

Reducing Conflict, Violence, and the Use of Seclusion & Restraint in Mental Health Settings NASMHPD's Office of Technical Assistance

The controversial and potentially dangerous interventions known as seclusion and restraint have received an extraordinarily increased level of interest, oversight and regulation by legislators and policy makers in recent years (*NETI, 2003*). In part, this interest is in response to increasing reports of aggressive and violent incidents occurring in inpatient settings that serve people with mental health conditions (*Duxbury, 2002*). Reports of aggression and violence in mental health settings have a significant impact on quality of care provided, safety for service users and staff, staff morale, and staff turnover (*Owen, Tarantello, Jones & Tennant, 1998; Haim, Rabinowitz, Lereya, & Fennig, 2002*).

Seclusion and restraint are the interventions most commonly chosen by staff in situations characterized by the threat of either verbal and/or physical aggression, and the use of these interventions often result in injuries for both parties (*Duxbury, 2002*).

Seclusion is defined, following regulatory guidelines, as the “involuntary confinement of a person in a room where they are physically prevented from leaving or believe they are” (*NETI, 2003*). A seclusion event begins when the person is detained physically or escorted involuntarily by staff to the seclusion room and ends when the door is unlocked and the person is informed that they can leave.

Restraint is a manual method or mechanical device, material, or equipment attached or adjacent to a person’s body that is not easily removed, and restricts the person’s freedom or normal access to one’s body (*NETI, 2003*). Restraint in this context includes leather or plastic cuffs for extremity immobilization, wrist to waste or ankle hobbles, lap belts, lap trays attached to chairs, restraint chairs, posey vests, bed rails when the person cannot remove these to exit, and any physical hold used most frequently with children (*NETI, 2003*). A restraint event begins when the person is detained physically and/or escorted or transferred, involuntarily, by staff to the restraint room, and ends when the restraint is removed. Manual restraint or physical holds are counted as restraints, but do not include the use of restraint equipment or restraint rooms. Most of these kinds of interventions are done without consent or willing compliance by the service user, although some individuals have become institutionalized to their use, and only argue momentarily (*NETI, 2003*).

Restraint and take down interventions alone are estimated to cause up to 1240 serious injuries or deaths affecting service users each year in the United States, according to the

Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 2005). The incidence of staff injuries has been studied much less, but one survey conducted in three states reported 26 injuries for every 100 mental health technicians (Weiss, Altimari, Blint, & Megan, 1998). This reported injury rate surpassed rates found in the lumber, construction and mining industries, and highlighted the safety issues in inpatient mental health environments (Weiss et al., 1998). As such, seclusion and restraint interventions are seen as high risk and potentially quite dangerous for both clients and staff, and have resulted in Federal, State and legal mandates to mental health facilities to significantly reduce or eliminate their use (NASMHPD, 1999; SAMHSA, 2004; CMS, 2002).

This Training and Technical Assistance (T&TA) work is designed to provide knowledge and a change in attitudes in mental health staff who work in community and institutional inpatient and residential settings. The primary overlay is a prevention approach to conflict and violence using primary, secondary, and tertiary prevention interventions, along with an understanding of the principles underlying trauma informed care and recovery, and the use of continuous improvement processes.

Target Audience: Executive, senior, and middle management staff in state mental health offices and, specifically, in facilities or agencies providing direct services.

Venue: Onsite training for 2 or 2.5 days with plan development. For any state or region, up to 300 leadership staff, and not less than 60 can be trained. Teams from each facility must be not less than 8-10.

Outcomes: Reduction in injuries to service users and staff, reductions in S/R use, reduction in use of stat involuntary medications, increased safety and staff/service user satisfaction.

TA Methods: Developed curriculum based on wide literature review, research, and actual practices. Uses multiple expert faculty to provide training. Training methods include didactic, experiential, drama, and developing a written plan for individual facilities. Curriculum is CEU ready with objectives, references, faculty bios, and evaluation forms. Curriculum has been used to train over 300 facilities nationally and internationally and over 3,500 staff leaders. Usual rating on a 5 point rating scale is 4.3 or more. Staff who participate receive all the training modules with trainer narratives on CD, all handouts, and any reference materials they would like to use.

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REFERENCES:

Center for Medicare and Medicaid Services (CMS). (2002, October). *Testimony from the public hearing on the one hour rule*. Baltimore, MD: CMS

Duxbury, J. (2002). An evaluation of staff and patient views of and strategies employed to manage inpatient aggression and violence on one mental health unit: A pluralistic design. *Journal of Psychiatric Mental Health Nursing*, 9 (3), 325-37.

Haim, R., Rabinowitz, J., Lereya, J., & Fennig, S. (2002). Predictions made by psychiatrists and psychiatric nurses of violence by patients. *Psychiatric Services*, 53, 622-624.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO). (2005). The Joint Commission's sentinel event policy: Ten years of improving the quality and safety of health care. *Perspectives*, 25, 5, 1-4.

National Association of State Mental Health Program Directors (NASMHPD). (1999, July 13). *NASMHPD position statement on seclusion and restraint*. Alexandria, VA: National Association of State Mental Health Program Directors.

National Executive Training Institute (NETI). (2003). *Training curriculum for reduction of seclusion and restraint. Draft curriculum manual*. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD), National Technical Assistance Center for State Mental Health Planning (NTAC).

Owen, C., Tarantello, C., Jones, M., & Tennant, C. (1998). Violence and aggression in psychiatric units. *Psychiatric Services*, 49, 1452-1457.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2004). *SAMHSA priorities: Programs and principles matrix*. Retrieved from the Internet on January 5, 2004 at: <http://www.samhsa.gov/policy/content/matrix>.

Weiss, E. M., Altimari, D., Blint, D. F. et al. (October 1998). Deadly restraints. *The Hartford Courant*.