

Second in  
a series of  
Technical  
Reports



# Reducing the Use of Seclusion and Restraint:

*Findings, Strategies, and Recommendations*

National Association of State Mental Health Program Directors'

## **Medical Directors Council**

66 Canal Center Plaza, Suite 302, Alexandria, VA 22314

(703) 739-9333 — FAX (703) 548-9517

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## **Acknowledgments**

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*Thomas W. Hester, M.D.  
Medical Director and Director of Facility Operations  
Georgia Division of Mental Health, Mental Retardation, and Substance Abuse*

## Process of Report Preparation

### III Background and Purpose

This report was prepared by the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council as one of an ongoing series of documents intended to provide information and assistance to state mental health commissioners/directors on emerging issues of clinical concern. Topics for technical reports are identified by the Medical Directors Council in conjunction with NASMHPD leadership. In order to ensure that Technical Reports are useful to all the populations served by state mental health systems, each report is, depending on the topic, developed through a process involving NASMHPD divisions and affiliates and outside experts.

The use of seclusion and restraint has been of long-standing concern to state mental health commissioners/directors and to state medical directors. Federal legislation is now being considered to address this issue. NASMHPD is developing an action plan for addressing the use of seclusion and restraint in public mental health settings; this report is the first step in the development of the action plan. The preparation of this report is particularly timely in view of tragedies brought to light by a series of articles in the *Hartford Courant* newspaper.

This report is intended to help guide the development of and to complement a NASMHPD position statement on seclusion and restraint. It includes specific recommendations for action to NASMHPD and to state mental health agencies. It is also intended as a tool for helping states to prevent and reduce the overall need for seclusion and restraint, and to employ “best practices” whenever these interventions are used.

### III Preparation of the Report

This report was prepared from the proceedings of a meeting held on February 18 and 19, 1999, in Atlanta, Georgia. Participants in the meeting included two state mental health commissioners/directors, five medical directors, two representatives from state offices of consumer affairs, representatives from other NASMHPD divisions, affiliates, and relevant workgroups, and NASMHPD staff. Representatives were selected by their organizations on the basis of experience, interest, and knowledge about the issue. An external facilitator and a technical writer assisted in the process. A list of participants and their organizational affiliations is included in the Appendix.

Prior to the meeting, relevant materials from the research literature, state policy manuals, and national advocacy groups were distributed to all participants. Although the materials did not reflect an exhaustive search, they provided a comprehensive overview of the field, and formed an empirical basis for the group discussion. This report attempts to integrate the major findings

from the literature as discussed at the meeting with the diverse perspectives and personal experiences brought to the table by meeting participants.

During the meeting, participants engaged in a spirited discussion and debate, putting all sides of the issue on the table, sharing their own viewpoints and personal experiences, and ultimately forging a strong sense of partnership and collaboration in grappling with these very difficult issues. An attempt has been made to capture the complexity of the discussion while striving to integrate different perspectives whenever possible.

### **III Editorial Review**

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. The final report was reviewed, amended, and approved by the Medical Directors Council and does not necessarily reflect the viewpoint of the NASMHPD membership.

As part of its review, the Medical Directors Council identified the following issues for further work:

- Differentiation of seclusion from restraint;
- Differentiation of levels of restraint, including protective devices;
- Definition of appropriate environments for use of seclusion and restraint;
- Review of chemical restraints and involuntary medication; and
- Examination of the process of restraining patients (as this is the time of most danger).

## Problem Statement

### **||| Definition of the Issues**

The issues raised by the use of seclusion and restraint in the mental health system go far beyond a narrow focus on the techniques involved in the use of these interventions. The overutilization of seclusion and restraint can be seen as a symptom of a larger problem in the culture of the clinical environment. An effective approach to this issue will, therefore, need to include consideration of clinical and cultural issues.

Misapplication of the techniques of seclusion and restraint creates safety problems for both the individual and the staff involved. The rate of work-related injuries is higher in mental health than in the construction industry, and more staff injuries occur during the implementation of seclusion and restraint than occur from unexpected assaults. Thus this report will take a broad, inclusive approach to the issue of the use of seclusion and restraint, attempting to convey some of the complexities involved. The report begins with a discussion of prevention and early intervention, and then identifies standards for safe and effective implementation.

In a fundamental way, this issue is about how mental health systems treat the people they serve. If the goals of the public mental health system are to treat people with dignity, respect and mutuality, to protect people's rights, to provide the best quality care possible, and to assist people in their recovery, any use of seclusion and restraint must be rigorously scrutinized. Many people enter the mental health system for help in coping with the aftermath of traumatic experiences. Others enter the system in hope of learning how to control symptoms that have left them feeling helpless, hopeless, and deeply fearful. Still others enter the system involuntarily. In these cases, the need for treatment has been expressed by the committing authority, not by the recipient. Any intervention that recreates aspects of previous traumatic experiences or that uses power to punish is harmful to the individuals involved. In addition, using power to control people's behavior or to resolve arguments can lead to escalation of conflict and can ultimately result in serious injury or even death.

### **||| Consensus Reached by Participants**

Given that seclusion and restraint are virtually always experienced by the individuals involved as traumatic, put both staff and patients at risk, and can seriously jeopardize the treatment milieu, are there ever instances when these interventions are justified? It was a consensus of those present that seclusion and restraint are justified only if they are being used for the clearly defined purpose of maintaining safety and if all other, less intrusive interventions have failed. Clearly, these factors will vary according to setting, with acute care and emergency room settings presenting a different challenge from long-term care settings. For example, substance abuse is more likely to be a complicating factor in emergency room settings than in long-term care facilities. Similarly, the justification for the use of seclusion and restraint may vary over time

even within the same setting, depending on what other alternatives have been tried and on other factors affecting the basic safety of the unit.

Regardless of the context, it is critical that seclusion or restraint be used only as a “last resort measure” to maintain safety. Substantial care must be taken to define the situations in which safety concerns are strong enough to justify the use of seclusion and restraint. Seclusion should be used only in situations of imminent risk to self or others or serious disruption to the treatment milieu, restraint only in situations of imminent risk. Neither technique should ever be included as part of an individual’s treatment plan, or as part of the day-to-day management of a unit. Finally, these interventions should under no circumstances be used as a threat, either implicitly or explicitly, nor should they ever be used as punishment.

Seclusion and restraint should be considered a security measure, not a form of medical treatment. However, given the medical risk of serious injury or even death posed to recipients, the use of seclusion and restraint should be medically supervised.

In addition to seclusion and restraint, it is imperative that other forms of control be closely monitored to ensure that one potentially abusive practice is not substituted for another. In particular, the use of emergency psychotropic medications should be closely monitored. When used properly, psychotropic medications can be helpful in treating agitation due to mental illness, allowing a complete clinical and medical assessment to be done. However, drugs should not be used solely to immobilize or sedate people as a mechanism for control. Over-medication and polypharmacy are of particular concern with children. Similarly, the use of law enforcement and stringent behavioral programs, while appropriate under some circumstances, should always be monitored to prevent misuse.

## Findings: What Works and What Doesn't Work

### III Overview of Research Findings

Review of the literature and discussion with clinical and administrative leaders in the mental health field reveals that well-documented, effective practices exist to reduce violence and simultaneously reduce or eliminate the use of restrictive measures such as seclusion and restraint. New and emerging treatment approaches in mental health — including a new understanding of the value of peer-delivered services and self-help techniques as well as new medications, a new emphasis on recovery, and an emerging understanding about the relationship between trauma and mental illness — make it increasingly possible to treat people with severe symptoms without resorting to coercive strategies. However, there is a significant gap between what we know about preventing violence and creating a safe clinical environment and what is practiced in many mental health settings. In addition, there is little research on the safest and least harmful methods to implement seclusion and restraint, or on the most effective methods for monitoring and making release decisions.

The most effective approach to take when considering the use of seclusion and restraint is a public health model, which addresses primary prevention (in this context, preventing and reducing the need for seclusion and restraint); secondary prevention (early intervention, using the least restrictive methods possible); and tertiary prevention (intervention to reverse or prevent negative consequences), and which uses feedback from each stage to inform and improve subsequent actions. A public health model should always lead to the selection and use of the least possible restriction consistent with the purpose of the intervention.

With this kind of approach, attention would be directed first towards establishing a culture that would minimize the occurrence of events that might lead to the use of seclusion and restraint, and that would emphasize the importance of valuing what service recipients say about what contributes to a safe environment. Efforts would also be made to ensure that conflicts are identified early and resolved before they can escalate, and that all staff are trained and experienced in techniques of early intervention. Finally, policies and procedures as well as staff training would support the safe use of seclusion and restraint on those rare occasions when it was required to maintain safety. Staff and service recipients would fully debrief each instance of the use of seclusion or restraint. Information obtained from the debriefing would be used to help understand what precipitated the event and how similar situations could be avoided in the future.

