Position Statement 24: Seclusion and Restraints

Policy Position

Seclusion and restraints have no therapeutic value, contribute to human suffering, and have frequently resulted in severe emotional and physical harm, and death[1]. Therefore, as a matter of fundamental policy, Mental Health America (MHA) urges abolition of the use of seclusion and restraints to control symptoms of mental illnesses, and prohibition of the use of sedatives and other medications as chemical restraints.

The federal government, the National Association of State Mental Health Program Directors (NASMHPD) and the Commonwealth of Pennsylvania have all adopted the goal of ultimately eliminating the use of seclusion and restraints. MHA supports the principles regarding the use of seclusion and restraints in behavioral health settings that have been promulgated by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in its "Roadmap to Seclusion and Restraint Free Mental Health Services"[2] and by NASMHPD in its position statement.[3]

As the states work toward eliminating the use of seclusion and restraints in behavioral health facilities, it is critical to have strict safeguards in place during the transition period. Also, despite deep abhorrence of the long history of abuse of seclusion and restraint and the fact that these practices cause trauma even when used by well-meaning practitioners, MHA's policy must also take into account exceptional circumstances in which restraint, in the least restrictive manner possible, may be required to avert serious physical harm. Such circumstances may be presented, for example, in the case of a person receiving intravenous medication who cannot be persuaded to stop removing the tubes, or a person who seeks to escape from traction.

Finally, although it is an indictment of American society that secure mental health facilities are not available in many rural areas and there may be no appropriate facility in a given area that will accept individuals without the latitude to use restraints, use of restraints under careful medical supervision as detailed in this policy may be preferable to confinement in a jail or other correctional facility. In all such circumstances, MHA insists that any use of restraints must be in the least restrictive manner and accompanied by ample safeguards to protect the person being restrained.

Background

Mental Health America evolved from the National Committee for Mental Hygiene, which was founded in 1909 by Clifford W. Beers, a person with a mental illness who had experienced restraint and seclusion and was horrified by the abuse that he witnessed and experienced in the back wards of a state hospital. He founded the organization that later became the National Mental Health Association and now is Mental Health America to put an end to such needless

suffering. MHA has as its symbol a 350-pound bell cast from melted-down shackles and chains formerly used to restrain people with mental illnesses in psychiatric facilities.

Charles G. Curie, administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) from November 2001 to August 2006, made reducing and ultimately eliminating the use of seclusion and restraints in psychiatric facilities one of his top priorities. In 2002 he stated:

"Seclusion and restraint - with their inherent physical force, chemical or physical bodily immobilization and isolation - do not alleviate human suffering. They do not change behavior. And they do not help people with serious mental illness better manage the thoughts and emotions that can trigger behaviors that can injure them or others. Seclusion and restraint are safety measures of last resort. They can serve to retraumatize people who already have had far too much trauma in their lives. It is my hope that we can create a single, unified policy - a set of primary principles that will govern how the Federal Government approaches the issue of seclusion and restraint for people with mental and addictive disorders."[4]

Under Charles Curie's leadership, continued under Pam Hyde, SAMHSA's vision has been to reduce and ultimately eliminate seclusion and restraints from behavioral health treatment and rehabilitation facilities. In July, 2006, SAMHSA published a curriculum that offers strategies for preventing and reducing the use of seclusion and restraints. The agency's "Roadmap to Seclusion and Restraint Free Mental Health Services for Persons of All Ages" is intended primarily to train direct-care staff, but it also provides a valuable overview of issues relevant to seclusion and restraint for advocates, consumers and family members.[5]

Likewise, NASMHPD has called seclusion and restraint, including "chemical restraints,""safety interventions of last resort" and "not treatment interventions," and NASMHPD has put a priority on "prevent[ing], reduc[ing], and ultimately eliminat[ing] the use of seclusion and restraint and . . . ensur[ing] that, when such interventions are necessary, they are administered in as safe and humane a manner as possible by appropriately trained personnel." This position was reiterated by NASMHPD executive director Bob Glover in 2005 when he wrote, "I believe that state facilities and other service providers must continue to make it a priority to reduce and ultimately eliminate these coercive practices in order to improve the quality of people's lives."[6]

Unfortunately, despite these good intentions, there is still a lack of consensus regarding the use of seclusion and restraint, and there is still a widespread lack of data to assess the current use of these techniques. There are still no uniform national standards over how and when to use seclusion and restraints. Few states even require the reporting and investigation of a death in a private or state psychiatric facility, and the federal government does not collect data on how many consumers are injured or killed by these techniques. The Harvard Center for Risk Analysis at the Harvard School of Public Health has estimated that the annual number of deaths range from 50 to 150 per year, which translates to three deaths every week.[7]

The federal government has failed to stand behind and enforce earlier-established regulatory standards governing seclusion and restraint. The Health Care Finance Administration (HCFA), now the Center for Medicare and Medicaid Services (CMS), promulgated revised regulations for

hospitals in 1999 and residential treatment facilities for young people under 21 in 2001 to make the use of seclusion and restraint safer for both young people and adults. The regulations require a face-to-face evaluation by a physician or licensed independent practitioner of any individual in seclusion or restraint, within one hour of the event to check on the need for these interventions and on the individual's safety. The "one-hour rule" evoked considerable controversy and strong objections from some quarters. CMS responded in 2007 by issuing a Final Rule which allowed for other staff members, including nurses, to conduct patient evaluations and issue seclusion and restraint orders, a change which has been decried as insufficiently protective of patient safety.[8]

People are still being traumatized and dying from the use of seclusion and restraints. Lack of adequate staffing cannot justify the use of seclusion and restraints, and staffing may need to be increased to further this goal. It is noteworthy, however, that Pennsylvania greatly reduced the use of seclusion and restraints without increasing staffing or other resources, and that reduction in the use of seclusion and restraints has increased staff safety.

In the tradition of Clifford Beers, Mental Health America challenges the mental health professions to live up to the vision expressed by the federal government and NASMHPD. State and federal agencies must take a greater role in assuring the safety and protection of children and adults in psychiatric settings. Use and abuse of restraints and seclusion are symptoms of poor quality of care in facilities, poor state oversight, and misdirected public policy.

Pennsylvania’s Success Story

As deputy secretary of the Pennsylvania Office of Mental Health and Substance Abuse Services, Charles Curie oversaw a statewide program initiated in 1997 to reduce and ultimately eliminate the use of seclusion and restraints in the state hospital system. Three years later, Pennsylvania had reduced the incidence of seclusion and restraints in its nine State hospitals by 74 percent, and reduced the number of hours consumers spent in seclusion and restraints by 96 percent. In the 2009-2010 fiscal year, seclusion was used only 11 times in the Pennsylvania hospital system. Five hospitals eliminated the use of seclusion and restraints entirely. Moreover, Pennsylvania's hospitals experienced no increase in staff injuries even though these changes were implemented using only existing staff and resources with no additional funding.[9] Pennsylvania worked to change the culture of its state hospitals by requiring open public access to seclusion and restraint data, by creating competition among hospitals to reduce seclusion and restraints, and by giving awards and acknowledgements for improvement.[10]

The key components of Pennsylvania’s seclusion and restraints reduction policy are:

- Seclusion and restraints are exceptional and extreme practices for any consumers and must be the intervention of last resort.
- A physician who has received training in the use of alternatives to restraint and how to reduce the physical and emotional harm caused by restraints must order seclusion and restraints.
- Staff must work with the consumer to end seclusion and restraints as quickly as possible.
- Orders are limited to one hour and require a physician to physically assess the consumer within 30 minutes.

- Consumers being restrained may not be left alone.
- Chemical restraints are prohibited.
- The treatment plan must include specific interventions to avoid seclusion and restraint.
- Consumers and staff must be debriefed after every incident and treatment plans must be revised.
- Staff must be trained in de-escalation techniques.

This initiative has produced a cultural change conducive to expedited consumer recovery, hospital discharge, and community reintegration. Seclusion and restraints are no longer considered the acceptable first response to aggressive or self-injurious consumer behavior.

To the Pennsylvania policy, Mental Health America would add the following six recommendations:

- Only physicians with a specialization in psychiatry should be authorized to restraints.
- Seclusion and restraints should only be used for the amount of time needed to restore safety and security to the consumer and others, and consumers in seclusion or restraints must be monitored continuously, in person by an appropriately trained staff person and not exclusively by video to ensure the consumer's safety. In order to minimize the length of time in restraints, the authorizing physician should write specific criteria for determining when restraints must be discontinued, and as soon as these criteria are met, the consumer must be released.
- Any use of seclusion or restraints should be documented in the consumer's file along with the rationale as to why alternative measures failed or were not attempted.
- Families or authorized representatives of consumers, as well as the management of the facility, must be informed of each restraint or seclusion event immediately.
- Families, consumers, and involved staff should engage in a de-briefing session after each event to discuss the circumstances leading up to the event, why alternatives to seclusion and restraints failed, and other interventions that might be more effective in future situations. In order to reduce trauma related to the event, de-briefing sessions with staff should be separate from de-briefing sessions with the consumer and/or family.
- An individual’s age, developmental needs, gender issues, ethnicity, and history of sexual or physical abuse should be taken into account when implementing seclusion and restraint procedures.

Call to Action

- The states should require all psychiatric facilities (public and private) to implement plans and staff training to prevent and ultimately eliminate the use of seclusion and restraints.
- The states should improve enforcement of the basic human rights of residents in psychiatric facilities by immediately investigating any harm resulting from a facility's use of seclusion and restraints.
- The states should maintain records of deaths and other complications which occur during the use of seclusion or restraints.
- Seclusion and restraints should never be used as punishment or discipline or for the convenience of staff.

- Medication should never be used as a "chemical restraint" to reduce the ability of a consumer to move for purposes of discipline or staff convenience. Mental Health America calls on professional associations and the federal government to develop practice guidelines for such emergency medical interventions.
- All staff should be trained and demonstrate competence in non-physical intervention and de-escalation techniques to prevent the use of seclusion and restraints and in the safest and least restrictive ways to use seclusion and restraints. These trainings should take place when staff are first hired and continually at regular intervals. Only staff persons who have received this training should be involved in seclusion or restraint of consumers. The Federal Center for Mental Health Services should develop a curriculum for states to certify trainers to do this work.
- Psychiatric facilities should encourage consumers to develop advance directives that address the extreme conditions in which seclusion and restraints may be used and detail alternative techniques that the consumer authorizes to diffuse his or her agitation and problematic behavior. Engaging consumers in this activity should take place immediately upon admission or at the next clinically appropriate time because a disproportionately large number of seclusion and restraint events take place in the first few days after a person is admitted to a psychiatric facility.
- Facilities should be sufficiently staffed to prevent the concern or need for restraints and seclusion.
- Weakened Federal regulatory standards on seclusion and restraint, including the Final Rule's less stringent interpretation of the "one-hour rule," should be returned to their previous strength in order to safeguard the rights of residents and ensure their well-being.
- To reduce and ultimately eliminate the use of seclusion and restraints, society should drastically improve the mechanisms currently available to monitor these activities and the harm caused by them to mental health consumers. As one step to improve monitoring of the use and abuse of seclusion and restraints, MHA calls on the states to publish on their websites data on the use of seclusion and restraints including the number of hours spent in restraint for each public facility and any private facility contracting with the state as well as data on any injuries or deaths associated with the use of seclusion and restraint and diversion to correctional facilities.
- External monitoring groups comprised of consumer advocates, family members, and concerned citizens should be established in each state.11 External monitors can educate the public and key policy-makers about the needs and problems of consumers. These monitors should be allowed to visit facilities any time and should file written reports to which the facilities must respond in a timely manner.
- Psychiatric facilities should be required to have offices of consumer or recipient affairs staffed by consumers and advocates that have meaningful participation in governance and policy-making activities, particularly regarding the use of seclusion and restraints.
- Public education and outreach is needed to better inform consumers, family members, and advocates about best practices for preventing the use of seclusion and restraint in order that they are aware of what activities should be conducted by facilities.
- Additional outreach is also needed to educate consumers, family members, and advocates about where to turn to address abuses by facilities.

- Judges should be educated about current thinking on the use of seclusion and restraints and how such actions can and should be prevented.

Effective Period

This policy was approved by the Mental Health America Board of Directors on March 5, 2011. It is reviewed as required by the Mental Health America Public Policy Committee.

Expiration: December 31, 2016

1. This policy position is not intended to apply to voluntary "time out" policies.
2. DHHS Pub. No. (SMA) 05-4055. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (2005).http://www.asca.net/documents/Roadmap_Seclusion.pdf
3. See also National Executive Training Institute: Training Curriculum for Reduction of Seclusion and Restraint. Alexandria, VA, National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning (July 2005).http://www.hogg.utexas.edu/uploads/documents/risk_factors-ref.pdf.
4. Conversation with Charles Curie, SAMHSA Administrator (2002). See also Curie, C. "SAMHSA's Commitment to Eliminating the Use of Seclusion and Restraint." *Psychiatric Services* 59(9):1139-1141 (2005). No URL available.
5. An updated Issue Brief from SAMHSA, reaffirming the organization's commitment to the *Roadmap* can be accessed online at http://www.samhsa.gov/matrix2/IssueBrief1_B.pdf
6. http://psychservices.psychiatryonline.org/cgi/content/full/56/9/1141
7. Weiss, E.M., "From 'Enforcer' to Counselor," Hartford Courant, October 15, 1998; Part of a five part series published by the Courant which brought national prominence to the issue of seclusion and restraint.
8. LeBel, Janice, "Regulatory Change: A Pathway to Eliminating Seclusion and Restraint or 'Regulatory Scotoma'?" *Psychiatric Services* 59:194-196 (2008).http://psychservices.psychiatryonline.org/cgi/content/full/59/2/194
9. Smith, G., Davis, R., Bixler, E., Lin, H., Altenor, A, Altenor, R., Hardenstine, B., & Kopchick, G., "Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program." *Psychiatric Services*, 56(9), 1115-1122 (2005). No URL available. Updated data and information about the Pennsylvania initiative's ongoing success available online through OMHSAS at http://www.parecovery.org/services_seclusion.shtml and http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/s_002670.pdf.
10. Pennsylvania found that making this kind of data publicly available was one of the key factors to decreasing the use of seclusion and restraint in its state hospitals. Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services (OMHSAS), "Leading the Way Toward a Seclusion and Restraint Free Environment: Pennsylvania's Success Story," Harrisburg, PA, 2001 (no URL available); see also Smith, G., Davis, R., Bixler, E., Lin, H., Altenor, A, Altenor, R., Hardenstine, B., Kopchick, G. (2005). New York State also reduced restraint use and the number of related deaths by requiring the reporting of usage rates and investigating all deaths, and through an initiative encouraging the use of comfort rooms as a preventive tool. Details online at http://www.omh.state.ny.us/omhweb/resources/publications/comfort_room/. Massachusetts has also implemented a successful restraint Initiative, the mechanics of which are discussed at length in LeBel, J., and Goldstein, R.. "The Economic Cost of Using Restraint and theValue Added by Restraint Reduction or Elimination." *Psychiatric Services*, 56(9):1109-1114 (2005).http://psychservices.psychiatryonline.org/cgi/content/abstract/56/9/1109
11. According to NAMI, "Some State hospital systems and some facilities such as Delaware, Massachusetts, New Hampshire, New Jersey, and Pennsylvania, have reduced the use of seclusion and restraints by using third party citizen, consumer and family monitoring groups." See www.NAMI.org and MHA's *Checking Up on Juvenile Justice Facilities: A Best Practices Guide*, a guide for developing these external monitoring programs. No URL available. See also World, Heather, "Mental Health Care's New Model Shuns Restraint and Seclusion -The Nursing Spectrum." (2007), online at: http://mentalhopenews.blogspot.com/2007/08/mental-health-cares-new-model-shuns.html.