is important that youth, parents/caregivers, and partner community professionals all accept responsibility for developing a post-discharge safety plan that can be informed by the inpatient safety plan. There are a number of existing guidelines primarily focusing upon suicide risk, for example, The Suicide Safety Planning Interventions (SPI) of the Suicide Prevention Resource

Center/American Foundation for Suicide Prevention Best Practices Registry for Suicide Prevention (www.sprc.org). The SPI guidelines recommend the plan include identification of (a) warning signs of an impending suicidal crisis, (b) internal coping strategies, (c) social contacts and social settings that can distract from suicidal thoughts, (d) family members or friends to help resolve the crisis, (e) contact information for mental health professionals or agencies; and (f) ways of restricting access to lethal means. Baren et al. (2008) recommended the use of a checklist prior to discharge from emergency care, and added details about clear cautions about the disinhibiting effects of drugs and alcohol, the need for firearms and lethal drugs be effectively secured, the identification of a supportive person at home, and the scheduled time for a follow-up appointment in the community.

Use of Technology. Safety planning has evolved with the use of technology with some units promoting use of cell phone applications for use during passes that allow youth and staff to create a digital safety and crisis management plan. Such applications can include decision aids to help youth to locate mental health and addiction resources in their community, select the best resources and develop a personal 'get help' script to assist in accessing needed supports at the time they need (e.g., Gregory, Sukhera, & Taylor-Gates, 2017).

SECLUSION & RESTRAINT

1.14 The unit provides, monitors, and minimizes need for seclusion and restraint.

Definition and Types. Restraint is an essential and valuable safety measure for patients in certain dangerous situations. According to the Ontario Mental Health Act (1990), "restrain" means to place under control when necessary to prevent serious bodily harm to the patient or to another person by the minimal use of such force, mechanical means, or chemicals, as is reasonable, given the physical and mental condition of the patient. Types of restraint comprise 1) physical restraint (holding), 2) mechanical restraint (e.g., straps, four-point restraints and jackets), 3) seclusion (environmental restraint), and 4) chemical restraint. Larson et al. (2008) offered the opinion that a padded seclusion room, although not an ideal option, may be preferable to mechanical restraint for children and adolescents because seclusion allows more freedom of movement and is less likely to be traumatizing and as degrading.

Rates. Rates of seclusion and restraint appear to be unstable and difficult to compare across settings and time. Some areas make less use or no use of certain types (e.g., Rydelius, 2007). Rates are also not stable because of differences in the types and amount of effort to reduce them across different units. They are difficult to compare nationally and internationally because they are applied under differing and occasionally changing legislation and definitions. Results of studies are difficult to compare because reported rates can report results for differing combinations of seclusion, mechanical, physical and sometimes chemical restraint. Prevalence is most often reported as percent of patients restrained across a one-year period. Number of occurrences by patient days is also sometimes used. Annual rates of patients restrained tend to average from around 5% to over 50% (Azeem et al., 2011; De Hert et al., 2011; Donovan et al., 2003; Furre, et al., 2016; Sourander et al., 2002). The ONCAIPS member inpatient units responded to a survey in 2016 which found the average and median numbers of patients restrained by any method per reporting unit in Ontario were 9% and 8% respectively. These numbers suggest that the majority of inpatients are not restrained. Earle and Forquer (1995) reported that 7% of the restrained children were responsible for 50% of the incidents. These

numbers suggest the need to identify and focus on the small number of children and adolescents who are most likely to precipitate risks that are difficult to otherwise manage.

Utilization by Type. Furre et al. (2016) found the percentages of patients restrained by type were 13.4% for mechanical restraint, 1.6% for pharmacological restraint, 5.9% for seclusion, and 78.7% for physical holding. Sourander et al. (2002) reported that time-out had been used for 28%, holding for 26%, seclusion for 8%, and mechanical restraints for 4% of a Finnish inpatient sample. Delaney and Fogg (2005) reported a mechanical utilization rate of 69% of all restraints and Hottinen et al. (2013) a rate of 6.9% indicating significant differences in utilization across different countries and periods of time. The National Health Service Benchmarking Network (2018) reported average seclusion rates for five Western countries as 65 per 10,000 bed days, and as 13 per 100 admissions or 13%. Changes to one type of restraint appear to affect other types. For example, Larson et al. (2008) found that mechanical restraints decreased by 93.7% after the increasing use of seclusion as a less restrictive alternative. The ONCAIPS 2016 survey reported that pharmacological restraint was the primary "go-to" restraint for almost all settings (91%), followed by mechanical restraint and seclusion at 78% and 74% respectively. Physical/manual restraint was the least used type of restraint at 65% in Ontario across the survey period. But it is possible that this underestimated the use of physical/manual restraint as brief physical restraints are necessary at times for transitioning to seclusion, using a Pinel restraint, and involuntary injections. ONCAIPS data indicate median duration of mechanical restraint was 3.5 hours. Median duration of seclusion was 30 minutes, and the median duration of physical holding was 10 minutes. There are insufficient numbers of studies to establish reliable benchmarks at present for overall use and use by type, but as more information becomes available it should be possible in the future.

Causes and Correlates. The most common reason for utilization of seclusion and restraint appears to be to prevent a patient from harming others (Furre et al., 2016). Hottinen et al. (2013) reported that violence preceded about 60% of mechanical restraint episodes and suicidality about 40%. This is followed by striving to prevent dyscontrolled self-injurious behaviour (e.g., head banging, self-biting, self-scratching). Other stated reasons include attempts to abscond by patients who are considered to lack the capacity to keep themselves safe if they do abscond (Faay et al., 2017). In terms of other characteristics of children and adolescents, it is not unusual for patients who require restrictive measures to have more severe problems, as well as to have greater likelihood of parents/caregivers with problems, and greater likelihood of recent stressful life events (Gullick et al., 2005). Fryer et al. (2004) reported that being male, being diagnosed with disruptive behaviour disorder and having a previous history of physical abuse increased risk of being secluded during an inpatient stay. Children are more likely to be restrained and secluded than adolescents (Pogge et al., 2013). It is not clear whether this is because of a greater frequency of risky behaviour, because of the greater use of alternative interventions with adolescents (e.g., calling for police and redirection to youth detention facilities), or for some other reason. Donovan et al. (2003) reported that children and adolescents who were admitted on an emergency basis and those belonging to ethnic minority groups were more likely to undergo seclusion or restraint. Using a functional assessment approach, Luiselli, Bastien, and Putnam (1998) reported that in the settings they studied, the most frequent antecedent conditions occurred when staff initiated physical contact towards a patient and the patient refused to go to, or remain in, the "quiet room" when instructed. Luiselli et al. (1998) noted that physical intervention and "quiet room" procedures were often being implemented in the absence of a comprehensive behavioral treatment formulation or understanding of the functions of behavior, and without reference to behavior-specific guidelines. The finding suggests that attempts to cue patients to stop escalation may at times threaten patients and escalate acting out (e.g., "This is your last warning").

Potential for Harm. The use of restrictive measures can harm therapeutic alliances (Mooney, 2013), and cause distress and trauma for both those being restrained and those observing (Prescott, 2000). Patients' opinions provide insights into the contrasting perceptions of staff and patients. Restraint that may be seen by staff to be a last resort may be seen by patients to be just another way to force patients to comply (e.g., "If you don't go to your room, we will have to use restraint. It's up to you"; e.g., Petti et al., 2001). Unnecessary use of seclusion and restraint can get in the way of recovery for previously traumatized and vulnerable children and adolescents for whom restrictions are intrusive, fearful, or demeaning (Bloom, 2005). More importantly, seclusion and restraint have been noted to harm and cause the deaths of child and adolescent patients, cause injuries to staff, and be vulnerable to institutional overuse and abuse (Finke, 2001; Nunno, Holden, & Tollar, 2006; Rydelius, 2007; Siponen, Valimaki, & Kaltiaila-Heino, 2012). Concerns about variability continue to lead to a desire to develop better guidelines, standards, and operational oversights which address not only how to best use restrictive procedures such as restraint but also how to minimize risks and reduce needs for these procedures (Commonwealth of Australia, 2010; Lucas, 2019; Masters & Bellonci, 2002).

Concerning Variability. Concerning variability in the use of restrictive measures has been found. Although units can operate under similar legislation they can nevertheless operate beyond its parameters. Legislative attempts to ensure homogenous practices have failed to eliminate undesirable variation across units (Siponen et al., 2012). For example, Hottinen et al. (2013) found that restraint was inconsistently applied and that one quarter of episodes occurred for reasons outside of those of the Mental Health Act. One study found that two nurses following the same intervention protocol can have very different outcomes with the same type of patient, with one nurse restraining and the other not (Voskes et al., 2014). Findings of inconsistencies in use are concerning, as are findings of large unexplained variation among units. A survey of 25 US child and adolescent units found a 6-fold higher rate of seclusion and restraint utilization compared to adult services in the same state, raising questions that were difficult to answer in terms of risk severity (LeBel et al., 2004). Siponen et al. (2012) reported rates from 1% to 30% across very similar units (Siponen et al., 2012). Findings have further suggested that the variability may be significantly linked to non-clinical rather than clinical variables (e.g., Mind for Better Mental Health, 2013; Persi & Pasquali, 1999; Siponen et al., 2012). Non-clinical variables include beliefs and interpretations about the need to use seclusion and restraint, staff fears, noncompliance with rules and demands, and organizational culture (Bowers et al., 2010; Busch & Shore, 2000; De Benedictis et al., 2011). For example, some units restrain to prevent property destruction, and some do not (Pogge, et al., 2013). Differences in staff training and competencies may also contribute to variability. Mohr and Anderson (2004) suggested that assumptions that all staff are well-trained, and that training generalizes to practice is not supported by general observations. New staff or staff providing coverage may not have the same capacity to avoid inadvertent triggering of aggression in real-life inpatient situations and to prevent escalation. Staff morale and unit emotional climate, and staff emotional reactions may differ across units and can contribute to differential use (Papadopolous et al., 2012).

Patient Perceptions. Children reported that their own experiences of being restrained were predominantly negative (Montreuil et al., 2018). Montreuil et al. (2018) studied a group of inpatient children under the age of 12 and found that children approved of restraints and seclusion, for example, if another child was being aggressive towards them or in exceptional cases to prevent self-injury. They preferred that staff develop a relationship with them rather than jumping to rapid de-escalation and coercive strategies. Most children did not support the use of seclusion and restraint when it was perceived to be a punishment or a logical consequence (Montreuil et al., 2018).

Restraint Reduction. Concerns about abuse and child and adolescent deaths and injuries resulting from restraints, particularly physical restraints, have provoked health care and legislative changes directed at minimizing restraint use (Busch & Shore, 2000). Most studies support the view that reduction of seclusion and restraint is both desirable and possible, and that reduction does not lead to higher rates of physical harm to patients or staff (De Hert, et al., 2011; Delaney, 2001; Valenkamp, Delaney, & Verheij, 2014; Witte, 2008). Reduction efforts have been associated with both patient and staff benefits. These include improvement in patient global functioning, reduction in patient injuries, reduction in staffing costs, decreased sick time, lower staff turnover rates, and lower workers' compensation claims (LeBel & Goldstein, 2005). There is no single narrow approach which is sufficient or best on its own, as there are many components which can be helpful (Berntsen et al., 2011). Organizational culture is important. Reductions to restraint are more likely in organizations which emphasize collaboration with patients, voluntary admission and participation, appreciation of the benefits of alternatives to seclusion and restraint, and the value of working with client strengths (Ahmann & Johnson, 2000, Azeem, et al., 2011; LeBel, et al., 2004). Staff success in using non-violent de-escalation alternatives also depends to some extent on the amount and quality of staff collaborations with patients including discussion on how to improve self-control (Berlin, 2017). LeBel et al. (2004) reported that data analysis, quality improvement efforts, regulatory oversight, and technical assistance to develop and implement system change improved restraint reduction in the absence of changes in either regulations or policy. Promising interventions that were discussed previously for the management of violence and aggression (see that section) include earlier risk assessment and risk management (Dean et al., 2007; Donovan et al., 2003; Swadi & Bobier, 2012), activity scheduling (Busch & Shore, 2000; Delaney, 2000), providing opportunity to calm down (Ahmann & Johnson, 2000, Busch & Shore, 2000; Delaney, 2000), having interdisciplinary support (Bonnell, Alatishe, & Hofner, 2014), assuring staff have the necessary communication, training, and education skills (Azeem et al., 2011), reducing demands on patients (Dean, 2009), teaching self-regulation (Dean et al., 2009), having access to behavioral consultation, antecedent analysis, functional assessment of the behaviour, and using principles of behavioral contingency management (Dean et al., 2007; Luiselli et al., 2000; Luiselli, Pace & Dunn, 2003), collaborative problem solving (Ahmann & Johnson, 2000, Greene et al., 2006; Martin et al., 2008), providing trauma informed care and sensory modulation activities and rooms (Bobier et al., 2015; Seckman et al., 2017), encouraging consumer participation, and engaging in vigorous debriefing with patients, family, and observers (Azeem et al., 2011), providing attachment supports and promoting patient confidence and competence (de Decker et al., 2017; Donovan et al., 2003). Safewards, as discussed as part of the introduction to this section, is a promising safety package that includes several of the components identified above and that helps to reduce use of seclusion and restraint (Fletcher et al., 2017; McDougall, 2020).

Parents/Caregivers. Youth and parents/caregivers should be involved to the extent possible, in decisions affecting choice of restraint methods and utilization. Engagement of parents/caregivers in the care process has been associated with reduced restraints (Regan, Curtin & Vorderer, 2006). Communication with parents/caregivers and substitute decision makers is essential to building trust and aligning response for the behaviours that precipitate seclusion/restraint. When parents/caregivers are primary targets of aggression, however, it is important that parents/caregivers are not put in a position where they inadvertently trigger the need for seclusion and restraint. In such cases, the patient may need to be helped regain self-control and parents/caregivers slowly introduced in a manner that benefits rather than harms what may already be fragile relationships.

Debriefing and Prevention. Restraint reduction is better if it focuses upon reducing the probability of occurrence of the internal conditions and the social and environmental events that provoke interactional "points of no-return" (Luiselli et al., 2000). Data collection is costly in terms of time

to gather and review but there is a widely accepted position that the use of restraints of all types needs to follow guidelines and standards, be transparent and documented, and that aggregate data need to be available for internal- and external oversight (American Psychiatric Nurses Association, 2014; Dean et al., 2007; Delaney, 2006; Masters, & Bellonci, 2002). Knowledge of prevalence, patterns of seclusion and restraint use, precipitating behaviors, antecedents and contributing factors, and outcomes are all required to better understand and to better help assure effective safety practices.

STAFF SAFETY

1.15 The unit monitors, reports, and assures the safety of staff.

Inpatient units appreciate the potential for staff to be harmed and the physical, psychological, and economic costs to staff, patients, and the hospital that ensue. Units are making increased use of personal alarms, staff training on how to physically protect themselves, and providing more opportunities to discuss safety concerns. Staff safety is essential for unit functioning. It is difficult for most staff to confidently manage patient safety if they are too afraid for their own. Although parents/caregivers are the likeliest targets for aggression outside the unit, staff (i.e., particularly nurses and child and youth workers) are frequent targets on child and adolescent units, and the most likely to suffer serious injury (van Kessel, et al., 2012). Staff are exposed to hair-pulling, pushes, punches, kicks, bites, sexual grabs, projectiles, and assaults with pencils and other sharps from assaults and from when they try to restrain patients. A unit that is perceived to be unsafe by staff leads to poorer morale (Johnson et al., 2010), and in turn poorer morale predicts increased inpatient incidents (Papadopolous et al., 2012). Staff who feel afraid and unsafe may come to interact with patients in a primarily self-protective, defensive, or controlling manner. Staff fears can increase overly coercive behaviours that in turn escalates defiant behaviours and likelihood of incidents. The focus on coercive control can in turn reduce trust required for patient contact, compromise therapeutic alliance, and give rise to over-reactive restrictions and increased reliance on seclusion and restraint (De Benedictis et al., 2011; Doyal et al., 2009; Johansson et al., 2013). Unaddressed staff fears and safety concerns can turn the unit from a recovery-oriented environment into a harsh authoritarian one that rigidly focuses on rules, and consequences/punishment. An atmosphere of fear can also create staff discord among milieu staff who are more anxious and others who are more confident. It can also create tensions between milieu staff who tend to directly experience risks and injuries, and clinicians and administrators who are more removed from the risks. Support from managers, clinical supervisors, and more experienced and confident staff is particularly important for staff who may be more anxious, and/or who may have been traumatized by past assaults. The question of if to prosecute sexual and physical assaults on staff is a complicated one for adult inpatient care where it occurs more often but is even more complicated when children and adolescents assault staff (Appelbaum & Appelbaum, 1991; Van Leeuwen & Harte, 2011). Minimally, units should have hospital policies and procedures, or explicit protocols, which help guide staff around how to be safe, when to call police supports, and when to make complaints that can lead to charges being laid against patients.

REPORTING CHILD ABUSE

1.16 The unit has a good working relationship with the Children's Aid Society and duly identifies and reports suspicion of child abuse.

Some safety concerns require collaboration with other services including child protection agencies (in Ontario this would be the Children's Aid Societies). Legislation requires hospital personnel to report suspicion of abuse and to prevent contact with adults who may abuse a child in their care (Fallon et al., 2019). It is important that allegations of abuse are reported regardless of whether they involve staff, parents/caregivers, teachers or doctors. Recovery is difficult if not impossible without safety (Baren et al., 2008; Brickell et al., 2009; Commonwealth of Australia, 2010; Lucas, 2019). Abuse, whether it occurs in hospital, home, or school, compromises safety and must be prevented. Children and adolescents who feel unsafe at home will feel unsafe in hospital. They may act out to prevent the return home. Collaboration with the Children's Aid is essential for the safety and recovery of these young patients. Parents/caregivers and young people should be informed about the limits to confidentiality that duty to report entails in ways that nevertheless seek to preserve a working alliance with the child and family. Abuse or physical assaults on older adolescents may not fall within the jurisdiction of child protection agencies and may require calls to the police.

RISKS FROM STAFF

1.17 The unit provides the background checks, supervision, education, and training that minimizes risks to patient safety from staff.

Inpatient units have a responsibility to assure that children and adolescents are not at risk from milieu staff, consultants, volunteers, students, and employees. Risks from staff include deliberate harm to patients as well as harm that results from personal problems like fatigue and systemic problems such as failure to provide training and supervision.

Patient Abuse. There is very little known about the prevalence of incidents of patient abuse on child and adolescent inpatient units but there are many documented occurrences of patient abuse in health care in other settings, with elders, and with patients with developmental disabilities (Battah 2006; Dyer, 2004; Purandare & Gravestock, 2019). Despite the lack of aggregate data on the prevalence of mistreatment and assault, hospitals are very aware of the need to assure that safe hiring practices (e.g., reference and criminal checks), supervision (e.g., walkabouts and safety meetings), and policies and procedures (e.g., providing patients with safe mechanisms to complain) are in place. Behaviours like slaps, pushes, and sexual touching may be uncommon but do occur and must be prevented. Provoking and threatening patients also has no place on inpatient units. Provoking patients escalates confrontation and may lead to use of seclusion and restraint for which the patient is then blamed. Staff-driven escalations do occur and can lead to preventable physical restraint that can result in physical injuries.

Supervision. Supervision is also required for other situations such as fatigue, illness (including symptoms of mental illness), intoxication and other variables that can impair staff judgement and increase risks to patients. Supervision including peer supervision and support is also important for new and relatively inexperienced staff, including those covering from adult units or medical

floors. Lucas (2019) recommends that all staff members receive 1) profession-specific individual clinical supervision at least monthly, or as otherwise specified by their professional body, from someone with appropriate clinical experience and qualifications, and 2) line management supervision at least monthly; this includes managers and administrators themselves who should be subject to similar processes as their staff. Regular meetings among managers, supervisors and staff including scheduled walk-arounds and/or regular safety meetings can further inform safety and supervision (e.g., Frankel et al., 2008).

Training. Emergency and safety procedures/codes and rehearsals (e.g., code white for violent patient, code yellow for missing patient, fire drills, as well as crisis de-escalation techniques) are necessary. Training and education for staff, patients, and parents/caregivers about potential risks and management practices including training to prevent escalation and incidents is more helpful than staff training alone.

SUICIDE RISK

1.18 The unit has the competencies and processes in place for the screening, assessment, and safe management of suicidal behaviour.

Suicide Risk. Suicidal threats and attempts can be stressful and traumatic for family, friends, and those providing care. Completed suicide can be devastating. Suicidal behaviours can trigger intense fears and anxieties that may last long after suicidal behaviour reduces. Parents/caregivers can experience recurring worry, increased arousal and vigilance, and deterioration of their own mental health. Community professionals are similarly vulnerable. In addition to worries about their patient, community mental health workers may also experience worries about their competence, their ability to keep their patient safe, losing their job, and possible litigation (Kjellin & Östman, 2005). Rapid admission provides immediate brief safety, and at least temporarily reduces worries and fears of most families and community care providers by transferring some responsibility for safety onto inpatient care.

Admission as a Safety Practice. Regardless of the evidence provided by research, inpatient care is generally considered by many in the Canadian public to be the gold standard suicide prevention. Severe imminent risk of suicidal behaviour is the leading cause of community and emergency department requests for admission and at times for treatment (Greenham & Persi, 2014; Hansen-Bauer, et al., 2011; O'Herlihy et al., 2008), and these types of admissions are increasing (Canadian Institute for Health Care Information (CIHI), 2014). The public expects units to provide around the clock observation on an involuntary basis if needed as well as restriction of access to lethal means of suicide (e.g., firearms, ligatures, sharps) in a way that is not possible in office care, schools, homes, or foster care settings.

One common area of agreement revolves around beliefs that inpatient care should not be used for commonly occurring mild or occasional suicidal ideation or threat (King et al., 2010). It needs to be mentioned that although admission to help reduce risk of suicide is the most common precipitant of admission in Ontario, risk of suicide is seldom the primary reason for admission to eating disorders, forensic, and concurrent disorders units. It is, however, not unusual for patients on these units to concurrently have suicidal behaviours that require safe management. Consequently, all types of inpatient units should have the capacity to identify risk and prevent suicide.

Inpatient admission is not a guarantee of safety. Completed inpatient suicides can and do occur after admission and are one of the primary reasons for lawsuits (e.g., Bartels, 1987; Combs & Rom, 2007; Hall, Platt, & Hall, 1999; Martin, 2000; Spiessl et al., 2002). Unfortunately, very little is known about the incidence of suicide attempts and completed suicides on child and adolescent units. More research is needed.

Inpatient Suicide Risk Screening and Assessment. Because of the severity of suicide risk, it is important that all youth in all inpatient settings are minimally screened for suicidal risk. Inpatient assessment can then provide a more detailed and thorough assessment for positive screens that have been completed in the community or Emergency Department, or on the unit. One of the benefits of inpatient assessment over Emergency Department is the capacity to take more time to gather details about types of suicidal thoughts and behaviours, degree of hopelessness, reasons to live compared to reasons to die, presence or absence of threats, and attempts, the functions of the behaviour, and association of suicidal behaviour to stresses and conflicts in home and school environments (e.g., you can't have your cell phone, you can't go to the party), or safety-seeking due to unwanted obsessions (Apter et al., 1995, Apter et al., 2003; Brent et al., 2013; Rachman, 2003). Assessment should be collaborative and integrate information provided by the patient, family, and community providers. The inpatient unit can then proceed to clarify severity of risk, and contributing factors, and then provide care for those with persisting severe ideation and hopelessness (Czyz & King, 2015). Assessment should include identification of antecedents and vulnerabilities such as emotional distress, loneliness, losing or being rejected by a primary attachment figure, the absence of a favourite staff, and fears of discharge (Adshead, 1998; O'Brien et al., 2019; Seager, 2013). Those at low risk can be discharged.

Risks and Safety Management during Admission. Research findings support the view that it is possible to reduce suicide risk on the ward by having a safe environment, optimizing patient visibility, supervising patients appropriately, careful assessment, awareness of and respect for suicide risk, good teamwork and communication, and adequate clinical treatment (Sakinofsky, 2004). It is important for units to appreciate and accommodate different opinions about what helps (Hill et al., 2019). Consumers may be more likely to endorse the value of non-clinical factors such as positive lifestyle skills, parenting skills, domestic support, harm minimization plans, and peer support, whereas professionals may be more likely to emphasize restricting access to items and situations that may enable suicide attempt, and involving parents/caregivers (Hill et al., 2019). Patients often mention the importance of staff empathy, compassion, protection from stigma, staff knowledge, and staff willingness to listen and provide non-judgmental supports. Interestingly professionals tended to think about costs more so than patients (e.g., lower endorsement for allocation of staff to accommodate suicide-related calls after-hours, higher endorsement for use of less costly telepsychiatry to fill gaps). Returns to the community during pass and shortly after discharge are particularly risky times when suicide is most likely (O'Brien et al., 2019). Collaborative discharges involving the scheduling of a post discharge session as soon as possible and continued caring supports may help to mitigate risks.

Concerns about the Value and Effectiveness of Admissions for Suicide Prevention. Hospitalization for suicide risk disrupts young lives and interrupts community treatment, and its efficacy in reducing suicidal trajectories in the longer term has not been established. Although hospitalization reduces access to unsafe items and locations, increased levels of observation and searches, and at least temporarily reduces worries and fears of most families and community care providers by transferring some responsibility for safety onto inpatient care, concerns continue to be voiced. Patients, parents/caregivers, and community supports may also be frustrated by the relatively short-term benefits that inpatient care provides and the return of suicidality for many patients. Questions continue to be raised about whether some of the resources should not be

better directed to preventing a suicide attempt rather than intervening after its occurrence. There is significant variability among providers about how the system of care should respond to suicide attempts including whether hospitalization is needed (Hulten et al., 2000). Findings that completed suicide is predicted by behavioral problems, school problems, co-morbid alcohol or drug abuse and criminality have led some to conclude that inpatient admission may not be the best way to address suicide. Lear and Pepper (2018) suggested that family admissions that address contributing family problems may represent a better alternative than admission of the young person alone for at least some patients. Engqvist and Rydelius (2006) add that suicide prevention among patients may not be a psychiatric issue per se or best addressed psychiatrically and may require a more prominent role for society's juvenile social-welfare services. Arguments for and against use of hospitals to prevent suicide continue. In some jurisdictions, short-term inpatient admission is mandatory after an emergency department visit for a suicide attempt even if a child appears to have stabilized and to be safe (Knafo et al., 2015). In other jurisdictions inpatient units are less likely to focus on suicide, less likely to utilize inpatient care for suicide prevention, and more likely to see inpatient care as limited in the safety it can provide.

There are also concerns about the possible overuse of inpatient care for assessment of suicidality. Young people who are admitted to crisis units are often assessed after admission as not severely or imminently suicidal, and most are rapidly discharged back to their homes and to the care of community services (e.g., Persi, Bird & DeRoche, 2016). This rapid discharge may understandably not be welcomed by worried community providers and parents/caregivers who may expect and demand a longer hospitalization and inpatient assurances of safety before a young person returns. Users may have difficulty believing hospital provider conclusions that further hospitalization is unlikely to change the likelihood of future completed suicide relative to intensive community services. The large numbers of patients who are referred but do not remain beyond initial assessment raises questions about whether better community assessments would be less disruptive and more cost-effective. Resource-rich community assessments that could include visits to schools and homes would be costly but likely less costly and no less accurate than hospital assessment. There are also possibilities that for some patients, hospitalization may be iatrogenic and result in increased risk for subsequent hospitalizations and continued suicidal behaviour (Linehan, April 2016; Prinstein et al., 2008). More detailed discussions of hospital utilization rates, availability of service alternatives, and outcomes for suicidal behaviours are discussed in future sections including Standard 3. Physical Environment, Standard 5. Mental Health System, Standard 11. Stabilization & Therapy, Standard 12. Medication, Standard 14. Utilization, and Standard 15. Outcomes.

NON-SUICIDAL SELF-INJURY

1.19 The unit assesses and helps reduce non-suicidal self-injurious behaviours and habits.

Definition and Types of Non-Suicidal-Self Injury (NSSI). It is important to distinguish NSSI from the umbrella term “self-harm”, from suicidal behaviours, and from culturally accepted practices like piercings and tattoos. Self-harm refers to any self-injury or self-poisoning regardless of intent. NSSI on the other hand refers to self-injury where the intent is not to die by suicide but rather more typically to cope. Severe, non-suicidal self-injuries can be difficult to distinguish from suicidal behaviour from the inside and outside. Patients themselves at times report some confusion about their intentions. Suicidal ideation and NSSI can occur in the same individual and at around the same time (Zhand, Matheson & Courtney, 2016) Not surprisingly there is an

association among NSSI and risk of suicide ideation, suicide attempts, and frequency of hospitalization (Lloyd-Richardson, et al. 2007). In most situations of NSSI it is clear to patients and staff that there is no intention to die by suicide. Cutting is one of the most frequent types of NSSI. Other types of self-harm include head-banging, burning, pinching, hair pulling, punching walls and other objects to induce pain, breaking bones, ingesting toxic substances, interfering with healing of wounds, ingestions of glass shards, inserting objects under the skin or in orifices, and eye self-enucleation (Darche, 1990; Osuch, Knoll, & Putnam, 1999; Peterson et al., 2008). Not eating, pica, substance abuse, and purging though self-harming are typically considered separately under other sections of the standards. Recently, NSSI has been defined as a disorder for further study in DSM5 (American Psychiatric Association, 2013; Zetterquist, et al., 2013). NSSID is a disorder involving clinically significant distress or interference in interpersonal, academic, or other important areas of functioning, where self-injury is not better accounted for by another disorder or a socially sanctioned practice (e.g., tattooing). The criteria include five or more days of intentional self-inflicted damage to the body likely to induce bleeding, bruising, or pain (e.g., cutting, burning, stabbing, hitting, excessive rubbing), with the expectation that the injury will lead to only minor or moderate physical harm (i.e., there is no suicidal intent), for relief from a negative feeling or cognitive state, resolution of an interpersonal difficulty, or to induce a positive feeling state. The criteria indicate that repeated use may lead to dependence. The criteria for NSSID require it to be associated with at least one of a) interpersonal difficulties or negative feelings or thoughts, such as depression, anxiety, tension, anger, generalized distress, or self-criticism, occurring in the period immediately prior to the self-injurious act, b) prior to engaging in the act, a period of preoccupation with the intended behavior that is difficult to control, and c) thinking about self-injury frequently, even when it is not acted upon.

NSSI as a Reason for Admission or as a Concurrent Problem. Most cutting, head banging, punching, and other self-injurious behaviors are not severe enough to require inpatient admission, and most do not come to the attention of mental health services. It is more typical for youth to be admitted because of suicidal statements and attempts where NSSI is a co-occurring behaviour. Sometimes NSSI, though mild, may frighten parents/caregivers and teachers and result in admission. NSSI is more usually the reason for admission when it is more severe and poses imminent risk of death or severe injury. Regardless of whether they are reasons for admission or concurrent problems, units are required to address all types of self-harming behaviours. NSSI can frighten co-patients, increase risk of infection, contribute to unintended risk of death, and generally get in the way of learning more adaptive strategies of coping. NSSI poses risks for other patients without a history of cutting who may imitate the behaviour. It also poses risks for patients with previous NSSI habits who may be triggered or influenced by co-patients to resume use of NSSI. This can lead to contagion or small-group rituals that may revolve around feelings of belonging and affiliation (Taiminen et al., 1998).

Functions and Contributors. NSSI can be triggered by self-blame, rumination, distress intolerance, oversensitivity to criticism, anger, agitation, sadness, loneliness, emptiness, anxiety, guilt, tension, boredom, intrusive unwanted thoughts and obsessions, intensely stressful and traumatic memories, dissociation, agitation, akathisia, and withdrawal from substance use (Allen et al., 2019; Chapman, Gratz, & Brown, 2006; Edmondson et al., 2016; Horowitz & Stermac, 2018; Kelada et al., 2018; Slabbert, Hasking, & Boyes, 2018). Adolescent and adult self-harmers report more frequent and more negative emotions, such as anxiety, depression, and aggressiveness, than persons who do not self-harm (Fliege et al., 2009). NSSI can provide a way of escaping or distracting from emotional distress after perceived rejection, attachment needs, and other relationship difficulties (Edmondson et al., 2016). Self-injury can result in habitual use and dependency by way of the rapid relief, calmness, and social reinforcement that it provides (Chapman et al., 2006; Lloyd-Richardson, et al., 2007). Although the actual act of injury during NSSI is painful, the removal or reduction of other pain stimulation appears to prompt a powerful

state of relief (Hooley & Franklin, 2018). Self-injury can also function as a less harmful alternative to suicide or to harming others, for sensation seeking, curiosity, mastery, connections with different memories, to fit in with a subculture, or to express one's individuality (Edmondson et al., 2016). Contributors to NSSI are associated with earlier exposure to violence (Sami & Hallaq, 2018), invalidating experiences at home and school (Adrian et al., 2018), and a history of childhood maltreatment (Paivio & McCulloch, 2004).

NSSI and Suicidal Behaviours. It is important for units to distinguish milder habitual forms of NSSI from more serious forms. It is important to also distinguish it from suicidality. Children's and adolescents' habits of coping by habitual self-harm often continue after admission and are difficult to stop. Brown, Comtois, and Linehan (2002) noted that non-suicidal acts in a sample of women with Borderline Personality Disorder were more often reported as intended to express anger, punish oneself, generate normal feelings, and distract oneself, whereas suicide attempts were more often reported as intended to make others better off. Patients who self-injure have been noted to have more positive views of life relative to patients who attempt suicide (Muehlenkamp & Gutierrez, 2007). Although there is clearly a positive relationship between NSSI and suicide, the nature of the relationship is not clear. It has been suggested that adolescents who engage in NSSI may develop an increased tolerance for pain and a decreased fear of death, as well as desensitizing habituation to self-injurious behaviors, more positive attributions regarding self-injury, and behavioral reinforcement of harm-to-self thoughts and behaviours through perceived social or internal rewards for NSSI (Guan, Fox & Prinstein, 2012).

Rates. NSSI appears to peak in the age ranges served by child and adolescent inpatient units. Individuals who visit the Emergency Department and those who are admitted to inpatient units, forensic settings, and residential care have greater likelihood and severity of NSSI compared to individuals in the community. It is very common in crisis prevention programs, ranging from 13% to 82% (Cloutier et al., 2010; Flores-Soto et al., 2018; Gandhi et al., 2018; Goldstein et al., 2009; Heath et al., 2008; Muehlenkamp & Gutierrez, 2004; Nixon et al., 2002; Nixon et al., 2008; Nock & Prinstein, 2004; Ross & Heath, 2002). Swannell et al.'s (2014) review across studies found overall, pooled NSSI prevalence was 17.2% among adolescents, 13.4% among young adults, and 5.5% among adults, once methodological differences had been accounted for. Earlier studies reported lower prevalence but the reason for the change is unclear and may involve increasing frequency, broader criteria for inclusion, and/or more accurate monitoring and reporting (Kress & Hoffman, 2008). Cloutier et al. (2010) noted that about half of the adolescents presenting to emergency crisis services had self-harmed within the previous 24 hours, with 91% of these being classified as NSSI only, 5% suicidal, and 4% combined NSSI and suicidal behaviour. A study in a juvenile detention centre found 16.4% had cut their wrists or forearms at least once, and 35.8% had burned themselves at least once (Bhaduri, 1982). Sevecke et al. (2017) found that 38.5%, of their inpatient sample fulfilled DSM-5 criteria for NSSID, and more than half (50.8%) of the adolescents indicated having injured themselves at least once in the past. A community study by Muehlenkamp et al. (2009) reported that females showed a significant increase in their rates of NSSI compared to males, who showed a significant decline, during the last 3 years of their study. One study found 25% or more of those attending hospital after self-harm have a history of previous episodes (Lilley et al., 2008), while some 15–25% were likely to repeat within 12 months (Owens et al., 2002). Kaba et al. (2014) observed that being alone and isolated in solitary confinement in prison populations can lead to increased risk of NSSI.

Age, Gender, and Diagnostic Groups. There appear to be both similarities and differences in NSSI use across age. After adjusting for the heterogeneity in prevalence estimates, one review reported an overall pooled NSSI prevalence of 17.2% among adolescents, 13.4% among young adults, and 5.5% among adults (Swannel et al., 2014). Reports of skin cutting appear to be more prevalent in depressed female adolescents with borderline personality disorder (Olfson et al.,

2005). In comparison men often use punching and burning (Goldstein et al., 2009; Kimbrel, et al., 2018). Male and female adolescent inpatients endorse comparable reasons for cutting themselves and that self-reported depressive and distressing negative emotions are positively associated with the number and intensity of different motivations for cutting (Kumar, Pepe & Steer, 2004). NSSI behaviour is not surprisingly correlated with increased likelihood of substance use (Sevecke et al., 2017) and misuse of prescription medications (Klassen, Hamza, & Stewart, 2018). Disturbed sleep also correlates with NSSI (Bandel & Brausch, 2018), perhaps by affecting level of calmness and emotionality. Svirko and Hawton (2007) reported that between 25.4% and 55.2% of youth with an eating disorder engaged in NSSI and that of those with suicidal self-injury, 54% to 61% had an eating disorder. NSSI was common in a sample of youth with bipolar disorder with 31% endorsed NSSI behaviors (MacPherson, Weinstein & West, 2018) and in youth with borderline personality traits (Taiminen et al., 1998). Individuals with autism spectrum disorder have increased risk for engaging in NSSI (Maddox, Trubanova & White, 2017).

Management. Education and training are essential for evidence-informed management of NSSI (Saunders et al., 2012). Although units can exercise vigilance, logical consequences, and use restraints to try to stop self-injury during inpatient stay, units have little control when a patient is on pass or after discharge. Communication and collaboration with patients are important. Zhand et al. (2016) reported that 12% of their unit sample engaged in self-harm and that about half of those incidents occurred outside of the hospital setting, when patients were on pass. Units make every effort to help patients reduce habitual NSSI including use of coercive controls when behaviours pose imminent and severe risk of harm. Information provided by inpatients suggests a six-step approach may be helpful that includes (a) limit setting for safety, initially by inpatient unit staff but gradually moving to limit setting by the patient themselves; (b) developing self-esteem; (c) discovering why the NSSI took place and what role it served for the patient; (d) helping patients develop an awareness that they can choose whether or not to self-injure; (e) replacing NSSI with other coping skills; and (f) a maintenance phase (Gonzales & Bergstrom, 2013). Attempts to manage NSSI, however, are not without their own risks. Focusing excessively on controlling NSSI may precipitate shame and guilt, increased suicidality, lying and secretiveness, defiance, and erosion of working alliances. When an adolescent self-injures, caregivers often experience confusion about how to react. Reports of feeling guilt, fear, and shame are common in the wake of learning about a child's self-injury. This cascade of negative feelings and negative self-appraisals may lead to hypervigilance and increased caregiver efforts to overly control the child's behaviour including hiding sharps and not allowing the child to go out. This may in turn serve to increase guilt and shame, escalation of urges, hiding of sharps, and defiance in ways that can threaten and at times compromise working alliances. This cascade is not well acknowledged or articulated in current literature. (Waals et al., 2018). Some patients smuggle 'sharps' and hide them from staff. Approaches involving collaborative harm reduction, and gradual or assisted gradual withdrawal may be more fruitful. This can include using global and more collaborative approaches like Safewards (Bowers et al., 2015; Fletcher et al., 2017; Hottinen et al., 2019) as well as making specific initiatives such as preventing boredom by having enough numbers and types of structured activities (Nederkoorn et al., 2016). Whenever possible inpatient management should strive to align itself with approaches used or to be used by community-based interventions and psychotherapies as there is evidence that there are a number of community approaches that can be helpful (Linehan et al., 2015; Turner et al., 2014). These approaches include working within the context of motivation to change, maintaining sobriety, preserving familial or non-familial support, promoting of positive affect, increasing distress tolerance and urge resistance, increasing capacity to self-calm, and maintaining healthy sleep habits.

VIOLENCE & AGGRESSION

1.20 The unit has the competencies and processes in place to identify, prevent, and manage aggressive behaviours that threaten physical safety.

Rates. Physical aggression that poses severe and often imminent risks to parents/caregivers, siblings, and/or peers is the most frequent precipitant of admission, second only to suicidal behaviour. Aggression may not always be identified as the reason for admission but may nevertheless present significant need for close supervision and management after admission. Whether it is the reason for admission or a concurrent problem, children admitted to inpatient care are more likely to present with severe aggression relative to patients in day treatment or outpatient care (Zimet et al., 1994). Estimates suggest that around 20 to 60% of children and adolescents engage in one or more aggressive incidents during their stay (Baeza et al., 2013; Crocker, Stargatt, & Denton, 2010; Dean et al., 2008; Philips, Stargatt, & Fisher, 2011; Ryan et al., 2004; van Kessel, Milne, Hunt, & Reed, 2012). Hill et al. (2012) reported that patients on inpatient units who are admitted under the Mental Health Act had particularly high rates of aggression which were like those of patients on forensic units. Aggression tends to decrease from admission to discharge (Dean et al., 2008). It can be reactive or proactive and used to intimidate, to dominate, to obtain tangible rewards, and to avoid unpleasant demands (Fite, Stoppelbeinn, & Greening, 2009), and it can be driven by one emotion or combinations of emotions such as anger and/or fear (Potegal et al. 2009).

Targets of Aggression. Violence and aggression on child and adolescent units can target the self but is more frequently directed at co-patients (e.g., Panagiotou et al., 2019) and staff (Dean et al., 2008, 2010; Garrison et al., 1990; Hill et al., 2012; van Kessel, et al., 2012). Staff and patients who are victims of violence and aggression can suffer a variety of problems including physical injuries, pain, headaches, fatigue, sleep disturbance, stress, anger, fear, anxiety, guilt, self-blame, shame, impaired concentration, and post-traumatic stress (Dean et al., 2010; Needham et al., 2005). Parents/caregivers and other family members are the most common targets of aggression for inpatient children before the children are hospitalized and after their return (Jacob et al., 2013). Hospitalization provides respite from the stresses of conflicts and from the burden of caregiving for children whose behaviours threaten family members. It is not surprising that parents/caregivers who use inpatient care for aggressive children tend to be more distressed than those who do not (Tsai, Yeh, & Slymen, 2015). Unfortunately, although inpatient care may be able to reduce stress particularly if recurrently used, it may contribute to dependency and hinder the development of family and community coping (Baeza et al., 2013).

Antecedents and Functions. Van Kessel et al. (2012) found that a very high proportion of violent incidents are preceded by two or more antecedents, supporting the notion that violent behaviour is rarely unpredictable and is often triggered following interaction with others (van Kessel, Milne, Hunt, & Reed, 2012). Impending aggression on inpatient units can be predicted by signs of restlessness, not listening, and signs of anger, irritation, agitation, hostility and anger (Faay, Valenkamp, & Nijman, 2017; van Kessel, et al., 2012). Aggression is often triggered when staff deny a child's request or set limits (van Kessel et al., 2012). Valenkamp (2011) found that limit setting or correction preceded over half of the incidents of aggression in their sample of children. Ryan et al. (2004) reported that 94% of incidents followed a provocation such as a request, direction or command from the staff that could be perceived by children and adolescents as coercive or limit setting. Phillips, Stargatt, and Fisher (2011) reported that the likelihood of aggression during an inpatient stay could be better predicted by unstructured clinical risk

assessment. Findings have suggested that aggression may also be tied to temporal patterns and staffing. Jacob et al. (2013) reported two thirds of aggressive episodes occurred in the evening. Hill et al. (2012) similarly found that the likeliest times for incidents were towards the end of each day and the beginning of the night shift. Riordan-Eva, Hill, and Leipold (2018), who studied a secure adolescent unit, found that the number of incidents both in the first week and first 28 days was higher in comparison to the whole admission, but stabilized subsequently.

Contributors. Contributors that predict aggression include history of previous aggression, diagnosis of a disruptive behavior disorder or bipolar disorder, positive symptoms of psychosis, previous hospitalization, placement instability, involuntary status, larger physical size, higher psychopathy scores, history of physical abuse, history of paternal violence and homicidality, maternal mental illness, seizures, and comorbid suicidality (Baeza et al., 2013; Boxer, 2007; Crocker, Stargatt, & Denton, 2010; Fryer, Beech, & Byrne, 2004; Lewis et al., 1983; Stafford, & Cornell, 2003; van Kessel et al., 2012). Children and adolescents with autism and intellectual disability are often referred/transferred to inpatient care because of precipitating problems that primarily include aggression, (Mandell, 2008; McGonigle et al., 2014; Siegel & Gabriels, 2014). Siegel and Gabriels (2014) noted that in their inpatient population with autism it was not uncommon to have daily counts of physical aggression in the double digits and self-injurious behavior in the hundreds. They recommended assessment for pain as a routine part of the assessment of possible contributors to aggression in this population. Hill et al. (2012), in their study, found that a small number of female patients with emerging emotionally unstable personality disorder accounted for most violent incidents. In contrast, acting out of patients with anxiety and certain other diagnoses may be less likely to have incidents of screaming, throwing and hitting/kicking; rather they may express their distress instead through expressions of sadness, remorse, and crying (Potegal et al., 2009). Certain studies have found no age differences in aggression (Connor et al., 1998; Delga et al., 1989; Sukhodolsky et al., 2005), whereas others have (Dean et al., 2008; Garrison et al., 1990; Vivona et al., 1995). Differences in findings may be due to the different age ranges compared and criteria used. One study found that aggression in younger children usually resembles forms of severe (i.e., easier to precipitate, longer to settle, and of greater intensity) childhood tantrums rather than manic or homicidal type rages (Potega et al., 2009). Most studies have found males on inpatient units are more likely to be aggressive than females (Barton et al., 2001; Dean et al., 2008; Fritsch et al., 1992; Gabel & Shindledecker, 1991; Garrison et al., 1990; Jacob et al., 2013; Pfeffer et al., 1983, 1985).

Past Aggressive and Criminal Behaviour. It is important for units to know about the potential for aggression prior to admission or, if this is not possible, upon admission. The use of checklists to identify likelihood of patient aggression and its contributors is helpful for safety planning (e.g., McNiel & Binder, 1994). It is particularly important for general mental health units to identify admissions of adolescents likely to engage in antisocial aggression which may involve use of aggression to intimidate co-patients into giving up medication, money, sexual favours, or belongings. A few such youth may in addition also try to bring harmful substances or weapons on the unit, or aggressively threaten unit staff. Many inpatient adolescents with criminogenic aggressive behaviours come from environments where aggression may be 'normal' (Ikaheimo et al., 2013). It is important that criminogenic aggression be assessed as early as possible to protect patients and staff, and that potential for youth to carry grudges into the community after discharge be minimized.

Consequences of Aggression. The extent of supports provided by staff and the perceived climate of recovery are important in understanding the likelihood and impact of aggression. For example, de Decker et al. (2017) found a significant inverse relation between the number and severity of aggressive incidents and the amount of perceived support from staff. The presence of aggression has been associated with a worsening of the emotional climate or atmosphere on units, as well

as lower likelihood of a therapeutic alliance and positive outcomes (Jacobs et al., 2004). Adolescents who had aggressive events that required intervention have also been found to be likelier to be discharged to out-of-home residential care (Baeza et al., 2013). Aggression predicts longer length of stay (Baeza et al., 2013; Boxer, 2007; Dean et al., 2008; Ryan et al., 2004). Aggression also predicts extensive and sometimes desperate attempts to manage it with medication and polypharmacy that fail in preventing admission (Baeza et al., 2013; Jacob et al., 2013). Jacob et al. (2013), for example, noted that over 90% of patients admitted for aggression had been previously prescribed a variety of different medications prior to admission.

Management. One of the more common management practices is the use of seclusion and restraint (including using prn medication; this is reviewed in the section on Standard 12. Medication). The most prevalent reason for use of seclusion and restraint on inpatient units is to keep a patient from harming others (Furre et al., 2016). However, because of concerns that seclusion and restraint can also compromise patient and staff safety, there has been a movement to reduce the need to use these practices. Although seclusion and restraint and other coercive procedures may need to be used at times, there are many other interventions that have been found to be effective in reducing both aggression and need for seclusion and restraint including Safewards (Bowers et al., 2015; Fletcher et al., 2017; Hottinen et al., 2019). Given that seclusion and restraint are most often used to manage aggression that poses risks to others, it is not surprising that reduction of seclusions and restraints involves reducing the the need to use these procedures by preventing and more effectively managing aggression. Most of the interventions to reduce seclusion and restraint reduce incidents of aggression as well. These include routine engagement of patients and parents/caregivers in incident identification, analysis and prevention (Regan, Curtin & Vorderer, 2006). Promising interventions include:

- earlier detection and planning, as a majority of risk management problems arise within the first seven days of admission (Dean, Duke, George, & Scott, 2007; Donovan et al., 2003; Swadi & Bobier, 2012);
- increased structure including better scheduling and more activities (Busch & Shore, 2000; Delaney, 2000);
- more time and better techniques to manage stressful situations and transitions, including giving children more time to calm down and using distraction techniques (Ahmann & Johnson, 2000, Busch & Shore, 2000; Delaney, 2000);
- availability of a broader range of disciplines involved in prevention and integration of their diverse knowledge bases (Bonnell, Alatishe, & Hofner, 2014);
- improved staff communication, training, and education (Azeem et al., 2011);
- reducing coping demands and improving self-regulation (Dean, 2009);
- behavioral consultation, antecedent analysis, functional assessment of the behaviour, increased consistency of behavioral contingency management (Dean et al., 2007; Luiselli, Pace & Dunn, 2003);
- engagement of youth in collaborative problem solving (Ahmann & Johnson, 2000, Greene et al., 2006; Martin et al., 2008);
- trauma informed care and introduction of a sensory modulation activities and rooms (Azeem et al., 2011; Bobier et al., 2015; Seckman et al., 2017);
- attachment-supporting care (de Decker et al., 2017);
- use of data to inform progress, increased consumer participation, and vigorous debriefing with patients, family, and observers (Azeem et al., 2011); and
- encouragement of autonomy, attachment-supporting sense of belonging, promotion of confidence and competence (Donovan et al., 2003).

Even though most inpatient aggression can be prevented and safely managed, it should not be forgotten that as physical size and strength increase, the ability of staff to manage may be insufficient. Police are sometimes called in highly dangerous situations such as when inpatients have weapons or when a number of patients work together to assault other patients or staff. The use of non-admissions and early discharge for severe aggression and violence is discussed in greater detail in the paragraphs on safety practices in the present section. More detailed information about hospital utilization rates, availability of service alternatives, and inpatient outcomes for aggression and violence are discussed in other sections (e.g., Standard 11. Stabilization & Therapy, and Standard 15. Outcomes).

SEXUAL ASSAULT & CONTACT

1.21 The unit monitors and assures sexual safety for all youth, with attention to the more vulnerable.

Children and adolescents on inpatient units can exhibit problematic sexual behaviour that may involve exposing genitals, grabbing and touching, sneaking into someone else's room in the middle of the night, trying to find a hidden place to connect romantically, and saying things that may upset others (Chaffin, Letourneau, & Silovsky, 2002). Protecting individuals with impairments in judgment who may present with problematic sexual behaviour or who could be victimized has been recognized as important for adult units (Ford et al., 2003), and is equally so for child and adolescent units. Ford et al. (2003) recommended that monitoring and prevention of all sexual interactions among patients should be part of unit responsibility and guided by policy, particularly given the potential for severe risk and liability that such behaviors pose on inpatient units. Although Ford et al. (2003) acknowledges that patients should be allowed as many rights as possible, they noted that sexual behaviours among patients can also lead to transmission of disease, pregnancy, violations of consent, trauma, and interference in treatment. Ford et al. (2003) notes that while some believe that personal rights should extend to freedom to engage in consenting sexual behavior, brief stay inpatient units with vulnerable patients are better to have rules of no physical interactions such as handholding and hugging in the interests of providing as safe an environment as possible. Ford et al. (2003) recommend that if a high-risk patient understands the hospital policy but does not agree to follow it, he or she should be placed on 15-minute checks (or an equivalent monitoring standard). If a high-risk patient is not capable of understanding the hospital policy, he or she should be placed on five- to ten-minute checks for sexual behavior with continued redirection and, if necessary, one-on-one observation. More research is needed to for confident conclusions.

ABSCONDING, FALLS & OTHER RISKS

1.22 The unit has procedures and practices in place that help to prevent and manage absconding, falls, accidents, and other risks.

Absconding. Absconding, which is also known as elopement, AWOL (Absent Without Leave), and "running away" is not uncommon. 'Missing patient' is a broader term that can include 'wandering patients' who may still be in the hospital but whose location is no longer known. Absconding can include leaving the hospital without permission as well as failing to return from pass (Guest, Baker, & Storaasli, 2008). Absconding is concerning because patients may abscond

with intentions to act on suicidal urges, plans to hurt others, or due to impaired judgments that escalate the likelihood of incidents when away from the hospital (Faay et al., 2017; James & Maude, 2015). It is important to identify children and adolescents at risk of absconding as early as possible, and to discuss how to prevent the need to abscond, and what procedures may prevent it. Risk of absconding cannot be managed by general hospital procedures alone and requires individualized assessment and intervention.

Units should have policies and procedures or protocols in place that describe the actions staff should take if a child or adolescent patient absconds (Lucas, 2019). These procedures should appreciate the developmental limitations and needs to protect children and should not be the same as those for adults. Risk reduction for absconding requires a thorough understanding of the interacting individual, familial, staff, co-patient, and environmental factors that can contribute to the absconding behaviour of the patient at risk (Bowden & Lambie, 2015). Some patients will use absconding as a coping behaviour, as part of excitement-seeking, and others to escape what they experience to be overly restrictive, boring inpatient environments. Others will abscond to reconnect with friends or romantic interests, to reduce isolation and access friends and attachments, to 'pay back' staff who denied a request or who are perceived to be rejecting, to escape rules and limits, to protest unfair involuntary admission, to return to protect or be protected by parents/caregivers, to escape stigma, and/or to reduce fears of co-patients, psychiatric care, or staff (Bowers, 2003; James & Maude, 2015).

Although total prevention of all absconding may not be possible, there are unit interventions that more successfully manage attachment vulnerabilities by finding and spending therapeutic time with patients (e.g., time to care) and identifying individuals at high risk for absconding, having a process for signing in and out, providing sensitive and supportive discussion of bad news, making time to complete post incident debriefing with patients and daily time to address prevention for those at high of absconding and facilitating increased social contact (Bowers, 2003; Emanuel et al., 2013; Mosel, Gerace, & Muir-Cochrane, 2010). Custodial and defensive restrictions that focus on external control and that fail to make use of patient collaboration may increase the risk of absconding (Emanuel et al., 2013). Some of the daily time with patients should involve all discussing risk of absconding and identifying urges or anxieties that may fuel intentions to abscond, and alternatives that may be more successful in addressing the underlying urges and anxieties. Urges to abscond based on feelings of loss of attachment supports and social contacts can be moderated by increasing opportunities for phone contact, encouraging visitors, and increasing social activities and engagement with staff members or volunteers that can become supportive attachment figures that provide some companionship. James and Maude (2015) noted there is a lack of consensus and research in the literature about whether locking doors can prevent absconding. Locked doors and restricted access to common areas on the unit may at times be more likely to generate a negative custodial prison-like climate that patients would prefer to escape.

All hospitals have policies and procedures that describe how to search for a missing patient, and how to help a missing patient return to hospital. Voluntary patients who have left the unit and have not been at severe imminent risk are less concerning and have the right to not return to hospital. It is important for parents to know that a hospital cannot prevent older adolescents who are voluntary from leaving, and to work with the patient and parents/caregivers to assure the patient leaves, even if against medical advice, by providing notification and whenever possible by completing the established discharge process. If the patient is an involuntary or informal one parents/caregivers and police may be engaged in helping to locate the missing patient and assuring they return to the unit. Child protection agencies may be involved as well if the patient has absconded to an unsafe home or is being prevented from returning to hospital by parents/caregivers.

Accidents. Youth in inpatient care comprise children with various neurodevelopmental and psychiatric vulnerabilities that puts them at greater risk of having accidents than other youth (Engqvist & Rydelius, 2006; Park et al., 2013). Individuals should be screened for their potential for accidents. Activities and environmental accommodations should be made to address identified vulnerabilities which may include physical disabilities as well as sedating medications. Environmental modifications such as will be discussed in Standard 3 on the physical environment will detail how the environment can be designed to be less likely to contribute to a serious accidental or intentional injury.

Fire-Setting. Although fire-setting is rare, there are children and adolescents who are admitted specifically for risks related to fire-setting or who have fire-setting as a secondary problem (Kolko, & Kazdin, 1988). When this occurs, units will take additional precautions to monitor and to reduce access to flammables and means of ignition.

Falls. Falls are rare among child and adolescent inpatients particularly as there are few admissions for children under the age of five where one might expect a greater incidence. Nevertheless, falls can occur, and it is important for inpatient units to screen for vulnerability and to put appropriate limits on activities in the hospital gym or on the unit that are unsafe. Young people taking sedating medication or with impaired mobility, and young people with conditions or illness affecting balance, a history of falling, and/or a history of disorientation may be at greatest risk (Razmus et al., 2016). Using wheelchairs and walkers and other assistive devices may at times be required (with some cautions for patients with health anxieties or factitious disorders).

Contraband. Friends may smuggle in tobacco, marijuana, or alcohol intending to use these in relatively 'safe' ways. Sometimes friends and visitors may bring these in after passes from the unit. These items are restricted because of hospital and societal rules which need to be followed. The focus on preventing smuggling of such contraband is important but is beyond the scope of the current section. Surveillance and searches should not distract from safety procedures for more serious and potentially lethal risks.

HEALTHY RISK TAKING

1.23 The unit provides patients with opportunities for reasonable risks essential for recovery

The idea that patients, particularly child and adolescent patients, should be allowed to experience some risks and should be engaged in managing their own safety runs counter to most popular beliefs about how inpatient units should operate. Parts of the public have become highly sensitized and fearful of the suffering that a serious injury or the loss of a child through suicide can bring. The more common view of inpatient units is that they are there to prevent such tragedies by providing extensive restrictions and surveillance for youth at risk of seriously harming themselves and others. Encouraging risk taking runs counter to a view that no risk is a good risk and that rules and control should be paramount. But an excessive focus on control may precipitate the very harmful behaviours it is trying to prevent. Slemon et al. (2017) argued that some inpatient approaches excessively value external control of patients using rules and coercion. Hospital safety procedures that excessively emphasize involuntary detention, seclusion and restraint, prn medication, constant observation, locked doors and room restrictions, room searches, and restrictions on movement may in fact undermine patient collaboration in the

management of risks, and opportunities for patients to learn how to better cope with risks. Coercive rule-oriented control may communicate that the rules are more important to staff than the patient and increase rather than reduce risks of eventual dangerous and defiant acting out. Excessive emphasis on control can also erode the need for ethical reflection on the part of staff and promote automatic justification for coercive measures (Landeweer, Abma, & Widdershoven, 2011). An "us versus them" mentality can develop between staff and patients which gets in the way of recognizing the need to work together as partners. In contrast, there are approaches that assert that inpatient units are safer when they provide a balance between control and permissiveness, including the freedom to question hospital rules, and opportunities to learn how to cope in somewhat risky environments (James & Javaloyes, 1999). Excesses in both permissiveness and control can be problematic. Slemon et al. (2017) offered the opinion that units need less control and more collaboration, calling for a re-centering of the balance by moving away from overly defensive nursing, 1:1 observation, door locking, and seclusion/restraint use. The section 'Standard 2. Psychological Safety, Dignity, & Rights' discusses approaches, such as trauma-informed care, that are more engaging, less restrictive, and yet nevertheless able to significantly reduce inpatient incidents without over-reliance on coercive control.

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SELF-AUDIT CHECKLIST

Ontario Network of Child and Adolescent Inpatient Psychiatry Services

Unit Name_____
Date(s) of Self-Audit: _____ Fiscal Year: _____

Total number of admissions_____

STANDARD 1: PHYSICAL SAFETY. The unit monitors, assesses, and assures the physical safety of patients, visitors, and staff.		
Qualitative Indicators & Benchmarks	**True**	**False**
1.1 The unit routinely monitors, analyzes, and reports incidents, near misses, and potential risks.	☐	☐
BENCHMARKS: Annual incidents (last fiscal year)		
1. Total # of incidents on the unit: _____		
2. Most common type of incident: _____		
3. Most serious type of incident: _____		
4. Total # of root-cause or similar analyses completed and reported: _____		
1.2 The unit provides a complete range of safety procedures and practices required to prevent all types of incidents and evaluates their effectiveness.	☐	☐
1.2.1 The unit has published safety practices and procedures for children and adolescents which are developmentally appropriate and distinct from those for adults	☐	☐
1.2.2 Unit safety practices and procedures are adapted for special needs and culture	☐	☐
1.3 The unit assures that staff have the time and numbers required to assure patient and staff safety.	☐	☐
1.4 The unit has access to psychiatric intensive care units (PICU) and other more secure services for patients that cannot be safely managed on the unit.	☐	☐
1.5 The unit <u>does not admit</u> children and adolescents that it cannot safely manage and redirects them to safer settings.	☐	☐
1.6 The unit <u>discharges</u> children and adolescents it cannot safely manage to safer settings.	☐	☐
BENCHMARKS: Redirection and discharges of unsafe admissions across last year		
1. # of admissions that were not admitted because of an unacceptable likelihood of risk of harm to the patient, co-patients, or staff _____		
2. # of admissions that were discharged because of unacceptable likelihood of risk of harm to the patient, co-patients, or staff _____		

3. # of admissions on the unit which resulted in harm to the patient, co-patients, or staff because there was no more secure place for the patient to be redirected or transferred to _____

1.7	**The unit encourages voluntary participation and only uses involuntary admission and treatment when essential to assure safety.**	☐	☐
1.7.1	Inpatient admitting physicians collaborate with emergency department sources and community referral sources to apply the same criteria to assure consistent and appropriate use of informal, involuntary detention, and voluntary admissions.	☐	☐
1.7.2	Unit and referral/transfer partners work together to assure that children and adolescents who are found to be capable of understanding why they are in hospital and the severity of their risk are offered the opportunity to be admitted on a voluntary basis.	☐	☐
1.7.3	All children and adolescents are assessed after admission and their informal, involuntary, and voluntary status is left the same or changed depending upon the findings.	☐	☐

BENCHMARKS: Involuntary Admissions Last Fiscal Year

1. Total number of admissions which were voluntary _____
2. Total number of admissions which were informal _____
3. Total number of admissions which were involuntary for psychiatric assessment (Form 1 or 2) _____
4. Total number of admissions which were involuntary for treatment (Form 3, of 4) _____

Provincial Benchmarks for involuntary admissions for general crisis and extended stay general treatment units: from past surveys Avg ~65%, Mdn ~68%

BENCHMARKS: Disposition Changes after Initial Psychiatric Assessment Last Fiscal Year

1. Voluntary (unchanged) _____ 2. Voluntary to Informal _____ 3. Voluntary to Treatment (Form 3) _____

4. Informal to Voluntary _____ 5. Informal (unchanged) _____ 6. Informal to Treatment (Form 3) _____

7. Involuntary Detention (Form 1) to Voluntary _____ 8. Involuntary Form 1 to Informal_____

9. Involuntary Detention to Involuntary Treatment (Form 1 to Form 3) _____

10. Involuntary Treatment (Form 3 to Form 3 or 4) _____

1.8	**The unit communicates and collaborates with patients, parents/caregivers, and community partners to identify risks and provide safety.**	☐	☐
1.8.1	Patients, and parents/caregivers are provided with handouts and orientation to potential risks and safety practices on units at or prior to admission.	☐	☐
1.8.2	The unit works with patients from admission and until discharge to identify potential risks and effective safety practices.	☐	☐
1.8.3	Patients are invited to participate in progress reviews and case conferences that review risks during their admission.	☐	☐
1.8.4	The unit works with parents/caregivers to identify risks and safety prior to admission or upon admission when that is not possible.	☐	☐
1.8.5	The unit works with community partners to identify risks and safety prior to admission or upon admission when that is not possible.	☐	☐
1.8.6	Milieu staff review of risks and safety needs for each patient at every shift change.	☐	☐

1.8.7	Staff review risks and safety needs with patients, parents, caregivers, and involved community partners prior to pass, at discharge, and as needed.	☐	☐
1.8.8	The unit routinely notifies the patient and parents/caregivers when a reportable incident or a near miss occurs; patients/caregivers are identified promptly or within 3 hours at latest.	☐	☐
1.8.9	After incidents, the unit debriefs with patients, parent/caregivers, and when important, with community mental health services after incidents with a view to improving safety.	☐	☐
1.8.10	Patients (not only staff) participate in weekly meetings that review the unit's general safety needs and possible improvements.	☐	☐
1.9	**The unit provides a risk assessment that considers risk of injury to self, to others, and from others.**	☐	☐
1.9.1	The risk assessment focuses on the risks which precipitated the admission.	☐	☐
1.9.2	The risk assessment considers risks stemming from other behaviours or sources.	☐	☐
1.9.3	The risk assessment is completed and reviewed with the patient, parents/caregivers, and involved community mental health services.	☐	☐
1.9.4	The risk assessment identifies predisposing factors, antecedents, reinforcers, and functions for the risky behaviours.	☐	☐
1.9.5	The risk assessment is informed by the diagnostic assessment.	☐	☐
1.9.6	Valid and reliable psychometric measures are used whenever they can contribute significantly to the understanding of safety needs and practices.	☐	☐
1.10	**The unit restricts access to unsafe items, activities, and social contacts.**	☐	☐
1.11	**The unit provides the least intrusive level of observation that assures the safety of all patients on the unit.**	☐	☐
1.11.1	The unit provides different levels of observation which are flexibly increased and reduced in response to changes in risk severity. The following are levels of observation provided: a) Knowing where patients are and what they are doing on the unit b) Intermittent observation for youth at somewhat higher risk, c) 'Line of sight' constant observation for high risk, d) within arm's length" for very high risk, and e) Two staff per patient for ultra-high risks of harms to staff, self, or other patients that could not be prevented by one staff	☐	☐
1.11.2	Patients and parents/caregivers are invited to participate in identifying risks and amount and type of observation that will best assure safety.	☐	☐
1.11.3	The unit does not expect or rely on 15-minute checks to prevent suicide risk and harm to others.	☐	☐
1.11.4	Observation is not passive but interactive with opportunities to be with more familiar staff to the extent possible.	☐	☐
1.11.5	The unit does not utilize inexperienced and untrained staff or staff who are unfamiliar with the patient and unit to provide observation.	☐	☐
1.11.6	The unit uses video cameras at night instead of intermittent observation and opening of doors that interrupts sleep.	☐	☐

1.11.7	If the unit uses cameras, it assures that the frequency of staff observation of the video is sufficient to assure safety.	☐	☐
1.11.8	To help with transition at discharge, the unit works with patients and parents/caregivers to approximate the types of observations that will be applied in homes and schools after discharge.	☐	☐
1.12	**The unit utilizes the least intrusive types of searches to prevent serious incidents of harm.**	☐	☐
1.12.1	Patients and their parents/caregivers are informed about the unit's reasons for searches and procedures before or upon admission.	☐	☐
1.12.2	The unit provides different types of searches which are appropriate for the perceived safety need including: a) searches of the environment, b) searches of personal belongings, c) searches of the person and their clothes, d) searches of packages, bags, and other items that are brought to the unit.	☐	☐
1.12.3	The primary expressed focus of searches is to assure safety and not fixate on stopping less low risk contraband (e.g., cigarettes).	☐	☐
1.12.4	Routine collaborative patient safety scans of the environment and belongings that involve all patients and staff, occur on a scheduled basis.	☐	☐
1.12.5	Searches of individual patients are preceded by private discussions with the patient and opportunities for the patient to disclose or reassure staff.	☐	☐
1.12.6	Staff wear protective equipment and are supported by another staff for all searches of individual patients.	☐	☐
1.12.7	Searches of individuals, their bedroom, their belongings or person occur as necessitated by observations of imminent and severe risk.	☐	☐
1.12.8	In situations where risk is not imminent, staff prepare the young person prior to the search by discussing rationale and need.	☐	☐
1.12.9	Debriefs, discussions, and problem-solving opportunities occur after all searches with a view to preventing future risks and reducing needs for searches.	☐	☐
1.12.10	To help with transition at discharge, the unit works with patients and parents/caregivers to approximate the types of searches that will be applied in homes and schools after discharge.	☐	☐
1.13	**The patient, parents, community service partners and staff develop and follow a common individualized safety plan.**	☐	☐
1.13.1	Each patient's safety plan is developed in collaboration with the patient, parents/caregivers, and community service partners.	☐	☐
1.13.2	The safety plan explicitly identifies and describes ways to prevent and manage the physically unsafe behaviours which precipitated the admission.	☐	☐
1.13.3	The safety plan also identifies and provides management directions for all other co-occurring behaviours and problems that pose imminent or significant physical risks to the patient or others (e.g., fire setting, absconding, sexual assault, extreme drug use, refusal to eat).	☐	☐
1.13.4	The safety plan explicitly identifies, and addresses antecedents (e.g., use of drugs and alcohol, being alone, distressing emotions, rejection) and reinforcers (e.g., distress reduction, social reinforcement) associated with the risks.	☐	☐

1.13.5	The safety plan identifies actions and coping strategies that patients can themselves take to reduce, manage risk, and reassure others (appreciating that these may be more limited for patients who less capable).	☐	☐
1.13.6	The safety plan lists a primary contact as well as secondary contacts among family members, mental health professionals, agencies, and crisis responders who the youth and/or parents/caregivers can use for immediate help and/or support.	☐	☐
1.13.7	The safety plan provides a list of telephone numbers and contact information for use during an emergency.	☐	☐
1.13.8	The safety plan is reviewed and used by the unit, the patient, parents/caregivers, and involved community services to prevent incidents and assure safety during admission, visits, and passes.	☐	☐
1.13.9	Risk and the safety plan are reviewed with the youth, parents/caregivers and community services who may have contact with the patient before the youth leaves the unit for pass.	☐	☐
1.13.10	The safety plan includes identification of items that should be secured for passes home including locking up firearms, reducing access to ligatures, and secure storage of medications and toxic substances.	☐	☐
1.13.11	The safety plan is not used as a safety contract where patients are blamed when they fail to follow the plan.	☐	☐
1.13.12	The last safety plan prior to discharge identifies risks at discharge and recommended safety practices (see the section under Standard 13: Discharge, for additional details).	☐	☐
1.13.13	The unit provides an opportunity for a discharge session where patient, parents/caregivers, and community services can review the inpatient safety plan and develop their post-discharge community safety plan (see the section under Standard 13: Discharge, for additional details).	☐	☐
BENCHMARKS: Individualized safety plans			
1. # of patients with an individualized safety plan _____			
1.14	**The unit provides, monitors, and minimizes need for seclusion and restraint.**	☐	☐
1.14.1	At admission the unit engages patients, parents/caregivers, and professional partners in a discussion to identify and prevent need for seclusion/restraint.	☐	☐
1.14.2	The unit uses the least restrictive options such as using room restrictions and seclusion room whenever possible, rather than using mechanical means of immobilizing limbs with straps, jackets, or Pinel-type restraints.	☐	☐
1.14.3	The unit notifies substitute decision makers and/or parents/caregivers as soon as possible after any incident of seclusion/restraint.	☐	☐
1.14.4	The unit management and staff complete a written review of every incident of seclusion and restraint.	☐	☐
1.14.5	Post-restraint debriefs include not only staff but also patient and parents/caregivers.	☐	☐
1.14.6	Findings and feedback are used to prevent future occurrences.	☐	☐
1.14.7	Use of restraints is monitored and evaluated for its appropriateness of use, effectiveness, and impact on patient dignity.	☐	☐
1.14.8	Types and prevalence of restraints are collected on an ongoing basis.	☐	☐

BENCHMARKS: Seclusion & restraints

1. # of admissions which included seclusion _____
2. # of admissions which included physical restraint _____
3. # of admissions which included mechanical restraint _____ (e.g., Pinel, 4 point etc.)
4. # of admissions which included chemical restraint _____

5. # of admissions which include a seclusion or restraint of any type _____

PROVINCIAL BENCHMARKS: Average and median numbers of admissions that included a restraint by any method per unit based on units which tracked data: <9% and <8% respectively

6. # of patients (not admissions) which were secluded or restrained _____

7. Total # of seclusions per 1000 bed days _____

8. Total # of seclusions per 1000 patient hours _____

1.15	**The unit monitors, reports, and assures the safety of staff.**	☐	☐

BENCHMARKS: Staff safety indicators

1. Total # of staff injuries resulting from patient aggression/assaults: _____

2. Total # of staff injuries suffered in the course of seclusion and restraint: _____

3. Most common type of staff injury: _____

4. Most serious type of staff injury: _____

5. Total # of root-cause or similar analyses completed and reported for staff injuries: _____

1.16	**The unit has a good working relationship with the Children's Aid Society and duly identifies and reports suspicion of child abuse.**	☐	☐
1.17	**The unit provides the background checks, supervision, education, and training that minimizes risks to patient safety from staff.**	☐	☐
1.17.1	The unit obtains criminal reference checks for all individuals working on the unit.	☐	☐
1.17.2	The unit monitors staff fatigue, illness, and other behaviours that can pose risks to patient safety.	☐	☐
1.17.3	The unit provides supervision that reviews patient safety needs with all staff.	☐	☐
1.17.4	The unit assures more intensive supervision and peer support for new and inexperienced staff.	☐	☐
1.17.5	Staff are trained in responding to all emergencies (e.g., fire drill, missing patient, nonviolent crisis intervention etc.).	☐	☐
1.18	**The unit has the competencies and processes in place for screening, assessment, and safe management of suicidal behaviour.**	☐	☐
1.19	**The unit assesses and helps reduce non-suicidal self-injurious behaviours and habits.**	☐	☐
1.20	**The unit has the competencies and processes in place to identify, prevent, and manage aggressive behaviours that threaten physical safety.**	☐	☐

1.21 **The unit monitors and assures sexual safety for all youth, with attention to the more vulnerable.**	☐	☐
1.22 **The unit has procedures and practices in place that help to prevent and manage absconding, falls, accidents, and other risks.**	☐	☐
1.23 **The unit provides patients with opportunities for reasonable risks essential for recovery.**	☐	☐
DETAILS, NOTES, & FEEDBACK: *Please refer to the other sections of the Guide, Standards, Benchmarks, and Literature Review for additional details and discussions beyond what was provided in the present section. In particular, refer to sections on assuring safety in the physical environment, psychological safety, medication, and treatment.*		