
Fourth
in a series
of
Technical
Reports

Reducing the Use of Seclusion and Restraint

PART II:

*Findings, Principles, and Recommendations
for Special Needs Populations*

National Association of
State Mental Health Program Directors (NASMHPD)
Medical Directors Council

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Acknowledgments

On behalf of the Medical Directors Council of the National Association of State Mental Health Program Directors (NASMHPD), I want to acknowledge the many important contributors to this second Technical Report on reducing the use of seclusion and restraints in psychiatric facilities.

This Technical Report complements our first report on this topic, which was released in July, 1999. We owe a debt of gratitude to all who participated in the development of that report and the NASMHPD Position Statement on Seclusion and Restraint. Both of these documents provide the framework of values and principles upon which this Technical Report is based.

All the participants in the Technical Report meeting held August 17-18, 2000 contributed greatly to the final document. (A roster of participants is included as an Appendix to the Report.) Many of the participants were involved in the development of the first report on this topic, and all of them contributed many long hours to support this initiative. We could not have produced this Technical Report without their time, expertise, and willingness to collaborate effectively and respectfully with others representing a broad range of experience and perspectives. In particular, representatives of the National Association of Consumer/Survivor Mental Health Administrators (NAC/SMHA) provided poignant insights about the lasting psychological harm caused by the use of seclusion and restraint and the wealth of knowledge that each consumer possesses about alternative interventions that are effective for them.

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POSITION STATEMENT ON SECLUSION AND RESTRAINT

The members of the National Association of State Mental Health Program Directors (NASMHPD) believe that seclusion and restraint, including “chemical restraints,” are safety interventions of last resort and are not treatment interventions. Seclusion and restraint should never be used for the purposes of discipline, coercion, or staff convenience, or as a replacement for adequate levels of staff or active treatment.

The use of seclusion and restraint creates significant risks for people with psychiatric disabilities. These risks include serious injury or death, retraumatization of people who have a history of trauma, and loss of dignity and other psychological harm. In light of these potential serious consequences, seclusion and restraint should be used only when there exists an imminent risk of danger to the individual or others and no other safe and effective intervention is possible.

It is NASMHPD’s goal to prevent, reduce, and ultimately eliminate the use of seclusion and restraint and to ensure that, when such interventions are necessary, they are administered in as safe and humane a manner as possible by appropriately trained personnel. This goal can best be achieved by: (1) early identification and assessment of individuals who may be at risk of receiving these interventions; (2) high quality, active treatment programs (including, for example, peer-delivered services) operated by trained and competent staff who effectively employ individualized alternative strategies to prevent and defuse escalating situations; (3) policies and procedures that clearly state that seclusion and restraint will be used only as emergency safety measures; and (4) effective quality assurance programs to ensure this goal is met and to provide a methodology for continuous quality improvement. These approaches help to maintain an environment and culture of caring that will minimize the need for the use of seclusion and restraint.

In the event that the use of seclusion or restraint becomes necessary, the following standards should apply to each episode:

- The dignity, privacy, and safety of individuals who are restrained or secluded should be preserved to the greatest extent possible at all times during the use of these interventions.
- Seclusion and restraint should be initiated only in those individual situations in which an emergency safety need is identified, and these interventions should be implemented only by competent, trained staff.

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- As part of the intake and ongoing assessment process, staff should assess whether or not an individual has a history of being sexually, physically or emotionally abused or has experienced other trauma, including trauma related to seclusion and restraint or other prior psychiatric treatment. Staff should discuss with each individual strategies to reduce agitation which might lead to the use of seclusion and restraint. Discussion could include what kind of treatment or intervention would be most helpful and least traumatic for the individual.
 - Only licensed practitioners who are specially trained and qualified to assess and monitor the individual's safety and the significant medical and behavioral risks inherent in the use of seclusion and restraint should order these interventions.
 - The least restrictive seclusion and restraint method that is safe and effective should be administered.
 - Individuals placed in seclusion or restraints should be communicated with verbally and monitored at frequent, appropriate intervals consistent with principles of quality care.
 - All seclusion and restraint orders should be limited to a specific period of time. However, these interventions usually should be ended as soon as it becomes safe to do so, even if the time-limited order has not expired.
 - Individuals who have been secluded or restrained and staff who have participated in these interventions usually should participate in debriefings following each episode in order to review the experience and to plan for earlier, alternative interventions.

States should have a mechanism to report deaths and serious injuries related to seclusion and restraint, to ensure that these incidents are investigated, and to track patterns of seclusion and restraint use. NASMHPD also encourages facilities to conduct the following internal reviews: (1) quality assurance reviews to identify trends in seclusion and restraint use within the facility, improve the quality of care and patient outcomes, and help reduce the use of seclusion and restraint; (2) clinical reviews of individual cases where there is a high rate of use of these interventions; and (3) extensive root cause analyses in the event of a death or serious injury related to seclusion and restraint. To encourage frank and complete assessments and to ensure the individual's confidentiality, these internal reviews should be protected from disclosure.

NASMHPD is committed to achieving its goals of safely preventing, reducing, and ultimately eliminating the use of seclusion and restraint by: (1) encouraging the development of policies and facility guidelines on the use of seclusion and restraint; (2) continuing to involve consumers, families, treatment professionals, facility staff, and advocacy groups in collaborative efforts; (3) supporting technical assistance, staff training, and consumer/peer-delivered training and involvement to effectively improve and/or implement policies and guidelines; (4) promoting and facilitating research regarding seclusion

and restraint; and (5) identifying and disseminating

information on “best practices” and model programs. In addition, NASMHPD supports further review and clarification of developmental considerations (for example, youthful and aging populations) which may impact clinical and policy issues related to these interventions.

Approved by the NASMHPD membership on July 13, 1999.

Report Preparation Process

III NASMHPD Medical Directors Council Technical Report Series

This technical report, prepared by the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, is fourth in a series intended to provide information and assistance to state mental health commissioners/directors on matters of clinical concern. Topics for technical reports are identified by the Medical Directors Council in conjunction with the NASMHPD leadership.

The use of seclusion and restraint is of great concern to the NASMHPD leadership, NASMHPD Division members, staff of mental health programs, and individuals who receive mental health treatment. Seclusion and restraint may cause significant trauma—both physical injury and psychological harm—to those subjected to the practices. A number of deaths in institutions around the country have been attributed to the misuse of seclusion and restraint. It is NASMHPD’s position that seclusion and restraint are safety measures, not treatment interventions, and “should be used only when there exists an imminent risk of danger to the individual or others and no other safe and effective intervention is possible.” (see NASMHPD “Position Statement on Seclusion and Restraint,” July 1999) Two equally important goals of NASMHPD are “to prevent, reduce, and ultimately eliminate the use of seclusion and restraint and to ensure that, when such interventions are necessary, they are administered in as safe and humane a manner as possible by appropriately trained personnel.” In addition, “the dignity, privacy, and safety of individuals who are restrained or secluded should be preserved to the greatest extent possible.”

In July 1999, the NASMHPD Medical Directors Council issued a first technical report defining policies and principles for seclusion and restraint. The report entitled “Reducing the Use of Seclusion and Restraint: Findings, Strategies, and Recommendations,” was made available as the Health Care Financing Administration (HCFA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) were developing new standards for seclusion and restraint in hospitals and as Congress was considering federal legislation on these practices.

This second technical report on seclusion and restraint enlarges the scope of the first by examining in more depth the use of these practices in populations with special needs: (1) children and adolescents; (2) older individuals; (3) individuals who have a mental illness and a co-occurring disorder of mental retardation and/or developmental disability; (4) individuals who have co-occurring mental illness and substance abuse or dependence; and (5) individuals in forensic psychiatric services.

III Preparation of the Report

This report was prepared from proceedings of a meeting held August 17 and 18, 2000 in Portland, Oregon. Meeting participants included one state deputy secretary for mental health services, four state medical directors, and two representatives from state offices of consumer affairs. One representative from each of the following NASMHPD Divisions participated: (1) Children, Youth, and Families; (2) Older Persons; and (3) Forensic Services. Staff of NASMHPD and the NASMHPD Research Institute (NRI) participated and a facilitator and a technical writer assisted in the proceedings. A list of participants and their affiliations is included in the Appendices. It is important to note that views expressed by the participants were their own and are not necessarily endorsed by their organizations.

Prior to the meeting, participants reviewed information on the general use of seclusion and restraint, and on the use of these practices with individuals with special needs. The materials were not a comprehensive survey of all current information about the use of seclusion and restraint with special needs populations, but sought to establish an informed basis for group discussion.

This report does not prescribe “best practices” for seclusion and restraint, but gives general findings related to each special population, including principles for reducing and eliminating the use of these interventions with individuals who have special needs. Included in this report are recommendations for additional discussion, review, research, and technical assistance. The report concludes with recommendations to NASMHPD, the NRI, and state mental health agencies.

Drafts of this report were prepared by the technical writer and chief editor and distributed for review and comment to all meeting participants and members of the Medical Directors Council’s Editorial Board. This report attempts to integrate findings of the literature with the diverse perspectives and expertise of the participants. The final report was reviewed and approved by the Medical Directors Council. This report is a product of that Council and does not necessarily reflect opinions held by all NASMHPD members or the experts participating in the August 2000 meeting.

A Synopsis of the July 1999 Technical Report on Seclusion and Restraint

III Findings, Principles, and Recommendations

The July 1999 technical report was a first assessment by the NASMHPD Medical Directors Council of seclusion and restraint in mental health programs. Central to the first report was application of the public health model to seclusion and restraint practices: primary prevention (preventing and reducing the need for seclusion and restraint); secondary prevention (using early and least-restrictive interventions to de-escalate situations); and tertiary prevention (service recipient and staff debriefing, program policies and procedures, and quality improvement evaluation to decrease harm when seclusion and restraint must be used). The first report created a foundation for further review of seclusion and restraint and guided development of this second technical report. The following are key findings, principles, and recommendations of the first report “Reducing the Use of Seclusion and Restraint: Findings, Strategies, and Recommendations.”

- Seclusion and restraint should be used only when there exists an imminent risk of danger to the individual or others and no other safe and effective intervention is possible.
- Seclusion and restraint should never be used: (1) as a threat; (2) as punishment; (3) for control; (4) as a substitute for active treatment; (5) because of low staffing levels; or (6) as a convenience for staff.
- Mental health programs should establish safe therapeutic environments that reduce and eliminate the need for seclusion and restraint.
- Programs that promote cultural examination and change and emphasize primary and secondary prevention strategies will be successful in reducing and eliminating seclusion and restraint. Programs that focus only on improving the methods and techniques for seclusion and restraint will not be successful in reducing or eliminating these practices.
- A culture of respect must be created for both individuals served and staff. This culture must stress least-restrictive options for dealing with critical situations.
- Individuals, their families, and advocates should help articulate sound treatment values to promote cultural change and reduce and eliminate seclusion and restraint.

- Individuals should help develop their own treatment or recovery plans containing measures chosen by them for crisis resolution and taking into account their physical health, past physical and psychological trauma, and risk for future harm.
- The safety, dignity, and privacy of each individual who experiences seclusion and restraint must be maintained to the greatest extent possible.
- Each event of seclusion and restraint should be debriefed with the individual and with staff, and the information and perceptions discussed in these sessions should be incorporated into the individual's treatment plan.
- Training for staff in prevention and early intervention techniques should be ongoing.
- Only staff who have been adequately trained should use seclusion and restraint. Staff should be trained in the use of physical holds, restraint equipment, in the need to check and document vital signs, and in other essential practices surrounding seclusion and restraint.
- Evaluation of seclusion and restraint events should be an integral part of each program's continuous quality improvement process.
- Mental health programs using seclusion and restraint should be open to independent, external reviews by JCAHO, state licensing, or other quasi-independent reviewers.

Seclusion and Restraint: Part II Background and Principles Endorsed by the Participants

III State Mental Health Agencies

State mental health agencies have as their missionserving individuals in need and those assigned to them by law, with due regard for public safety. In carrying out this responsibility, state programs are increasingly serving individuals with complex, multiple diagnoses and disabilities (e.g., mental illness and mental retardation and/or developmental disability, or substance abuse or dependence). In some cases, individuals entering the state mental health system, such as those ordered for pre-trial evaluation in forensic psychiatric programs, may not be affected by a mental illness. Regardless of diagnostic complexity, state mental health agencies must ensure each individual appropriate, high quality care, including efforts to reduce and eliminate the use of seclusion and restraint. The mission of each state mental health agency extends beyond state-operated facilities to include state funded or licensed community programs.

III Cultural Change

Changing standards of national accrediting and certifying organizations (e.g., JCAHO, HCFA) may influence mental health programs to reduce and eliminate seclusion and restraint. Participants agreed change is most likely to occur when states and mental health programs decide to improve their own treatment cultures by: (1) establishing high standards for respectful, therapeutic interactions; (2) increasing the amount and types of “active treatment” given each day; (3) insuring timely and thorough biological/psychological assessments upon admission; (4) evaluating the number and type of all staff, their qualifications, and the role each has in potential seclusion and restraint events; (5) de-emphasizing “control” and “compliance” in favor of therapeutic relationships that offer individuals choices for interventions and routines; and (6) explicitly adopting the concept that treatment can only occur in the context of continuous quality improvement. Such cultural changes involve all staff and will be most effective when equally supported by program administration, by direct care staff, by individuals served, their families, and advocates.

III General Principles Endorsed by the Participants

Participants at the August 2000 meeting reaffirmed support for the NASMHPD “Position Statement on Seclusion and Restraint” (July 1999) and for the findings, strategies, and recommendations contained in the first technical report on seclusion and restraint. Participants achieved further consensus in areas described below.

- System-wide Change*: State mental health commissioners/directors must work to reduce and

eliminate seclusion and restraint in all the systems under their control. They must

examine and improve treatment cultures to rely on prevention and early intervention strategies and consider seclusion and restraint a last resort for securing the safety of the individual or treatment staff. It is not enough to change seclusion and restraint practices for some of those in treatment, but not others; change must be made as broadly as possible.

- ❑ *Strength-based Treatment:* Behavioral health treatment services should focus on the unique strengths and abilities of each individual child, adolescent, and adult. An individual's functional ability, and not simply age, should guide therapeutic interventions.
- ❑ *Early Assessment:* A disproportionately large number of seclusion and restraint events occur in the first days after individuals are admitted to mental health treatment programs. Individuals should receive thorough biological and psychological evaluations immediately upon admission to identify their medical problems, to understand their psychological histories, including any histories of trauma, and to engage them in helping to plan their own intervention approaches. Knowledge gained in this process should serve to lower the possibility of seclusion or restraint.
- ❑ *Consumer, Family, and Advocacy Involvement:* State mental health programs should work closely with consumers, families, and advocates for all individuals with special needs to reduce and eliminate seclusion and restraint. Individuals who themselves have experienced seclusion and restraint should be encouraged to participate in the development of program seclusion and restraint policies and procedures.
- ❑ *Primary and Secondary Prevention:* Program staff should not let minor problems become crises. For example, offering an individual experiencing difficulties only the option of going to his or her room may make seclusion and restraint more likely. An individual's noncompliance in such a context is more a failure of the staff to respond with flexibility than a sufficient cause for the use of seclusion and restraint. Staff must also be able to recognize escalating, potentially harmful behaviors and intervene before seclusion or restraint become necessary.
- ❑ *Program Assessment:* Repeated seclusion and restraint events in any treatment environment should prompt evaluation of program routines and practices that may contribute to such events.

Preventing, Reducing, and Eliminating Seclusion and Restraint with Special Needs Populations

Participants in the August 2000 meeting hosted by the NASMHPD Medical Directors Council focused on five special needs populations: (1) children and adolescents; (2) older individuals; (3) individuals with mental illness and a co-occurring disorder of mental retardation and/or developmental disability; (4) individuals with co-occurring mental illness and substance abuse or dependence; and (5) individuals being served in forensic programs.

These populations offer valuable lessons for achieving NASMHPD's goal of preventing, reducing, and eliminating seclusion and restraint. Children and adolescents teach us that seclusion and restraint decisions must take into account the child's *physical and cognitive development*, rather than just his or her chronological age. Older individuals may be fragile and present with *complex medical, psychological, and physical conditions* best served from a multidisciplinary perspective (e.g., physicians, nurses, pharmacists). Individuals with co-occurring disorders of mental illness and mental retardation and/or developmental disability often *communicate by means of behavior* which must be assessed in context when considering the use of seclusion or restraint. Individuals with co-occurring disorders of mental illness and substance abuse or dependence must be assessed to determine their capacity for exercising *self-control* and taking personal responsibility in weighing the use of seclusion and restraint. Treatment of individuals in forensic psychiatric programs must balance *public safety* against therapeutic issues in the use of seclusion and restraint. Many issues and recommendations identified in this report apply equally to all special needs populations, while others may apply only to one or more, but not all.

III Children and Adolescents

Findings

Treatment settings for children and adolescents are diverse. More children are served in residential and group treatment programs than in state hospitals or other inpatient settings. Others receive mental health services in detention centers and secure facilities for those adjudicated delinquent. Standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Health Care Financing Administration (HCFA) regarding seclusion and restraint apply to hospitals, including state psychiatric hospitals, serving children and adolescents. In addition, HCFA has developed regulations to address the use of seclusion and restraint in child and adolescent residential settings. Promising practices to reduce and eliminate seclusion and restraint may differ between hospital and residential settings.

Seclusion and restraint decisions for children and adolescents must be made using a developmental model, and not be based solely on chronological age. Such decisions must take into account children's physical, cognitive, and developmental age. For example, in any use of seclusion and restraint, program staff must take special care to avoid damaging the formative growth plates in children's long bones. Children's level of cognitive development governs the accuracy of their understanding of social interactions and situations. Children's sexual development also must be considered so as to avoid or minimize trauma when staff respond to crisis situations.

Staff of child and adolescent programs are at risk, in an especially immediate way, of confusing their own childhood experiences and child-rearing practices in their own families with their duties as professionals to the children they serve. Training and supervision that recognizes and addresses these tensions are important for maintaining clear professional boundaries.

Recommendations

- Families, custodians, and/or guardians should be informed of a program's seclusion and restraint policies and procedures when their children are admitted. Programs should provide timely notification to these parties if their children are secluded or restrained and give them an opportunity to participate in debriefing each event.
- Mental health programs should develop standardized assessment protocols to identify children who have experienced physical, psychological, or sexual trauma, including abuse, and those at high risk for seclusion and restraint events for any reason. Physical and psychological risk assessments should be completed within 24 hours of admission, and before any seclusion or restraint is used.
- Assessment should include a review of the child's medical condition and disability, if any. Substance abuse or dependence should be evaluated in the assessment process for individuals of all ages.
- Initial treatment plans should include positive interventions to avoid the use of seclusion and restraint, especially for children most likely to lose self-control.
- In the event a child is restrained, he or she must be continually observed to prevent physical harm. These observations should be included in debriefing the event with the child and with staff.
- Children who have experienced seclusion and restraint and who can articulate the effects of these experiences should be involved in shaping program policies and procedures and in training staff.

- ❑ Child and adolescent programs should involve consumers, families, and other advocates to improve all treatment services, and specifically to reduce and eliminate seclusion and restraint.
- ❑ Many state mental health agencies currently do not have Offices of Consumer Affairs specifically for child and adolescent treatment services. States should be encouraged to develop or support specialized advocacy programs for children and adolescents.

III Older Individuals

Findings

Geriatric mental health is defined as specialized services for individuals 65 years old or older; this definition is found both in law and federal and state funding decisions. However, age is not necessarily proportionally related to an individual's functional status and the kinds of interventions that may be therapeutic. Despite this, an older individual's functional level is often not a large factor in determining services or settings. Older individuals may present multiple, complex diagnostic issues, including medical, psychological, and physical needs calling for attention by a multidisciplinary team of physicians, nurses, and pharmacists.

Aging may cause changes in the ability to communicate, some obvious, others subtle. Dementia and delirium may profoundly compound loss of thinking and speaking ability. The effects of depression may be less dramatic, but may also seriously impair the ability to communicate. An individual unable to communicate will be more likely to experience seclusion and restraint.

Aging may lead to sensory impairments, incontinence, falls, and cognitive disabilities. Older individuals affected by degenerative brain disease may be unusually loud, may become combative when approached or touched, or may intrude upon others. In addition, older individuals served in combined, general adult mental health programs may be vulnerable to stronger, more aggressive younger individuals. The design of treatment spaces should contribute to safety and support.

Cultural and generational factors of staff and the individuals served may determine if and how programs use seclusion and restraint. Family dynamics also play a role in how older individuals are treated in mental health programs. Some research indicates that seclusion and restraint events with older individuals increase following family visits. Adult children who place elderly parents in treatment may react with grief or guilt and those placed may feel anger toward their adult children for being placed in unfamiliar situations.

Recommendations

- Individuals, families, custodians, or guardians should be informed of program policies and procedures for use of seclusion and restraint at the time older individuals are admitted. Programs should provide these parties timely notification and an opportunity to participate in debriefing sessions if their relatives or wards are secluded or restrained.
- A biological/psychological assessment should be conducted within 24 hours of an individual's being admitted to a mental health program. The assessment should pay special attention to the individual's medical condition and unusual fragility (e.g., possible swallowing difficulties). Restraints or PRN medications should not be administered until assessment is completed.
- Staff should be trained to recognize and treat chronic and acute diseases, to understand the dynamics of control issues, and the effect of these issues on interactions with older individuals. Staff training should not be compromised by high employee turnover rates.
- Physicians and nurses should consult with qualified pharmacists to assess the effects medications may have on individuals (e.g., gait problems, incontinence), including the use of PRNs, psychotropic medications, and polypharmacy considerations.
- An older individual should never be restrained on his or her back due to risk of choking on aspirated material.
- Only soft restraints should be used with older individuals. Leather restraints should never be used as these may cause lesions or fractures, especially in cases of osteoporosis.
- Programs should encourage individuals and families to use advance mental health directives when feasible. Advance directives spell out treatment preferences and may include alternatives to seclusion and restraint that individuals believe are safer, more effective, and humane.
- Many states have ombudsmen for older individuals. Mental health programs should be open to working with older consumers, ombudsmen, and other advocates, particularly to reduce and eliminate seclusion and restraint.

III Individuals with Co-occurring Disorders of Mental Illness and Mental Retardation and/or Developmental Disability

Findings

For individuals with a co-occurring mental illness and mental retardation and/or developmental disability, behavior is often a principal means of communication. Behavior by these individuals should be assessed as a matter of course before making decisions to use seclusion and restraint. For example, uncontrolled agitation caused by interpersonal conflict might be hard to distinguish from agitation caused by physical illness or discomfort, agitation that would only be exacerbated by seclusion and restraint.

Individuals served by the mental retardation/developmental disability (MR/DD) system present a broad range of levels of severity, from those affected by mild or moderate mental retardation and/or developmental disability, to those with severe or profound disabilities. Individuals with developmental disability are at high risk for seclusion and restraint in mental health settings because these settings generally are designed for persons with greater cognitive and verbal abilities. Less severely affected individuals may be easier to integrate into mental health programs, and traditional interventions to avoid seclusion and restraint may be more effective.

Mental health program culture may view individuals with severe developmental disability as “hopeless” or “untreatable.” Mental health program staff may not understand the time and number of repetitions necessary for individuals with developmental disability to learn new behavior.

Individuals with developmental disability have relatively high rates of self-injurious behavior (e.g., biting, pinching, head banging) that, in mental health programs, could lead to seclusion and restraint. In addition, individuals with developmental disability have a high incidence of chronic or disabling medical conditions (e.g., curvature of the spine, osteoporosis) that may cause physical restraints to be unduly uncomfortable or unsafe.

Downsizing and closing MR/DD facilities in many states reduced acute-care capacity for individuals with developmental disability. In many states, the only acute-care placements for these individuals are in public mental health programs, regardless of whether the individuals are also affected by co-occurring mental illnesses. HCFA has different rules for state mental health programs than for Intermediate Care Facilities for the Mentally Retarded (ICF/MR). HCFA rules generally allow restraint in ICF/MR when specified in an individual’s behavioral management or support plan and when approved by the ICF/MR “human rights committee.” A restraint order apart from the individual’s behavior management plan may be effective for up to 12 hours. Different program regulations may cause confusion in working with this special needs population.

Individuals with developmental disability may be subjected to physical holds or escort supports that are not considered as restraints by the MR/DD system. The MR/DD system, in contrast to the mental health system, may use less-restrictive alternatives than restraint to calm agitated individuals, such as permitting them to take walks away from their treatment facilities.

Recommendations

- Individuals affected by mental retardation or developmental disability who become agitated or violent should be carefully assessed for an underlying medical condition that may be causing the behavioral change.
- Individuals with developmental disability may be victimized more easily than others. Mental health program staff should monitor peer interactions to prevent abuse.
- The habilitation or treatment program and environment should be evaluated to determine what factors may contribute to repeated events of seclusion and restraint.
- Mental health and MR/DD experts should jointly develop “promising practices” for individuals affected with co-occurring disorders of mental illness and developmental disability.
- Individuals with mental retardation or developmental disability staying more than very short periods in psychiatric facilities should have habilitation plans and services developed by providers experienced in working with individuals who have a developmentally disability.
- Habilitation and treatment services for individuals with co-occurring disorders of mental illness and developmental disability should be integrated by behavior specialists and mental health program staff in consultation.
- Consumer, family, and advocacy organizations for individuals with co-occurring disorders of mental illness and developmental disability should be formed in each state and at the national level. Currently, only four state mental health agencies are known to have Offices of Consumer Affairs with staff who specialize in co-occurring mental health and developmental disability issues.

III Individuals with Co-occurring Disorders of Mental Illness and Substance Abuse or Dependence

Findings

Individuals with co-occurring disorders of mental illness and substance abuse or dependence are a heterogeneous group with a complex matrix of psychiatric diagnoses, substances abused, degrees of dysfunction, and severity of symptoms.

Individuals with co-occurring mental illness and substance abuse disorders have two primary, chronic biological disorders; they require specific, coordinated treatment for each to stabilize acute symptoms and specialized services to promote recovery.

Mental health and substance abuse treatment models can be somewhat incongruent. Substance abuse treatment is typically confrontive, focused on breaking through an individual's denial, and internalizing self-control and responsibility. Substance abuse treatment programs may tend to underestimate an individual's need for understanding and support. Mental health programs, in contrast, are mostly supportive and rely on specialized medications to control symptoms. Mental health treatment programs may underestimate an individual's ability to assume personal responsibility for his or her actions and to exercise self-control. Integrated, interdisciplinary mental health and substance abuse treatment is needed to avoid exacerbating one condition while treating the other. It is important that an individual with these co-occurring disorders be assessed for self-control and the ability to take responsibility for behavior.

Mental health programs may refuse to admit individuals affected by mental illness who are intoxicated. Detoxification programs have unusually high rates of seclusion and restraint. Once individuals are detoxified and admitted to mental health programs, seclusion and restraint rates tend to decrease.

Recommendations

- All individuals entering mental health treatment programs should be screened upon admission for intoxication, signs and symptoms of withdrawal, and substance abuse or dependence disorders.
- Environmental stimulation and requirements to participate in treatment should temporarily be reduced for intoxicated individuals and those in withdrawal. Individuals affected by mental illness whose behavior places them at risk for seclusion or restraint within the first 72-hours following admission should be reevaluated for symptoms of withdrawal.

- Individuals experiencing withdrawal symptoms should be appropriately treated following the American Society of Addiction Medicine (ASAM) guidelines to reduce agitation, risk of violence, and seclusion and restraint events.
- Specialized training is essential for work with individuals having these co-occurring disorders; training should include integrated treatment strategies for both conditions.
- Programs should develop treatment settings where individuals who are experiencing acute episodes of mental illness may safely detoxify from the effects of alcohol and drugs without being unduly subjected to seclusion and restraint.

III Individuals Served in Forensic Psychiatric Programs

Findings

Treatment of individuals in forensic mental health programs must balance two responsibilities: providing treatment and ensuring public safety. Forensic psychiatric service may be a last resort for individuals who cannot be safely managed in less restrictive programs. Indeed, some individuals served in forensic programs may not be affected by mental illness (e.g., individuals on pre-trial evaluation status). In keeping with their custody function, forensic program cultures tend to be more authoritarian and controlling than other treatment settings. Individuals admitted to forensic units are sometimes held in “administrative” seclusion and restraints for safety purposes until evaluations or assessments have been completed.

Use of transport restraints when individuals move between treatment programs and correctional institutions, courts, or other public places is a particular use of restraints that may be beyond influence by forensic mental health programs.

Violent behavior as a result of mental illness can often be predicted in individuals well known to staff and may be preceded by advance warning signs. Violent behavior that is criminal in nature, unrelated to mental illness, is often not predictable. The rate of seclusion and restraint may be higher for unpredictable violent behavior.

Individuals often stay in forensic programs for long periods. Staff may have less control over discharge decisions than staff in other settings, a factor they may experience as disempowering.

Individuals committed to a forensic program on a finding of “not guilty by reason of insanity” typically have very long lengths of stay, as do individuals with developmental disability, due in part to a lack of available, less restrictive services. Long stays can undermine staff objectivity and weaken client motivation for treatment.

Recommendations

- Even in forensic psychiatric settings, seclusion and restraint should be considered a safety measure of last resort.
- As staff initially impose control for safety in forensic settings, they should work with individuals to internalize self-control. Individuals should be progressively withdrawn from reliance on seclusion and restraint as they learn to react less violently to events in the treatment milieu, and to gain more control over their behavior.
- Forensic treatment staff should always use objective, “people first” language to discuss and report seclusion and restraint.
- Seclusion and restraint should not be a direct or indirect consequence of low staff-to-client ratios in forensic treatment programs.

Questions for Further Consideration or Research in Preventing, Reducing, and Eliminating Seclusion and Restraint With Special Needs Populations

The NASMHPD Medical Directors Council proposes the following questions for further consideration or research in reducing and eliminating seclusion and restraint with each of the five special needs populations examined.

III Children and Adolescents

- Mental health programs for children and adolescents appear qualitatively different from other mental health settings. How is physical contact with children and adolescents distinguished from restraint? Can contact to prompt, guide, or console a child be clearly distinguished from restraint? Can “time-out” in the child’s room be defined and practiced so as not to constitute seclusion?
- Children and adolescents, as well as others, rely on learned behavior to cope with difficult situations. If children learn early to rely on seclusion and restraint imposed by others to help control their behavior, can they later learn other less restrictive and coercive means of regaining control? Can critical components of developmentally acceptable seclusion and restraint be identified and provided in staff training?

III Older Individuals

- What, if any, correlation exists between the general health and medical conditions of individuals admitted to geriatric psychiatric treatment and the unusually high incidence of seclusion and restraint in the days immediately following admission?

III Individuals with Co-occurring Disorders of Mental Illness and Mental Retardation and/or Developmental Disability

- JCAHO and HCFA standards on seclusion and restraint differ for mental health and developmental disability programs. In case of co-occurring disorders of mental illness and developmental disability, which program standards best apply for those admitted to mental health programs for acute care and for long-term treatment?

III Individuals with Co-occurring Disorders of Mental Illness and Substance Abuse or Dependence

- What are the effects of medical conditions in individuals with co-occurring mental illnesses and substance abuse on rates of seclusion and restraint? For example, are rates higher with individuals who have HIV/AIDS or hepatitis?
- Is it possible to determine if, or how, staff attitudes influence seclusion and restraint in different treatment settings (e.g., psychiatric inpatient, detoxification programs)?

III Individuals Served in Forensic Psychiatric Programs

- How can terms such as “security restraints,” “safety,” “control,” “containment,” and “custody” use in forensic mental health programs be further clarified as they apply to seclusion and restraint practices? Do rates of seclusion and restraint differ between juvenile and adult forensic treatment programs? If different, can the causes be discovered?
- What, if any, relationship exists between the use of seclusion and restraint for individuals in forensic mental health programs who are: (1) affected only by a DSM Axis I disorder; (2) affected only by an Axis II disorder; or (3) affected by both Axis I and Axis II disorders?

Recommendations for NASMHPD

This second technical report on reducing and eliminating seclusion and restraint is intended to provide an overview of issues and principles and makes recommendations for use of these practices with individuals with special needs. Much additional work needs to be done to: (1) fully understand current practices of seclusion and restraint in mental health programs; (2) comprehend the effect of program culture on the use of seclusion and restraint; (3) further define terms, especially with respect to forensic treatment settings; and (4) make informed policy decisions and recommendations based on research data, program experience, and the involvement of individuals, their families, and advocates.

The Medical Directors Council recommends that the NASMHPD leadership continue to encourage states to participate in national research efforts, and begin to define “promising practices” for preventing, reducing, and eliminating the use of seclusion and restraint in all mental health programs. In addition, the Medical Directors Council recommends NASMHPD take the following actions:

- Continue working with NASMHPD Divisions, national and state partners, and consumers, families, and advocates to remove barriers for reducing and eliminating seclusion and restraint with individuals who have special needs.
- Confer with its partners at the national level, including the National Association of State Directors of Developmental Disability Services (NASDDDS) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD), to promote better understanding of treatment populations with co-occurring disorders, to integrate and coordinate treatment services, and to reduce and eliminate seclusion and restraint.
- Work with NASMHPD Divisions, states, and individual mental health programs to evaluate human resource development issues relevant to the use of seclusion and restraint. Develop a multifaceted strategy to advocate nationally and at the state level for human resource development improvements.
- Several proprietary staff training programs on seclusion and restraint are available to state mental health and developmental disability facilities. NASMHPD should explore the development of guidelines for states to evaluate staff training programs and curricula.
- Confer with the National Institutes of Mental Health and the Center for Mental Health Services to develop “promising practices” on the use of seclusion and restraint with special needs populations, including alternatives to such practices and tertiary prevention (i.e., “harm reduction”) when the use of seclusion and restraint is deemed necessary.

- The August 2000 discussion of the use of seclusion and restraint in forensic settings was incomplete due to time limitations. The NASMHPD Medical Directors Council recommends that NASMHPD arrange future meetings to permit this subject to be reviewed in more depth.

- Distribute this technical report to all state mental health agencies, interested federal agencies, and advocacy organizations.

Recommendations for the NASMHPD Research Institute, Inc. (NRI)

The NASMHPD Research Institute, Inc., (NRI), under the direction of its Board of Directors and the NASMHPD membership, has made a commitment to develop, maintain, and improve behavioral healthcare performance measures for state inpatient facilities that submit measures to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as part of that organization's ORYX requirements. Measures that relate to seclusion and restraint could be critical for understanding the complex efforts required to reduce and eliminate these practices. The NASMHPD Medical Directors Council makes the following recommendations to the NRI, independent of, and separate from, its ORYX performance measurement system.

- Conduct root-cause analysis to understand the entire system of care, including interactions between individuals and staff that precipitate seclusion and restraint events. Factors may include: (1) individual and staff demographic factors that influence program culture; (2) staff qualifications, length of employment, and salaries; (3) training available to staff; and (4) differences in day, swing, and night shift event rates related to staffing and active treatment.
- Conduct a functional analysis of programs that have successfully reduced or eliminated seclusion and restraint. Look at patient demographics, the physical design of programs, the mix of security and non-security staff employed, and staff roles in seclusion and restraint events. Disseminate information about these successful programs to all state mental health agencies.
- Do service research to evaluate "density" of special needs populations in mental health programs, the percentage of co-occurring disorders in these programs, and percentage of individuals in programs who are not affected by mental illness. Examine the relationship between density and seclusion and restraint events.
- Research efforts should pay particular attention to mental health programs at both ends of the seclusion and restraint data distribution continuum (i.e., outliers). Such analysis would include: total population under consideration; program outliers; and populations remaining after program outliers have been removed.
- In conjunction with the NASMHPD Technical Assistance Center for State Mental Health Planning (NTAC), survey state facilities to learn the types, amounts, and effects of training provided to staff to reduce and eliminate seclusion and restraint.

- ❑ The impact of staff training courses on seclusion and restraint needs to be evaluated. Conduct comparative evaluations of the effectiveness of these courses. Evaluate the effect of program culture and staff competence on reducing and eliminating seclusion and restraint.

Recommendations for State Mental Health Agencies

The NASMHPD Medical Directors Council recommends that state mental health agencies take the following steps to prevent, reduce, and eliminate seclusion and restraint in their mental health programs.

- Work with NASMHPD on state and national strategies advocating human resource development improvements to reduce and eliminate seclusion and restraint.
- Evaluate program culture and work force issues (e.g., staff demographics, supervisory structures, salary rates) that may affect use of seclusion and restraint.
- Use NRI performance measurement data in continuous quality improvement processes to reduce and eliminate seclusion and restraint.
- Encourage reciprocal consultations among local treatment specialists (e.g., behavior, alcohol and drug) and mental health specialists, including ones outside the system of state-operated programs. The aim of consultation should be to ensure that the treatment and habilitation needs of individuals with co-occurring disorders are identified and that appropriate, coordinated and/or integrated services are available.
- Establish or expand state agency-university collaboration to reduce and eliminate seclusion and restraint, especially an exchange of research opportunities, training, and curricula development.
- States are encouraged to share local research findings with the NRI and other recognized research organizations.
- Consider developing information videos for mental health programs that describe client rights, grievance policies of state facilities, and local policies and procedures for the use of seclusion and restraint.
- Programs need technical assistance to evaluate the safety and effectiveness of restraint products, including their ability to preserve individual dignity and privacy when used. Purchase and use of restraint or safety products should be determined by informed decisions, not staff bias, manufacturer pressure, or cost. For any program considering their use, it is recommended that if several similar products are available, each should be tested and evaluated before a purchase decision is made.

Appendices

Selected References

Bath, H., 1994. "The Physical Restraint of Children: Is It Therapeutic?," American Journal of Orthopsychiatry, 64(1), 40-49.

Caley, L. M. and Pinchoff, D. M., 1991. "Some Considerations in Clinical Evaluation of Mental Health Care Products," Psychiatric Quarterly, 62(4), 311-322.

State of Connecticut, Office of the Child Advocate, May 1998. Child Fatality Review Panel, Investigation into the Death of Andrew M., Part I: The Immediate Circumstances.

Fisher, W. A., 1994. "Restraint and Seclusion: A Review of the Literature," American Journal of Psychiatry, 151(11), 1584-1591.

Heilbrun, K., Golloway, G. C., Shoukry, V. E., and Gustafson, D., 1995. "Physical Control of Patients on an Inpatient Setting: Forensic vs. Civil Populations," Psychiatric Quarterly, 66(2), 133-145.

Morales, E. and Duphorne, P. L., 1995. "Least Restrictive Measures: Alternatives to Four-Point Restraints and Seclusion," Journal of Psychosocial Nursing, 33(10), 13-16.

Sullivan-Marx, E. M., 1995. "Psychological Responses to Physical Restraint Use in Older Adults," Journal of Psychosocial Nursing, 33(6), 20-25.

Visalli, H. and McNasser, G., 1997. "Striving Toward a Best Practice Model for a Restraint-Free Environment," Performance Improvement Ideas and Innovations, 1-4.

Visalli, H., McNasser, G., Johnstone, L., and Lazzaro, C. A., 1997. "Reducing High-Risk Interventions for Managing Aggression in Psychiatric Settings," Journal of Nursing Care Quality, 11(3), 54-61.

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ON SECLUSION AND RESTRAINT**

August 17-18, 2000
The Benson Hotel, Portland, Oregon

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