

**Implementation of Aggressive Behavior Management Intervention in Adult Psychiatric**

**Inpatient Unit**

by

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A DNP Project Manuscript

Submitted in Partial Fulfillment of the Requirements for

the Doctor of Nursing Practice Degree

University of Maryland School of

Nursing

May, 2024

**Authors Note**

The project has no conflict of interest as the project lead is a student at the University of Maryland, not a staff at the project site.

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## IMPLEMENTATION OF AGGRESSIVE BEHAVIOR MANAGEMENT INTERVENTION

### Abstract

*Problem:* The use of seclusion and restraints increases ligature risks in hospitals. An inpatient behavioral health unit's restraint and seclusion rate is 67.6%, higher than the national benchmark of 32%. Unit leaders report that seclusion and restraints are associated with staff turnover, callouts, and staff disability due to injury sustained while restraining patients with aggressive behavior. *Purpose:* This quality improvement project aimed to implement interventions using three selected domains of the evidence-based aggressive behavior management Safewards model to reduce seclusion and restraint rates and improve safety. *Methods:* Clinical nurses were educated about the Safewards model, and the domains selected for intervention, which included Regulatory Framework, Patient Community, and Physical Environment. These nurses served as champions on interdisciplinary teams to implement the three interventions: 1) obtaining a mutual safety agreement during the admission process, 2) collaborating with the treatment team to schedule family meetings for acceptable discharge planning, and 3) maintaining a safe physical environment by offering agitated patients a quiet or sensory room for de-escalation. Intervention implementation was monitored weekly by chart audit, and seclusion and restraint use were monitored monthly. *Results:* Of the 190 patients admitted during the project, 137 (72 %) patients signed mutual safety agreements, 190 (100%) family discharge planning meetings took place, and 57 (30 %) patients used the sensory or quiet room. Fifty-seven (30 %) patients required seclusion and restraints. *Conclusion:* Results demonstrate that implementing strategies aligned with the Safewards model may be associated with a decreased incidence of seclusion and restraint. This evidence-based project facilitated safety and care optimization in a behavioral health unit. Ongoing training is needed to facilitate the sustainability of the intervention.

Keywords: Keywords: Safewards, aggressive behavior management, behavioral health unit

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### **Implementation of Aggressive Behavior Management Intervention in Adult Psychiatric**

#### **Inpatient Unit**

Twenty-five to 85% percent of healthcare workers experience verbal or physical aggression from patients annually. Furthermore, most violence experienced by healthcare workers occurs in psychiatric settings (Goldstein, 2022; Odes et al., 2021). In a Maryland urban community hospital with a thirty-eight-bed inpatient adult behavioral health unit, the restraint and seclusion rate was 67.6 % over six months. The benchmark use of restraints and seclusions in hospitals is 32% (American Psychiatric Association, 2020). Unit leaders and staff verbalized the need to reduce the rate of seclusion and restraints to align more closely with the national benchmark, which reflects over 50% reduction. Unit leaders reported that seclusion and restraints were associated with increased behavioral staff turnover and callouts.

Furthermore, nursing staff have been placed on disability due to bodily injury sustained while restraining patients with aggressive behavior. The stakeholders, including the director, manager, and assistant manager, verbalized that increased restraints and seclusion on the unit also impact staff productivity because staff members are no longer willing to work extra shifts to cover staffing needs. The current situation compromises the safety of staff and patients. Root cause analysis identified that the primary reasons for high restraints and seclusion utilization were existing policy and procedure, patient admission status, and the severity of diagnoses. See the fishbone diagram in Figure 1. As reported by the stakeholders, admission status significantly impacts the rate of seclusion and restraints on the unit, as emergency petitioned patients, involuntarily admitted and court retained, are often agitated; and may pose an imminent danger, requiring restraints and seclusions. This project aimed to implement three components of the evidenced-based aggressive behavior management program Safewards in an urban community

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hospital's behavioral health unit (BHU) to reduce the seclusion and restraint rate.

### **Available Knowledge**

Safewards is an evidence-based model of six domains with strategies to reduce aggressive behavior, seclusion, and restraints of hospitalized psychiatric patients. The model targets six domains: patient community, patient characteristics, regulatory framework, physical environment, staff team, and outside hospital (Dickens et al., 2020). This model addresses the root causes identified at this site to maintain the safety of the milieu and people in the behavioral health unit. See Figure 1.

Four level I, high-quality randomized control trials found that family involvement in treating patients diagnosed with severe mental illnesses such as schizophrenia helps to minimize symptoms, such as aggression that increases seclusion and restraints (Chien et al., 2016; Chien et al., 2018; Li et al., 2020; Rami et al., 2018). Involving family members and caregivers in coordinating patients' discharge plans will facilitate acceptable discharge plans for patients and their family members. The patients will have an avenue to communicate about their living situation or concerns to the social workers in the hospital to facilitate safe discharge into the community. The deinstitutionalization of psychiatric patients involving caregivers in discharge plans prevents patients from staying longer than necessary in the hospital and, as such, reduces the cost of healthcare. Patients with acceptable discharge plans are compliant with milieu safety requirements. Three level II, good quality quasi-experimental studies indicated the effectiveness of Safewards intervention by evaluating ten interrelated interventions in inpatient psychiatric units, such as verbal de-escalation when anxious and adequate preparation for discharge planning challenges due to family issues. Safewards intervention effectively managed aggressive behavior and reduced the rate of seclusion and restraints (Baumgardt et al., 2019; Dickens et al., 2020;

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Fletcher et al., 2017). Domains of the Safewards model also facilitate therapeutic relationships with the patients, staff, and family members or caregivers as they collaborate to improve the patient's functionality. Finally, a systemic review of twenty-one articles validated the effective use of non-coercive aggressive behavior management, including Safewards (Fernández-Costa et al., 2020). Non-coercive interventions enable treatment adherence. As patients are treated respectfully, they become more receptive to care modalities such as psychotherapy and medication management. As such, they have less aggressive behaviors, and the use of seclusion and restraints decreases. See Appendix A and B.

### **Framework Rationale**

The framework used to implement this project is the Framework for Complex Innovation (Helfrich et al., 2007). The Framework for Complex Innovation was appropriate for this quality improvement project because it focused on the management support and organizational culture that led to the implementation of evidence-based practice. The staff of the behavioral health unit were willing and ready for change. This quality improvement project is an innovative change, and the staff values were consistent with the new behavior, which resulted in an accommodating implementation climate. Also, the project had organizational support, which contributed to a conducive implementation climate. The stakeholders of the behavioral health unit perceived safety as the priority of the unit; therefore, they support the quality improvement project to reduce the rate of seclusion and restraints on the unit and promote the safety of the patients and staff. See the framework for implementation in Figure 2.

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### Methods

#### Context

Initially, the BHU had a low tolerance for aggressive behavior, and that increased the rate of restraints and seclusion. There are different restraints known as manual, chemical, and mechanical restraints. Restraints and seclusion should be the last resort in managing aggressive behavior. The milieu is staffed with security officers. Whenever a patient is in dyscontrol, the officers intercede by walking the patient out of the milieu into the quiet room, which will become locked (seclusion) when the patient becomes more aggressive. Staff briefly manually restrained most patients before putting them in seclusion or mechanical restraints. Contact with an aggressive patient creates a safety issue because the patient or staff restraining them may be injured. Seclusion and restraints in the behavioral health unit are reinforcers for increased incidence as the patients become upset after the intervention ends and must be restrained again as the agitation continues. As indicated in the root cause fishbone diagram, patients on involuntary admission are restrained and secluded more frequently than those admitted voluntarily.

#### Intervention

There were three interventions implemented during this project: 1) obtaining a mutual safety agreement during the admission process, 2) collaborating with the treatment team to schedule family meetings for acceptable discharge planning, and 3) maintaining a safe physical environment by offering agitated patients a quiet or sensory room for de-escalation. During the first week of the implementation, the project lead held daily in-services at the change of shift to review and educate staff about the critical components of Safewards model. The content of the in-service materials included techniques for initiating therapeutic communication and setting mutual expectations on admission, meetings with family members to facilitate care

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coordination involving discharge plans, and knowing how to mitigate potentially distressing information, such as placement issues. The nurses learned how to use verbal de-escalation to manage aggression, provide room for de-escalation, and monitor the effectiveness of the intervention. In alignment with the Safewards model, patients' admission and discharge process was revised. During the admission process, patients were provided rights of admission and adequate information about restraints and seclusion. Also, patients were given information about their responsibilities during their admission process. See the revised process map in Figure 3. The importance of documenting interventions used in de-escalating aggressive behaviors was reiterated during the education process. The project lead monitored the implementation of the three interventions weekly by chart audit and obtaining feedback from the staff members. See Appendix C.

### **Measurement**

This project has one structure measure, three process measures, and one outcome measure. All measures are shown in Table 1. The structure measured is the percentage of staff trained for aggressive behavior management before implementing the quality improvement project. Process measure one is the percentage of patients admitted to the behavioral health unit who signed a mutual safety agreement upon admission. Process measure two is the percentage of patients admitted to the behavioral health unit that had family meetings for acceptable discharge plans before discharge. Process measure three is the percentage of patients that used the sensory and quiet rooms when agitated. The outcome measure is the percentage of patients who were restrained and secluded. Data from signed mutual safety agreements, family meetings for acceptable discharge plans, and patients who used the sensory and quiet rooms when agitated were collected weekly for the newly admitted BHU patients.

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### **Ethical considerations**

This DNP project is for quality improvement and does not involve human subject research. The project proposal was submitted to the institutional review board and received a non-human research determination before the project's implementation. The project has no conflict of interest as the project lead is not a staff member at the project site. To maintain privacy, the project lead collected only the minimal data required to monitor the implementation of the intervention. Medical record numbers were required to prevent auditing a patient twice. All audits were conducted on the unit in a private area, and all data collected was stored on the institution's password-protected REDCap platform.

### **Results**

The structure measure, staff training education about the Safewards Model and the intervention, was completed by 100% of staff before implementing the project. After fifteen weeks of implementation, 190 patients were admitted. One hundred thirty-seven (72 %) patients signed mutual safety agreements, 190 (100%) family discharge planning meetings took place, and 57 (30 %) patients used the sensory and quiet room. Fifty-seven (30 %) patients required seclusion and restraints during this time.

### **Analysis**

The structure change helped the behavioral health unit staff demonstrate their understanding of evidence-based behavioral management. Safeward domains were implemented as planned after attaining the structure goal. Three processes were implemented simultaneously. In week three, process one, obtaining a mutual agreement, required staff re-education to offer the mutual safety agreement to patients again if they refused initially. The mutual safety agreement run chart shows a trend from week six to eleven. The mutual safety agreement run chart trend



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indicated process change after staff reeducation. See Figure 4. Process two attained 100% implementation because the social workers were dedicated to the goal of an acceptable discharge plan. They reported constant attempts to connect with the family members to initiate a discharge plan. See Figure 5. Data for process three, using sensory and quiet rooms, was incomplete. Staff did not routinely document the use of the sensory and quiet room and reported that it was difficult to track the number of times patients used it to de-escalate.

The seclusion and restraint run chart is the outcome run chart of this quality improvement project, and it shows that seclusion and restraints were reduced more closely aligned with the national benchmark, which reflects over 50% reduction in eleven out of fifteen weeks of the intervention. In weeks three, ten, and thirteen, there were exceptional cases of patients who were seriously agitated and needed seclusion multiple times per day to maintain the safety of the milieu. See Figure 6.

### **Discussion**

The quality improvement project is cost-neutral as there is no cost to implementing the project. Also, it is beneficial for maintaining the safety of the patients and staff in the behavioral health unit. The result of the quality improvement project is consistent with the literature stating that implementing the Safewards model reduces the rate of seclusion and restraints in inpatient psychiatric units. According to the literature, implementing some of the Safewards model domains had the same effect as implementing all the domains. Three domains out of six were implemented at this time. It was noted that the implementation of the Safewards model for aggressive behavior management in an adult inpatient psychiatric unit may have contributed to the decrease in the rate of seclusion and restraint in the unit.

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There were no records of any patient discharged to a shelter at this time due to the diligent effort of the social workers to meet with the family members or caregivers to determine an acceptable discharge plan for the patients. The nursing staff also reported no aggressive behavior triggered by an unsatisfied discharge plan. Processes one and three did not meet the hundred percent goal but still had some positive impact on the outcome. At the end of the project, outcome data demonstrated that the seclusion and restraint rate was 30% post-implementation, meeting the original goal of a 50% reduction.

The barriers to implementing the quality improvement project were the incomplete documentation of one of the processes (the use of sensory and quiet rooms) and staff turnover. Staff could not document the number of times patients were offered sensory and quiet rooms, which led to the de-escalation of aggressive behavior. However, they were able to track the number of times it was unsuccessfully used in de-escalating aggressive patients. Staff turnover in the unit will be a significant constraint on the sustainability of the quality improvement project. Hence, the interventions associated with this quality improvement project should become standard of practice and be added as a required training module or package for new staff at the BHU.

### **Conclusion**

In conclusion, this quality improvement project demonstrates that implementing strategies that target domains of the Safewords model is feasible and may be associated with a decreased incidence of seclusion and restraint in the behavioral health unit. This evidence-based quality improvement project may facilitate safety and care optimization in the behavioral health unit of a hospital. Ongoing training of new staff will be needed to facilitate sustainability. The project's strength is that it provides an opportunity for staff working on the BHU to obtain

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evidence-based skills required for managing aggressive patients in the behavioral health units of the hospital. It is unknown if Safewards domains can be implemented in different settings to manage patients' aggressive behaviors. Additional research and more literature reviews are required to determine if the use of evidence-based interventions such as Safewards domains and their strategies are successful for managing aggressive behaviors in the community and other ambulatory care settings such as day hospitals.

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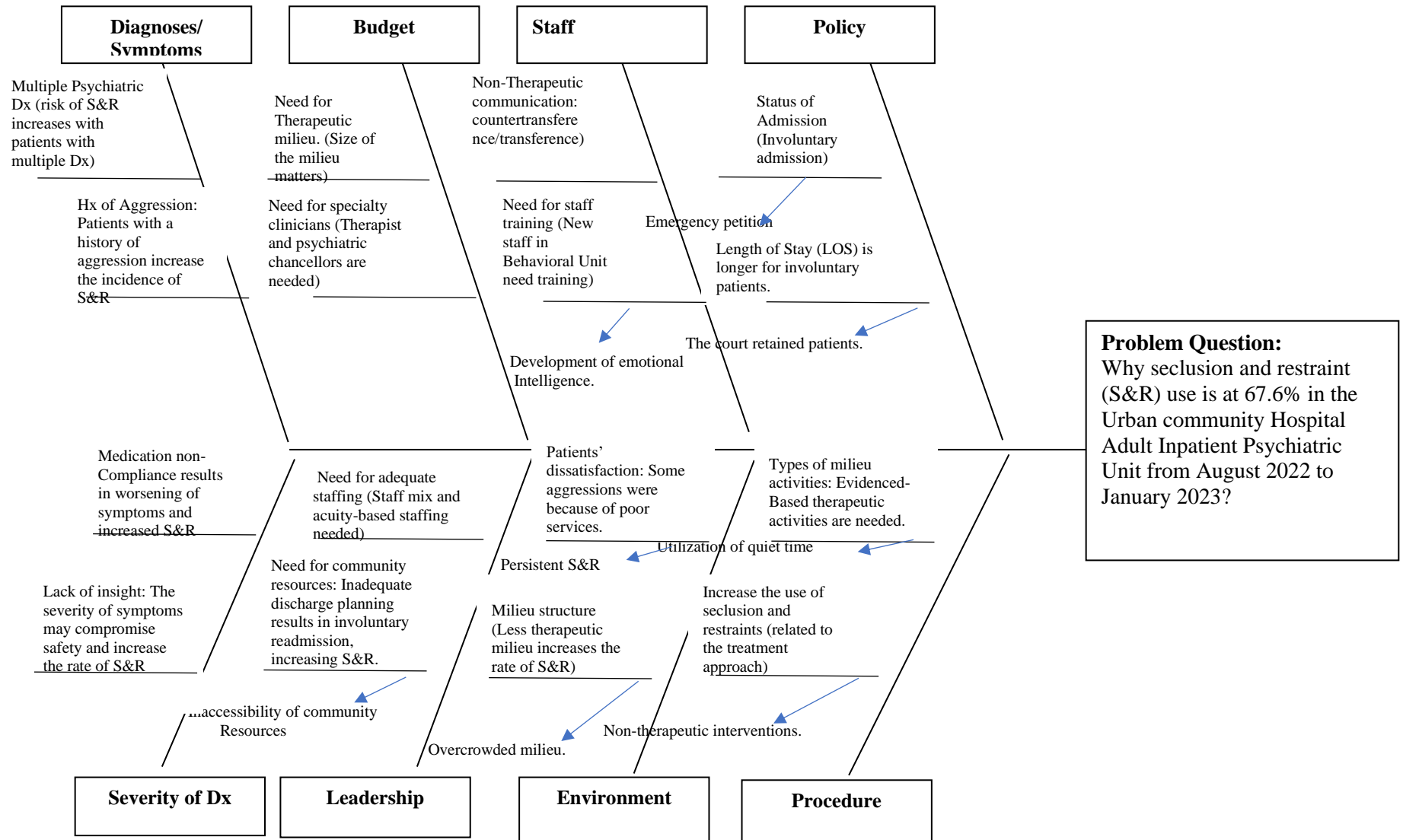
## IMPLEMENTATION OF AGGRESSIVE BEHAVIOR MANAGEMENT INTERVENTION IN ADULT PSYCHIATRIC

**Table 1 Measures**

Project Goals	Measure Pre-Implementation	Measure During and Post-Implementation
Structure Measure	Numerator /Denominator x100	Numerator /Denominator x100
<ul style="list-style-type: none"> <li>100% of BHU staff trained for aggressive behavior management</li> </ul>	Numerator: The number of trained BHU staff Denominator: The number of BHU staff	N/A
Process Measures	N/A	
<ul style="list-style-type: none"> <li>Process measure one – 100% of patients admitted to BHU will sign a mutual safety agreement upon admission.</li> <li>Process measure two – 100% of patients admitted to BHU will have an acceptable discharge plan before discharge.</li> <li>Process measure three – 100% of patients needing sensory and quiet rooms will have accessibility.</li> </ul>	N/A	<b>Numerator:</b> # of patients that signed mutual safety agreement. <b>Denominator:</b> # of patients admitted on BHU  <b>Numerator:</b> # of patients with an acceptable discharge plan <b>Denominator:</b> # of patients admitted on BHU  <b>Numerator:</b> # of patients that used quiet and sensory rooms <b>Denominator:</b> # of patients admitted on BHU
Outcome Measure <ul style="list-style-type: none"> <li>The rate of seclusion and restraints</li> </ul>	<b>Numerator:</b> # of seclusion and restraint <b>Denominator:</b> # of patients admitted on BHU	<b>Numerator:</b> # of seclusion and restraint <b>Denominator:</b> # of patients admitted on BHU

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**Figure 1**  
**Fishbone diagram**

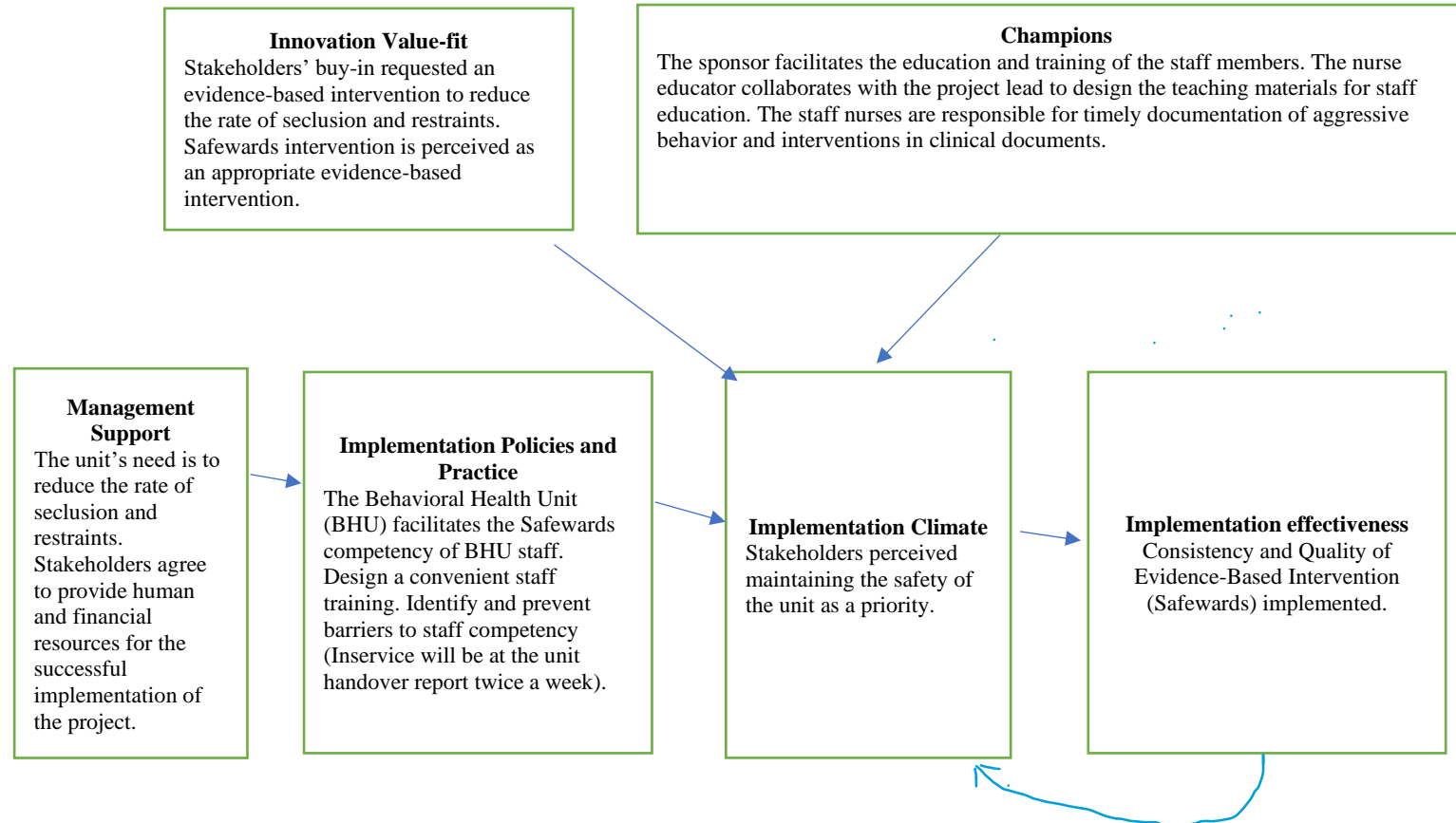




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**Figure 2**

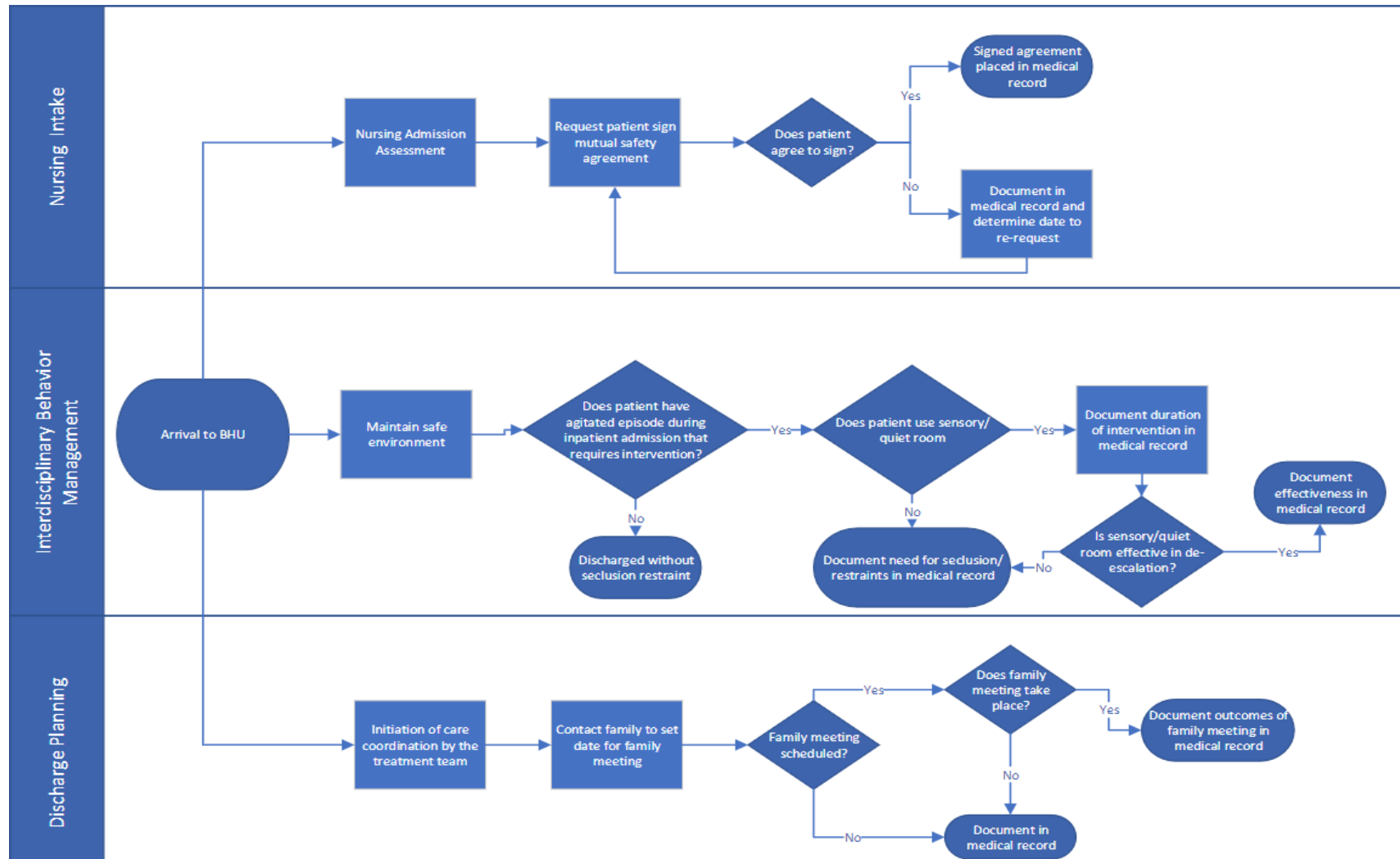
### Conceptual Framework of Complex Innovation Implementation on Behavioral Health Unit



Source : adapted from Helfrich et al. (2007)

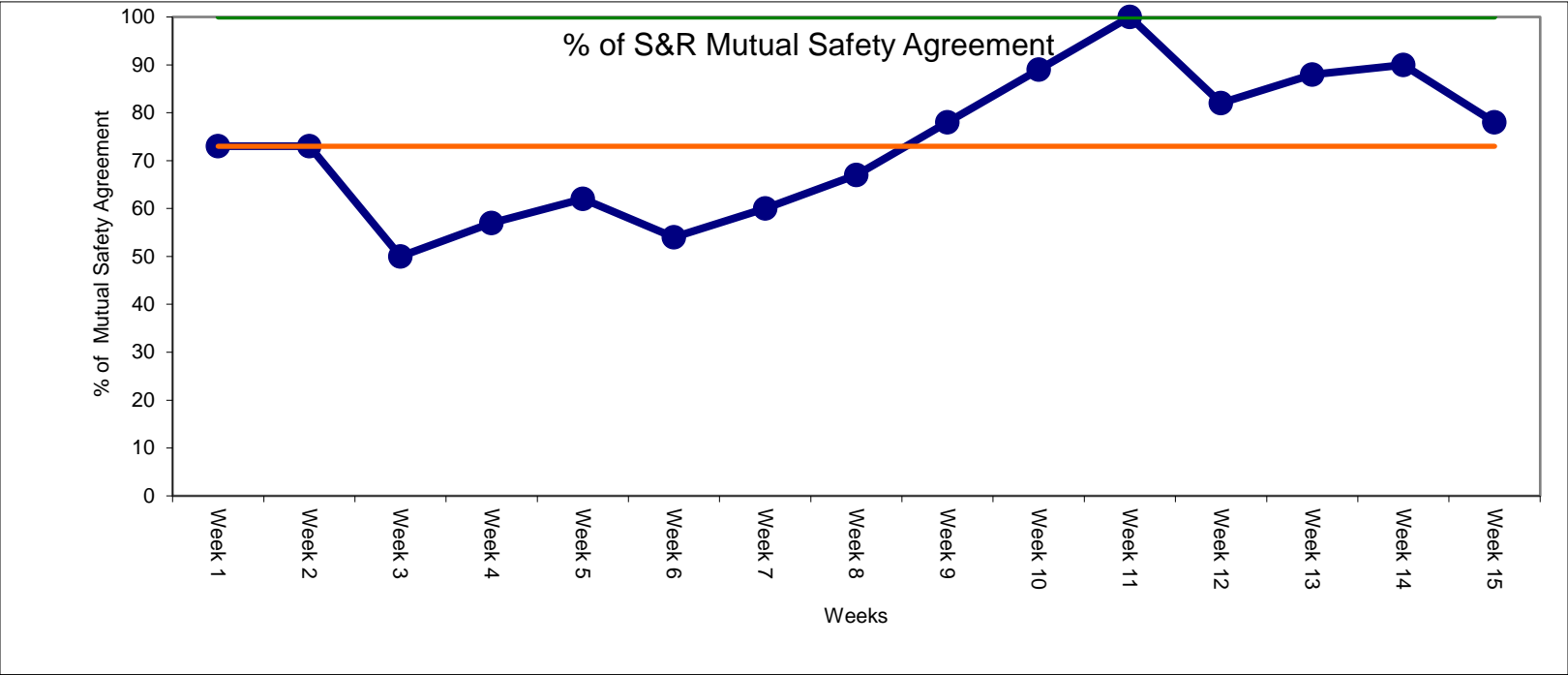
IMPLEMENTATION OF AGGRESSIVE BEHAVIOR MANAGEMENT INTERVENTION

**Figure 3**  
**Revised Process Map**



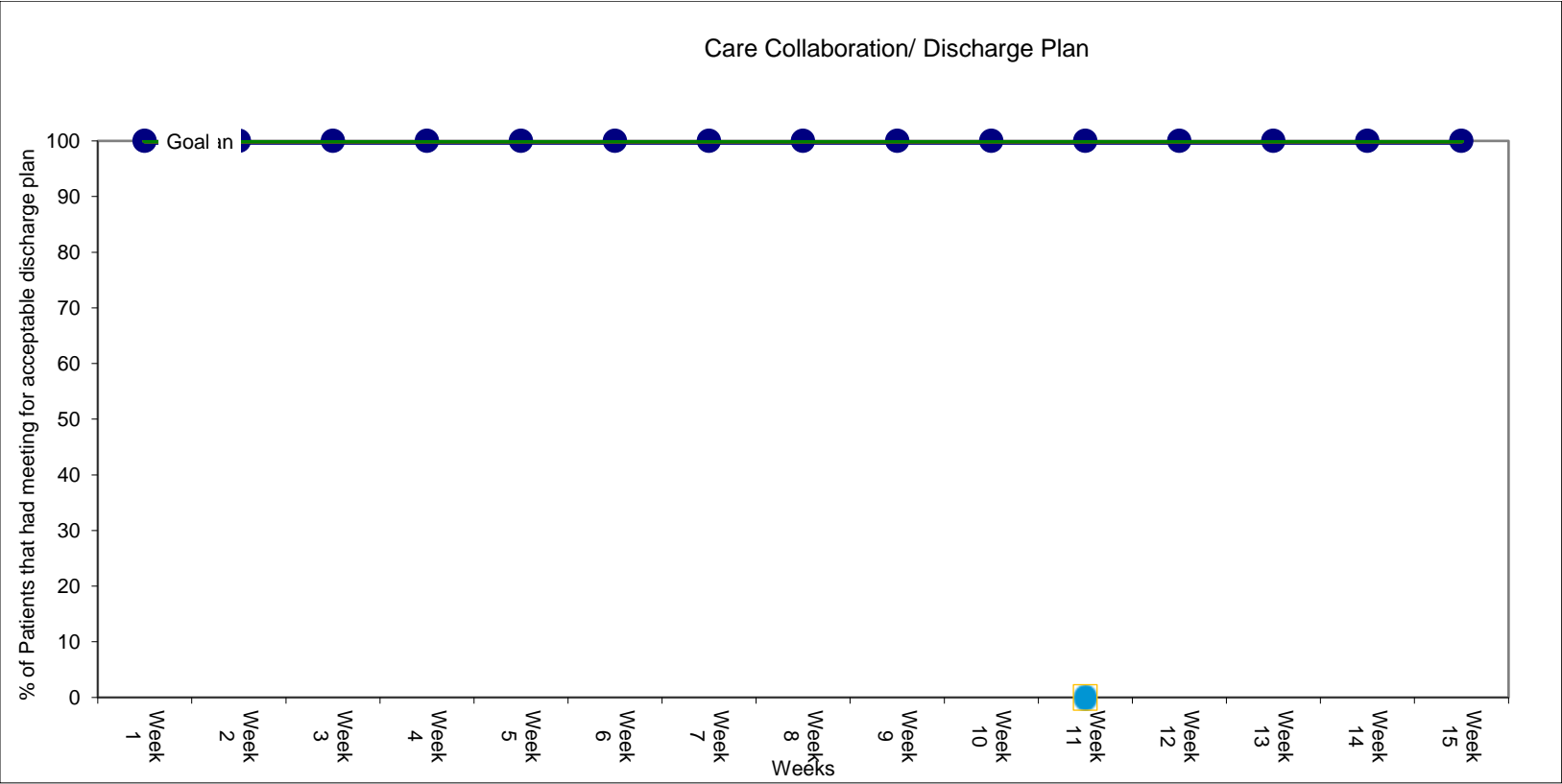
IMPLEMENTATION OF AGGRESSIVE BEHAVIOR MANAGEMENT INTERVENTION

Figure 4



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Figure 5



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Figure 6



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## Appendix A

## Evidence Review Table

<p><b>Citation:</b> Baumgardt, J., Jäckel, D., Helber-Böhlen, H., Stiehm, N., Morgenstern, K., Voigt, A., Schöppe, E., Mc Cutcheon, A. K., Lecca, E. E. V., Löhr, M., Schulz, M., Bechdorf, A., &amp; Weinmann, S. (2019). Preventing and Reducing Coercive Measures-An Evaluation of the Implementation of the Safewards Model in Two Locked Wards in Germany. <i>Frontiers in psychiatry</i>, 10, 340. <a href="https://doi.org/10.3389/fpsy.2019.00340">https://doi.org/10.3389/fpsy.2019.00340</a></p>	
<p><b>Purpose or Hypothesis (Alternative Hypothesis)</b></p>	<p>The research aims to evaluate the Safewards model's effect in reducing coercive intervention in inpatient psychiatric units.</p>
<p><b>Design</b></p>	<p>Quasi-experimental study (Quantitative design with no randomized control).</p>
<p><b>Sample</b></p>	<p><b>Sampling Technique:</b> nonrandomized sample  <b>Sample size:</b> 103 patients  <b>Group Homogeneity:</b> Patients with psychiatric conditions.</p>
<p><b>Intervention</b></p>	<p>Ten interrelated interventions of Safewards were implemented for ten weeks in two inpatient psychiatric units, such as talking patients down when anxious and preparing them for the bad news.</p>
<p><b>Outcomes</b></p>	<p>Decrease in the rate of seclusion and restraints interventions (p-value &lt;0.001 and &lt; 0.01) in both units post-intervention.</p>
<p><b>Results</b></p>	<p><b>Statistical Results:</b>  <b>Conclusions:</b> There is a decrease in coercive interventions post-implementation of the Safewards intervention.</p>
<p><b>Level/Rational</b></p>	<p>Level II and good quality, according to the JHNEBP hierarchy. A quasi-experimental study with no randomized control</p>

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<p><b>Citation:</b> Chien, W. T., Bressington, D., &amp; Chan, S. W. C. (2018). A Randomized Controlled Trial on Mutual Support Group Intervention for Families of People with Recent-Onset Psychosis: A Four-Year Follow-Up. <i>Frontiers in Psychiatry</i>, 9, 710. <a href="https://doi-org.proxy-hs.researchport.umd.edu/10.3389/fpsy.2018.00710">https://doi-org.proxy-hs.researchport.umd.edu/10.3389/fpsy.2018.00710</a></p>	
<p><b>Purpose or Hypothesis (Alternative Hypothesis)</b></p>	<p>"A family-led mutual support group (FMSG) participants could significantly improve caregivers' family functioning and patients' rehospitalization rates (i.e., primary outcomes), reduce the family burden and patients' psychotic symptoms (aggressive behavior) and functioning, as well as improve their utilization of mental health services when compared with those in family psychoeducation group or TAU only." Treatment as usual (TAU).</p>
<p><b>Design</b></p>	<p>Single-blind, Parallel groups, Randomized Controlled Trial</p>
<p><b>Sample</b></p>	<p><b>Sampling Technique:</b> Computerized randomly selected. <b>Eligible</b></p> <p><b>Participants:</b> Adults outpatient with recent onset of psychosis &lt;= five years, and caregivers were mainly family members.</p> <p><b>Excluded:</b> Caregivers with a history of mental illness, primary caregiver for &lt; 3 months, with co-morbid cognitive disorders, learning disability, or personality disorders, illiterate patients, and participating or scheduled to participate in the psychological program within the last six months.</p> <p><b>Accepted:</b> 210 patients were randomly selected and divided into three groups</p> <p><b>Control:</b> 70 patients in Treatment as Usual Group (TAU)</p> <p><b>Intervention:</b> FMSG started with 70 patients; 11/70 were lost in the follow-up period. The Psychoeducation group had 70 patients 10/70 were lost in the follow-up period. TAU had 70 patients; 10/70 were lost in the follow-up period.</p> <p><b>Power analysis/Achieved:</b> Study power of 0.8, P&lt; 0.05 was set for the calculation, and the moderate effect size was achieved—<b>P-value</b> 0.005.</p> <p><b>Group Homogeneity:</b> Yes, the groups are similar at the baseline on diagnosis, and family intervention is at the baseline.</p>
<p><b>Intervention</b></p>	<p><b>Control Protocol:</b> allocation of treatment as usual in the TAU group. Medication administration and routine follow-ups</p> <p><b>Intervention Protocol:</b> Provision of psychoeducation to the patients in the Psychoeducation Group. Provision of psychoeducation, stress management, problem-solving skills, and cognitive appraisal to the patients and family members in the FMSG group.</p>

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	<b>Treatment Fidelity:</b> Patients' baseline and post-test measurements were conducted by psychiatrists blinded to the groups, using the same standard instrument of measurements. For instance, the Positive and Negative Syndrome Scale (PANSS) assessed patients' psychotic symptoms.
<b>Outcomes</b>	<b>Dependent Variable:</b> Patients' symptoms, perceived caregiving burden and service utilization are dependent variables. <b>DV Measure:</b> Patients' psychotic symptoms were assessed using the Positive and Negative Syndrome Scale (PANSS). Perceived caregiving burden was measured with Family Assessment Device (FAD), and service utilization was measured with Family Support Service Index (FSSI).
<b>Results</b>	<b>Statistical Results:</b> There is a significant difference in the groups. The P-value was 0.005. <b>Conclusions:</b> The FMSG group has reduced relapse and rehospitalization more than psychoeducation and treatment as usual groups.
<b>Level/Rational</b>	Level 1 and high quality, according to the JHNEBP hierarchy. Experimental study, randomized control trial, with three groups with randomization of subjects.

<b>Citation:</b> Chien, W. T., Thompson, D. R., Lubman, D. I., & McCann, T. V. (2016). A randomized controlled trial of clinician-supported problem-solving bibliotherapy (de-escalation techniques) for family caregivers of people with first-episode psychosis. <i>Schizophrenia Bulletin</i> , 42(6), 1457–1466. <a href="https://doi-org.proxy-hs.researchport.umd.edu/10.1093/schbul/sbw054">https://doi-org.proxy-hs.researchport.umd.edu/10.1093/schbul/sbw054</a>	
<b>Purpose or Hypothesis (alternative Hypothesis)</b>	"The CSPSB group, compared to usual outpatient-and-family support (US), would demonstrate a greater reduction in burden and improved caregiving experience at 1-week and 6- and 12-month follow-up. Secondary hypotheses were that compared with the US group. The CSPSB group would have significantly greater improvements in caregivers' social problem-solving skills and patients' psychotic symptoms, functioning, and rehospitalization rates (number and duration) over the 12-month follow-up."
<b>Design</b>	Randomized control trial
<b>Sample</b>	<b>Sampling Technique:</b> computerized randomly selected technique. <b>Eligible Participants:</b> The caregiver should be 18 years old, educated, and a first-time caregiver with patients diagnosed with mental illness who live and provide care to the patients. Patients must be experiencing the first episode of psychosis without other mental illnesses, and this intervention is the first contact with mental health services.



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	<p><b>Excluded:</b> Hospitalization before randomization and receiving another family intervention.</p> <p><b>Accepted:</b> 116 patients were randomly selected.</p> <p><b>Control:</b> 58 patients were randomly selected in the control group; 2/58 were lost in the follow-up period</p> <p><b>Intervention:</b> 58 patients in the intervention group; 4/58 were lost in the follow-up period</p> <p><b>Power analysis/Achieved:</b> significance level was set at 0.05 and achieved at a P-value of 0.006.</p> <p><b>Group Homogeneity:</b> The groups are the same based on the diagnosis.</p>
<b>Intervention</b>	<p><b>Control Protocol:</b> Routine psychiatric and family support outpatient care was delivered to the UOFS group.</p> <p><b>Intervention Protocol:</b> CSPSB group completed five modules of the self-help problem-solving manual.</p> <p><b>Treatment Fidelity:</b> Trained research assistants conducted the collection of data and information.</p>
<b>Outcomes</b>	<p><b>Dependent Variable:</b> Burden and experience of caring, and Experience of Caregiving Inventory (ECI),</p> <p><b>DV Measure:</b> Burden and experience of caring, assessed by the Family Burden Interview Schedule (FBIS). Experience of Caregiving Inventory (ECI),</p>
<b>Results</b>	<p><b>Statistical Results:</b> Using one way ANOVA test, there is a statistical difference between the two groups. (P-value 0.006).</p> <p><b>Conclusions:</b> There is a significant improvement in burden and improved caregiving experience in the CSPSB group compared to the UOFS group. Also, the CSPSB group has a more decrease in relapse rate than other groups.</p>
<b>Level/Rational</b>	Level one and high quality, according to the JHNEBP hierarchy. Experimental study, randomized control trial, with two groups with randomization of subjects.

Dickens, G. L., Tabvuma, T., Frost, S. A., & SWSLHD Safewards Steering Group (2020). Safewards: Changes in conflict, containment, and violence prevention climate during implementation. *International journal of mental health nursing*, 29(6), 1230–1240. <https://doi.org/10.1111/inm.12762>

<b>Purpose or Hypothesis</b>	The “aims of the study were to measure, for the first time in Australia, changes in shift-level reports of conflict
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## IMPLEMENTATION OF AGGRESSIVE BEHAVIOR MANAGEMENT INTERVENTION

<b>(Alternative Hypothesis)</b>	and containment associated with Safewards introduction, and to measure any association with change in the violence prevention climate (milieu) using a tool validated for use in the current study setting.”
<b>Design</b>	Quasi-experimental study (Quantitative design with no randomized control).
<b>Sample</b>	<p><b>Sampling Technique:</b> Nonrandomized sample</p> <p><b>Sample size:</b> 143 patients participated in 16 weeks of implementation of Safewards intervention occurred in eight out of 11 inpatient psychiatric units.</p> <p><b>Group Homogeneity:</b> Psychiatric patients with aggressive behavior</p>
<b>Intervention</b>	<p>Safewards strategies were implemented over 24 weeks (4-week preparation, 16-week implementation, and 4-week outcome phases).</p> <p><b>Treatment Fidelity:</b> Conflict and containment were measured using the Patient–Staff Conflict Checklist Shift Report and violence prevention climate using the VPC-14.</p>
<b>Outcomes</b>	From a 63.2% response rate, the mean (SD) reported conflict and containment incidents per shift decreased from 3.96 (6.25) and 6.81 (5.78) to 2.94 (4.22) and 5.82 (4.62), respectively. Controlling for other variables, seclusion was reduced by 12%, and conflict events such as verbal aggression were reduced by 23%
<b>Results</b>	<b>Conclusions:</b> The intervention improves the safety of the units. It was recommended to be widely used while providing mental health services in acute settings such as hospital psychiatric units.
<b>Level/Rational</b>	Level II is good quality, according to the JHNEBP hierarchy. A quasi-experimental study with no randomized control

Fernández-Costa, D., Gómez-Salgado, J., Fagundo-Rivera, J., Martín-Pereira, J., Prieto- Callejero, B., & García-Iglesias, J. J. (2020). Alternatives to the Use of Mechanical Restraints in the Management of Agitation or Aggressions of Psychiatric Patients: A Scoping Review. *Journal of clinical medicine*, 9(9), 2791. <https://doi.org/10.3390/jcm9092791>

## IMPLEMENTATION OF AGGRESSIVE BEHAVIOR MANAGEMENT INTERVENTION

<b>Purpose or Hypothesis (Alternative Hypothesis)</b>	The use of non-restrictive intervention for managing aggressive behavior of psychiatric patients.
<b>Design</b>	Systemic review
<b>Sample</b>	<p><b>Sampling Technique:</b> 105 studies were selected, with 61 remaining after removing duplication. Application of exclusive criteria such as dementia, no research methodologies, and studies not focused on seclusion and restraints decreased the sample studies to 21. 3 RCT, six quasi-experimental studies, nine systemic reviews, and three observational studies</p> <p><b>Excluded:</b> heterogenous, dementia  <b>Accepted:</b> 21 studies  <b>Intervention:</b> Aggressive interventions such as Safewards, DASA,  <b>Group Homogeneity:</b> present in the studies population with psychiatric conditions</p>
<b>Intervention</b>	Evidence-based aggressive behavior management. The review included the evaluation of Safewards Implementation and other evidenced-based interventions for aggressive behavior management in acute settings. The research followed the PRISMA guideline (Preferred Reporting Items for Systemic Reviews and Meta-Analysis)
<b>Outcomes</b>	Decrease aggressive behavior and rate of restraints and seclusions in inpatient psychiatric units.
<b>Results</b>	<b>Conclusions:</b> High degrees of evidence validate the effectiveness of non-restrictive intervention in managing aggressive behavior in inpatient psychiatric units.
<b>Level/Rational</b>	Level: III Systemic reviews of a combination of RTC, Quasi experiment, and non-experimental studies

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Fletcher, J., Spittal, M., Brophy, L., Tibble, H., Kinner, S., Elsom, S., & Hamilton, B. (2017). Outcomes of the Victorian Safewards trial in 13 wards: Impact on seclusion rates and fidelity measurement. <i>International journal of mental health nursing</i> , 26(5), 461–471. <a href="https://doi.org/10.1111/inm.12380">https://doi.org/10.1111/inm.12380</a>	
<b>Purpose or Hypothesis (Alternative Hypothesis)</b>	The study assesses the impact of Safewards intervention on the seclusion rate in inpatient psychiatric units and Fidelity measurement.
<b>Design</b>	Quasi-experimental study (Quantitative design with no randomized control). The study used a before-and-after design, with a comparison group matched for service type.
<b>Sample</b>	<p><b>Sampling Technique:</b> Nonrandomized</p> <p>Experimental group: 13 psychiatric inpatient units.</p> <p>Control group: 31 psychiatric inpatient units</p> <p><b>Group Homogeneity:</b> Patients with a psychiatric condition, inpatients</p>
<b>Intervention</b>	<p>The units implementing Safewards were provided three train-the-trainer sessions to representative nurse educators by the Victorian Department of Health and Human Services, who then rolled out local training, reaching an estimated 75% of nurses employed on the wards.</p> <p>Data: Data were analyzed in three pre-, post, and one-year follow-up phases.</p> <p><b>Treatment Fidelity:</b> The goal rate of fidelity to the intervention was set before the start of the trial to be at least 70%; by the end of the trial, it was at 75%.</p>
<b>Outcomes</b>	Seclusion rates were reduced by 36% in Safewards trial wards by the 12-month follow-up period. There was a reduction in the seclusion rate after 12 months post-intervention of the 13 participating units. Fidelity analysis revealed a trajectory of increased use of Safewards interventions after the trial phase to follow-up.

## IMPLEMENTATION OF AGGRESSIVE BEHAVIOR MANAGEMENT INTERVENTION

<b>Results</b>	<b>Conclusions:</b> The findings implied that Safewards is appropriate for practice change in Victorian inpatient mental health services and effectively reduces the use of seclusion.
<b>Level/Rational</b>	Level: II and high quality, according to the JHNEBP hierarchy. A quasi-experimental study with no randomized control.

<b>Citation:</b> Li, X., Yuan, X., Kang, Y., Pang, L., Liu, Y., Zhu, Q., Lv, L., Huang, X. F., & Song, X. (2020). A synergistic effect between family intervention and rTMS improves cognitive and negative symptoms in schizophrenia: A randomized controlled trial. <i>Journal of psychiatric research</i> , 126, 81–91. <a href="https://doi-org.proxy-hs.researchport.umd.edu/10.1016/j.jpsychires.2020.04.009">https://doi-org.proxy-hs.researchport.umd.edu/10.1016/j.jpsychires.2020.04.009</a>	
<b>Purpose or Hypothesis</b>	The study explored an efficient new therapy that combined repetitive transcranial magnetic stimulation (rTMS), family intervention, and risperidone to improve schizophrenia symptoms (i.e., aggressive behavior).
<b>Design</b>	Randomized control trial
<b>Sample</b>	<p><b>Sampling Technique:</b> randomly selected technique using a random number generator.    <b>Eligible Participants:</b> Patients diagnosed with schizophrenia with PANSS total score &gt; 70 points that have never been administered antipsychotics were selected.</p> <p><b>Excluded:</b> pregnant or lactating women, patients treated with electroconvulsive therapy (ECT) or modified ECT (MECT) in the previous month), patients with local or diffuse encephalopathy (stroke, meningitis, tumor, or epilepsy), family history of epilepsy or a history of alcohol or other substance abuse or dependence, and autoimmune disease, heart disease hepatobiliary and gastrointestinal disease were excluded.</p> <p><b>Accepted:</b> 200 patients</p> <p><b>Control:</b> 50 healthy patients.</p> <p><b>Intervention:</b> 50 assigned to risperidone, 3/50 lost during the follow-up period. Fifty were assigned to risperidone and 10Hz rTMS, and 3/50 were lost in the follow-up period. Fifty were assigned to risperidone and family intervention, and 3/50 were lost in the follow-up period. Fifty were assigned to risperidone, 10Hz rTMS, and family intervention (combined group) 3/50 lost in the follow-up period.</p> <p><b>Power analysis/Achieved:</b> A P value of less than 0.05 (two-tailed) was considered significant. The P-value is 0.001.</p> <p><b>Group Homogeneity:</b> The groups met the inclusion criteria and were randomly selected from the same population.</p>

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<b>Intervention</b>	<p><b>Control Protocol:</b> 50 people in the healthy control group. No intervention was provided to the control group.</p> <p><b>Intervention Protocol:</b> All patients in intervention groups were treated with risperidone, then additional treatment with ECT and family intervention was included.</p> <p><b>Treatment Fidelity:</b> Patients in intervention groups had the exact attributes at baseline, were divided randomly into four groups, and were all treated with the same antipsychotic (risperidone).</p>
<b>Outcomes</b>	<p><b>Dependent Variable:</b> Negative and Positive symptoms of schizophrenia,</p> <p><b>DV Measure:</b> Patients' psychotic symptoms were assessed using the Positive and Negative Syndrome Scale (PANSS).</p>
<b>Results</b>	<p><b>Statistical Results:</b> Post Hoc comparison of the groups indicated a significant difference in groups, and the combined group had more significance than the other groups. <b>The P-value is 0.001.</b></p> <p><b>Conclusions:</b> There is a more remarkable improvement in Negative and Positive symptoms of schizophrenia in the combined therapy group after 12 weeks compared to other groups. There is a significant decrease in relapse rate in the combined therapy group compared to other groups.</p>
<b>Level/Rational</b>	Level one and high quality, according to the JHNEBP hierarchy. Experimental study, randomized control trial, with four groups and randomization of subjects.

<p><b>Citation:</b> Rami, H., Hussien, H., Rabie, M., Sabry, W., Missiry, M. E., &amp; Ghamry, R. E. (2018). Evaluating the effectiveness of a culturally adapted behavioral family psycho-educational program for Egyptian patients with schizophrenia. <i>Transcultural psychiatry</i>, 55(5), 601–622.</p> <p><a href="https://doi-org.proxy-hs.researchport.umd.edu/10.1177/1363461518782520">https://doi-org.proxy-hs.researchport.umd.edu/10.1177/1363461518782520</a></p>	
<b>Purpose or Hypothesis</b>	The study aims to evaluate the effectiveness of culturally adapted behavioral family psychoeducation programs in minimizing psychotic symptoms (i.e., aggressive behavior), improving social function, adherence to medications, and the quality of life of patients diagnosed with schizophrenia.
<b>Design</b>	Randomized control trial
<b>Sample</b>	<p><b>Sampling Technique:</b> random sampling</p> <p><b>Eligible Participants:</b> Patients aged 18 to 65 years with at least one previous schizophrenia episode; and one available caregiver willing to be enrolled in the study. Caregiver Living with the patient and as a direct caregiver of the patient.</p> <p><b>Excluded:</b> Non-educated patient, co-morbid psychiatric disorders or substance abuse; living alone; neurological</p>

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	<p>disorder and caregiver with a psychiatric disorder.</p> <p><b>Accepted:</b> 60 patients accepted.</p> <p><b>Control:</b> 30 patients in the control group 6/30 were lost in the follow-up period</p> <p><b>Intervention:</b> 30 patients in the intervention group 4/30 were lost in the follow-up period.</p> <p><b>Power analysis/Achieved:</b> A significant level was set at <math>P &lt; 0.05</math> and was achieved at <math>P\text{-value} = 0.001</math></p> <p><b>Group Homogeneity:</b> The experimental and control group have the same diagnosis and meet the inclusion criteria. Also are of the same social demographic.</p>
<b>Intervention</b>	<p><b>Control Protocol:</b> Standard treatment was given to the control group, which included monthly consultation, advice, and two brief education sessions.</p> <p><b>Intervention Protocol:</b> Behavioral family psycho-educational program (BFPEP) given to the experimental group: Includes psychoeducation, communication enhancement training, and problem-solving skills training.</p> <p><b>Treatment Fidelity:</b> To conform to Egyptian cultural norms, the Arabic-translated and validated version of the Structured Clinical Interview for DSM - IV was implemented in diagnosing the patients.</p>
<b>Outcomes</b>	<p><b>Dependent Variable:</b> Functioning level, quality of life, and attitude towards medications.</p> <p><b>DV Measure:</b> The Social Functioning Questionnaire (SFQ) was used to assess individuals' levels of adaptive functioning. The quality-of-Life scale (QLS) was used to measure the quality of life, and Drug Attitude Inventory (DAI) was used to measure the attitude of individuals towards psychotropics.</p>
<b>Results</b>	<p><b>Statistical Results:</b> The result is significant if <math>P</math> is less than 0.05. <math>P\text{-value} = 0.001</math> achieved.</p> <p><b>Conclusions:</b> There is an improvement in the social function, adherence to medications, and quality of life of the patients diagnosed with schizophrenia during the six months of the behavioral psychoeducation program with the experimental group (BFPEP) compared to the standard treatment as usual (STU). Also, there is a reduction in the rate of relapse and rehospitalization in (BFPEP).</p>
<b>Level/Rational</b>	Level one and high quality, according to the JHNEBP hierarchy. Experimental study, randomized control trial, with two groups with randomization of subjects

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## Appendix B

## Evidence Synthesis

Project Title: Implementation of Aggressive Behavior Management Intervention in Adult Psychiatric Inpatient Unit			
JHNEBP Model Level	Total Number of Sources	Author and Quality Rating of each study	Synthesis of Findings
<b>Level 1</b> Experimental study · Randomized Controlled Trial (RCT) · Systematic review of RCTs with or without meta-analysis	4 RCTs	Chien et al., 2016. Chien et al., 2018. Li et al., 2020. Rami et al., 2018. The quality of the studies is rated A (high quality because the studies are randomized).	Four studies and randomized control trials found that family involvement in the treatment of patients diagnosed with severe mental illnesses such as schizophrenia helps to minimize symptoms, such as aggression that increases seclusion and restraints and ligature risks. Note: Family involvement is one of the components of Safewards that shows evidence of reduced seclusion and restraints in inpatient psychiatric units. Family involvement also decreases relapse, decreases rehospitalization rate, and improves patients' functionality. It is recommended that family members be involved in managing the patients diagnosed with psychiatric conditions to minimize the relapse rate. Even though these studies were conducted outside the USA, they all used standard psychometric tools used in America to assess the participants. Psychometric tools such as Patients' psychotic symptoms were assessed using the Positive and Negative Syndrome Scale (PANSS). The quality rating



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			and recommendation based on evidence and synthesis were rated A. There is no difference between the articles. They are of the same level.
<p><b>Level II</b> Quasi-experimental studies · Systematic review of a combination of RCTs and quasi-experimental studies, or quasi-experimental studies only, with or without meta-analysis</p>	3 Quasi-experiments	<p>Baumgardt, et al., 2019. Dickens, et al., 2020. Fletcher et al., 2017.</p> <p>The quality of the studies is rated A. It includes only level II quantitative studies.</p>	<p>The three studies used nonrandomized assignment of groups and intervention. The participating groups reported significant differences in pre and post-implementation of Safewards. Ten interrelated interventions of Safewards were implemented in inpatient psychiatric units, such as talking patients down when anxious and preparing them for discharge difficult news. The unit that participated also experienced a therapeutic milieu post-intervention. Staff and patients developed a therapeutic relationship and mutual respect. There is no difference between the articles. All indicated the effectiveness of Safewards in aggressive behavior management. Safewards reduce the rate of seclusion and restraints and are effective for managing aggressive behavior.</p>
<p><b>Level III</b> Non-experimental study · Systematic review of a combination of RCTs, quasi-experimental, and non-experimental studies, or non-experimental studies only, with or without meta-analysis · Qualitative study or systematic review of qualitative studies with or without meta-synthesis</p>	1 Systemic review	<p>Fernández-Costa et al., 2020. The quality of the study is rated A; because there is transparency, and it has an insightful interpretation.</p>	<p>Noncohesive Aggressive behavior management is achievable in the inpatient psychiatric unit by implementing evidenced-based noncohesive management techniques and strategies such as those seen in Safewards. The systemic review contains twenty-one studies of 3 RCTs, six quasi-experimental studies, nine systemic reviews, and three observational studies. No difference in the articles; they all supported noncohesive management of aggressive behavior.</p>

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<p><b>Level IV</b> Opinion of respected authorities and reports of nationally recognized expert committees/consensus panels based on scientific evidence</p>			
<p><b>Level V</b> Evidence obtained from literature reviews, quality improvement, program evaluation, financial evaluation, or case reports · Opinion of nationally recognized expert(s) based on experiential evidence</p>			
<p>Overall quality Rating w/rational and Recommendation: Strong, compelling evidence, consistent results: solid indication for a practice change.</p>			
<p>Recommendations Based on Evidence Synthesis</p> <ul style="list-style-type: none"> <li>• Strong, compelling evidence, consistent results: solid indication for a practice change.</li> <li>• Good and consistent evidence–practice change</li> <li>• Good but conflicting evidence: questionable indication for practice change; consider the risk/benefit analysis.</li> <li>• Little or no evidence: no indication for practice change</li> </ul>			

Appendix C

**BHU Chart Audit**

MRN No

\_\_\_\_\_

Seclusion and Restraints Mutual agreement obtained ?

- Yes
- No

How many times did the patient used Seclusion and restraints during this admission ?

\_\_\_\_\_

How many times was the patient offered the sensory or quiet room on this admission?

\_\_\_\_\_

Treatment team collaboration with family completed ?

- Yes
- NO (Family related barrier)
- NO (Process/staff related barrier)