

APNA Position Papers

2007 Position Statement on the Use of Seclusion and Restraint (Original, 2000; Revised, 2007)

Introduction

Psychiatric-mental health nursing has a 100-year history of caring for persons in psychiatric facilities. Currently, nurses serve as front-line care providers as well as unit-based and executive level administrators in virtually every organization providing inpatient psychiatric treatment. Therefore, as the professional organization for psychiatric-mental health nurses, the American Psychiatric Nurses Association (APNA) recognizes that the ultimate responsibility for maintaining the safety of both individuals and staff in the treatment environment and for maintaining standards of care in the day-to-day treatment of individuals rests with nursing and the hospital leadership or behavioral health care organization leadership that supports the unit. Thus, APNA supports a sustained commitment to the reduction and ultimate elimination of seclusion and restraint and advocates for continued research to support evidence-based practice for the prevention and management of behavioral emergencies. Furthermore, we recognize the need for and are committed to working together with physicians, clients and families, advocacy groups, other health providers and our nursing colleagues in order to achieve the reality of eliminating seclusion and restraint.

Background

In the mid-1800's proponents of "moral treatment" of psychiatric patients advocated the elimination of the practice of restraining patients. Despite the relative success of this movement in England and Europe, psychiatrists in the United States concluded that restraints could never be eliminated in the United States (Bockoven, 1963; Deutsch, 1949; Rogers & Bocchino, 1999; Strumpf & Tomes, 1993). Until recently, belief in the necessity for continuing the practice of secluding and restraining patients persisted. For example, in 1994, Fisher concluded from his review of the literature that not only was it "nearly impossible to operate a program for severely symptomatic individuals without some form of seclusion or physical or mechanical restraint" (p. 1584) but that these methods were effective in preventing injury and reducing agitation. Others, however, concluded that the practice of restraining and secluding patients was not grounded in research that supported the therapeutic efficacy of this intervention, but upon the observation that these measures interrupted and controlled the patient's behavior (Allen, 2000; Bower, McCullough & Timmons, 2003; Walsh & Randell, 1995).

Reports of patient death and injury while in restraints (Evans, Wood & Lambert, 2003; Mohr, Petti & Mohr, 2003; Nunno, Holden & Tollar, 2006; Weiss, 1998) and studies of patients' experiences in restraint and seclusion (Johnson, 1998; Holmes, Kennedy & Perron, 2004; Meehan, Vermeer & Windsor, 2000) have prompted psychiatric-mental health nurses to question the benefit of secluding and restraining psychiatric patients. These studies bring to the fore the ethical dilemmas inherent in the use of seclusion and restraints (Bower, et al., 2003; Lee, et al., 2003; Mohr, Mahon & Noone, 1998). On the one hand, this practice has the potential for physically and/or psychologically harming patients (Evans, et al., 2003; Martinez, Grimm & Adamson, 1999; Mohr, et al., 2003) and for violating the patient's right to autonomy and self-determination (Bower, et al., 2003; Prescott, 2001) On the other hand, studies of violence on inpatient units underscore the reality that violence often

cannot be predicted. Since the nursing staff are held responsible for maintaining the safety of all of the patients, they often see seclusion and restraint as a necessary last-resort intervention to maintain that safety (Alty, 1997; Lee, et al., 2003). Therefore, studies of the impact of assault on those who care for patients must be taken into consideration when developing standards for practice and when addressing organizational strategies to assure equal commitment to worker as well as patient safety (OSHA, 1998; Flannery & Walker, 2003; Kindy, Petersen & Parkhurst, 2005; Lanza, 1992; Nijman, Bowers, Oud, & Jansen, 2005; Poster, 1996; Poster & Ryan, 1994; Ryan & Poster, 1989; Ryan, Hart, Messick, Aaron, & Burnette, 2004).

Research has highlighted the influence of unit philosophy and culture, treatment philosophy, staff attitudes, staff availability, staff training, ratios of patients to staff and location in the United States on either the disparity in the incidence of seclusion and restraint or the perpetuation of the practice of secluding and restraining psychiatric patients (Bower, et al., 2003; Gerolamo, 2006; Holzworth & Wills, 1999; Morrison, 1990, 1992, 1993, 1994, 1998; Sailas & Wahlbeck, 2005). From the research, it appears that the key to seclusion and restraint reduction is prevention of aggression by (a) maintaining a presence on the unit and noticing early changes in the patient and the milieu (Delaney & Johnson, 2006; Johnson & Delaney, 2007), (b) assessing the patient and intervening early with less restrictive measures such as verbal and non-verbal communication, reduced stimulation, active listening, diversionary techniques, limit setting and prn medication (Canatsey & Roper, 1997; Johnson & Hauser, 2001; Johnson & Delaney, 2007; Lehane & Rees, 1996; Maier, 1996; Martin, 1995; Morales & Duphorne, 1995; Richmond, Trujillo, Schmelzer, Phillips, & Davis, 1996) and (c) changing aspects of the unit to promote a culture of structure, calmness, negotiation and collaboration rather than control (Cahill, Stuart, Laraia & Arana, 1991; Delaney, 1994; Harris & Morrison, 1995; Johnson & Morrison, 1993; Whittington & Patterson, 1996).

To date, there is some evidence that changes in a unit's treatment philosophy can lead to changes in patient behavior that will ultimately impact the incidence of the use of seclusion and/or restraints (Bennington-Davis & Murphy, 2004; Goren, Abraham & Doyle, 1996; Huckshorn, 2004; LeBel et al., 2004; Regan, Curtin & Vorderer, 2006). There is also growing awareness that inpatient treatment must be shaped by the principles of trauma-informed care and the recovery movement and that these philosophies will create a collaborative spirit that is essential to restraint reduction and elimination efforts (Bloom, et al., 2003; SAMSHA, 2005)

Despite the best efforts at preventing the use of seclusion and restraint, there may be times that these measures are used. Thus, it is important to be cognizant of the vulnerability of individuals who are secluded or restrained and the risks involved in using these measures (Mohr, et al., 2003; Nunno, et al., 2006; Weiss, 1998). Moreover, the dangers inherent in the use of seclusion and restraint include the possibility that the person's behavior is a manifestation of an organic or physiological problem that requires medical intervention and may therefore, predispose the person to increased physiological risk during the time the individual is secluded or restrained. Therefore, skilled assessments of individuals who are restrained or secluded will not only ensure the safety of individuals in these vulnerable conditions but also will ensure that the measures are discontinued as soon as the individual is able to be safely released.

Position Statement

APNA believes that psychiatric-mental health nurses play a critical role in the provision of care to persons in psychiatric settings. This role requires that nurses provide effective treatment and milieu leadership to maximize the individual's ability to effectively manage potentially dangerous behaviors. To that end, we strive to assist the individual in minimizing the circumstances that give rise to seclusion and restraint use. Therefore:

- We advocate for policies at the federal, state, and other organizational levels that will protect individuals from needless trauma associated with seclusion and restraint use while supporting both individual and staff safety.
- We take responsibility for providing ongoing opportunities for professional growth and learning for the psychiatric-mental health nurse whose treatment promotes individual safety, as well as autonomy and a sense of personal control.
- We promulgate professional standards that apply to all populations and in all settings where behavioral emergencies occur and that provide the framework for quality care for all individuals whose behaviors constitute a risk for safety to themselves or others.
- We advocate and support evidence-based practice through research directed toward examining the variables associated with the prevention of and safe management of behavioral emergencies.
- We recognize that organizational characteristics have substantial influence on individual safety and call for shared ownership among leaders to create a work culture that supports minimal seclusion and restraint use and that will enable the vision of elimination to be realized.
- We articulate the following fundamental principles to guide action on the issue of seclusion and restraint:
 - Individuals have the right to be treated with respect and dignity and in a safe, humane, culturally sensitive and developmentally appropriate manner that respects individual choice and maximizes self determination.
 - Seclusion or restraint must never be used for staff convenience or to punish or coerce individuals.
 - Seclusion or restraint must be used for the minimal amount of time necessary and only to ensure the physical safety of the individual, other patients or staff members and when less restrictive measures have proven ineffective.
 - Individuals who are restrained must be afforded maximum freedom of movement while assuring the physical safety of the individual and others. The least number of restraint points must be utilized and the individual must be continuously observed.
 - Seclusion and restraint reduction and elimination requires preventative interventions at both the individual and milieu management levels using evidence based practice.
 - Seclusion and restraint use is influenced by the organizational culture that develops norms for how persons are treated. Seclusion and restraint reduction and elimination efforts must include a focus on necessary culture change.

- Effective administrative and clinical structures and processes must be in place to prevent behavioral emergencies and to support the implementation of alternatives.
- Hospital and behavioral healthcare organizations and their nursing leadership groups must make commitments of adequate professional staffing levels, staff time and resources to assure that staff are adequately trained and currently competent to perform treatment processes, milieu management, de-escalation techniques and seclusion or restraint.
- Oversight of seclusion and restraint must be an integral part of an organization's performance improvement effort and these data must be open for inspection by internal and external regulatory agencies. Reporting requirements must be based on a common definition of seclusion and restraint. Specific data requirements must be consistent across regulatory agencies.
- Movement toward future elimination of seclusion and restraint requires instituting and supporting less intrusive, preventative, and evidence-based interventions in behavioral emergencies that aid in minimizing aggression while promoting safety.

Acknowledgements:

2007 APNA Seclusion and Restraint Steering Committee: Lynn DeLacy (Chair), Amy Rushton (Co-Chair), Diane Allen, Hyman Beshansky, Laura Curtis, Kathleen Delaney, Germaine Edinger, Carole Farley-Toombs, Kathryn Fritsche, Susan Griffin, Lyons Hardy, Mary E. Johnson, William Koehler, Georganne Kuberski, Lee Liles, Kathleen McCann, Marlene Nadler- Moodie, Pamela Nold, Douglas Olsen, Kathleen Regan, , Theodora Sirota, Joan van der Bijl, Karen Vergano, Theresa Warfield.

2000 APNA Seclusion and Restraint Task Force: Lynn DeLacy (Chair), Terri Chapman, Sue Ciarmiello, Kathleen Delaney, Germaine Edinger, Carole Farley-Toombs, Mary Johnson, Lyn Marshall, Marlene Nadler- Moodie, Marilyn Nendza, Pamela Nold, Linda Ovitt, Brenda Shostrom, Mary Thomas, Linda Wolff

Approved by APNA Board of Directors, May 26th, 2007

References

- Allen, J.J. (2000). Seclusion and restraint of children: a literature review. *Journal of Child and Adolescent Psychiatric Nursing, 13*, 159-167.
- Alty, A. (1997). Nurses' learning experience and expressed opinions regarding seclusion practice within one NHS trust. *Journal of Advanced Nursing, 25*, 786-793.
- Bennington-Davis M. & Murphy T. (2004). Eliminating seclusion and restraint. *Clinical Psychiatry New, 32*, 16.
- Bloom, S.L., McCorkle, D., Farragher, B., Nice-Martini, K., Wellbank, K., Bennington-Davis, M. (2003). Multiple opportunities for creating sanctuary. *Psychiatric Quarterly, 74*, 173-190.
- Bockoven, J.S. (1963). *Moral treatment in American psychiatry*. New York: Springer Publishing Co.
- Bower, F.L., McCullough, C.S., & Timmons, M.E. (2003). A synthesis of what we know about the use of physical restraints and seclusion with patients in psychiatric and acute care settings: 2003 update. *The Online Journal of Knowledge Synthesis for Nursing, 10*, Document Number 1.
- Cahill, C., Stuart, G., Laraia, M., Arana, G., (1991). Inpatient management of violent behavior: nursing prevention and intervention. *Issues in Mental Health Nursing, 12*, 239-252.
- Canatsey, K. & Roper, J. (1997). Removal from stimuli for crisis intervention: Using least restrictive methods to improve the quality of patient care. *Issues in Mental Health Nursing, 18*, 35-44.
- Delaney, K. (1994). Calming an escalated psychiatric milieu. *Journal of Child and Adolescent Psychiatric Nursing, 7*(3), 5-13.
- Delaney, K.R. & Johnson, M.E. (2006). Keeping the unit safe: mapping psychiatric nursing skills. *Journal of the American Psychiatric Nurses Association, 12*(4), 1-10.
- Deutsch, A. (1949). *The mentally ill in America*. New York: Columbia University Press.
- Evans, D., Wood, J., & Lambert, L. (2003). Patient injury and physical restraint devices: a systematic review. *Journal of Advanced Nursing, 41*, 274-282.
- Fisher, W. (1994). Restraint and seclusion: A review of the literature. *American Journal of Psychiatry, 151*, 1584-1591.
- Flannery, R.B & Walker, A.P. (2003). Safety skills of mental health workers: empirical evidence of a risk management strategy. *Psychiatric Quarterly, 74*, 1-10.

- Gerolamo, A.M. (2006). The conceptualization of physical restraint as a nurse-sensitive adverse outcome in acute care psychiatric treatment settings. *Archives of Psychiatric Nursing, 20*, 175-185.
- Goren, S., Abraham, I. & Doyle, N. (1996). Reducing violence in a child psychiatric hospital through planned organizational change. *Journal of Child and Adolescent Psychiatric Nursing, 9*(2), 27-36.
- Harris, D. & Morrison, E., (1995). Managing violence without coercion. *Archives of Psychiatric Nursing, 9*, 203-210.
- Holzworth, R. & Wills, C. (1999). Nurses' judgments regarding seclusion and restraint of psychiatric patients: A social judgment analysis. *Research in Nursing and Health, 22*, 189-201.
- Holmes, D., Kennedy, S.L., & Perron, A. (2004). The mentally ill and social exclusion; a critical examination of the use of seclusion from the patient's perspective. *Issues in Mental Health Nursing, 25*, 559-578.
- Huckshorn, K.A. (2004). Reducing seclusion and restraint use in mental health settings. Core strategies for prevention. *Journal of Psychosocial Nursing and Mental Health Services, 42*, 22-23.
- Johnson, M.E (1998). Being restrained: a study of power and powerlessness. *Issues in Mental Health Nursing, 19*, 191-206.
- Johnson, M.E. & Delaney, K.R. (2007). Keeping the unit safe: the anatomy of escalation. *Journal of the American Psychiatric Nurses Association, 13*(1). 42-52.
- Johnson, M.E. & Hauser, P.M. (2001). The practices of expert psychiatric nurses: accompanying the patient to a calmer personal space. *Issues in Mental Health Nursing, 22*, 651-668.
- Johnson, K. & Morrison, E. (1993). Control or negotiation: a health care challenge. *Nursing Administration Quarterly, 17*, 27-33.
- Kindy, D., Petersen, S., & Parkhurst, D. (2005). Perilous work: nurses' experiences in psychiatric units with high risks of assault. *Archives of Psychiatric Nursing, 19*, 169-175.
- LeBel, J., Stromberg, N., Duckworth, K., Kerzner, J., Goldstein, R., Weeks, M., Harper, G., & Sudders, M. (2004). Child and adolescent inpatient restraint reduction: a state initiative to promote strength-based care. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 37-45.
- Lehane, M. & Rees, C. (1996). Alternatives to seclusion in psychiatric care. *British Journal of Nursing, 5*, 974, 976-979.
- Lanza, M. (1992). Nurses as patient assault victims: An update, synthesis, and recommendations. *Archives of Psychiatric Nursing, 6*, 163-171.

- Lee, S., Gray, R., Gournay, K., Wright, S., Parr, A.-M., & Sayer, J. (2003) Views of nursing staff on the use of physical restraint. *Journal of Psychiatric and Mental Health Nursing, 10*, 425-530.
- Maier, G. (1996). Managing threatening behavior. The role of talk down and talk up. *Journal of Psychosocial Nursing, 34*, 25-30.
- Martin, K. (1995). Improving staff safety through an aggression management program. *Archives of Psychiatric Nursing, 9*, 211-215.
- Martinez, R., Grimm, M. & Adamson, M. (1999). From the other side of the door: Patient views of seclusion. *Journal of Psychosocial Nursing, 73* (3), 13-22.
- Meehan, T., Vermeer, C., & Windsor, C. (2000). Patients' perceptions of seclusion: a qualitative investigation. *Journal of Advanced Nursing, 31*, 370-377.
- Mohr, W.K., Petti, T.A., & Mohr, B.D. (2003). Adverse effects associated with physical restraint. *Canadian Journal of Psychiatry, 48*, 330-337.
- Mohr, W., Mahon, M. & Noone, M. (1998). A restraint on restraints: The need to reconsider the use of restrictive interventions. *Archives of Psychiatric Nursing, 12*, 95-106.
- Morales, E. & Duphorne, P. (1995). Least restrictive measures: alternatives to four-point restraints and seclusion. *Journal of Psychosocial Nursing and Mental Health Services, 33*, 13-16; 42-43.
- Morrison, E.F. (1990). The tradition of toughness: A study of nonprofessional nursing care in psychiatric settings. *Image: Journal of Nursing Scholarship, 22*, 32-38.
- Morrison, E. (1992). A coercive interactional style as an antecedent to aggression in psychiatric patients. *Research in Nursing and Health, 15*, 421-431.
- Morrison, E. (1993). Toward a better understanding of violence in psychiatric settings: debunking the myths. *Archives of Psychiatric Nursing, 7*, 328-335.
- Morrison, E. (1994). The evolution of a concept: aggression and violence in psychiatric settings. *Archives of Psychiatric Nursing, 8*, 245-253.
- Morrison, E. (1998). The culture of caregiving and aggression in psychiatric settings. *Archives of Psychiatric Nursing, 12*, 21-31.
- Nijman, H., Bowers, L., Oud, N., & Jansen, G. (2005). Psychiatric nurses' experience with inpatient aggression. *Aggressive Behavior, 31*, 217-227.
- Nunno, M.A., Holden, M., & Tollar, A. (2006). Learning from tragedy: a survey of child and adolescent restraint fatalities. *Child Abuse and Neglect, 30*, 1333-1342.

- Occupational Safety and Health Administration. (1998). Guidelines for preventing workplace violence for health care and social service workers (OSHA Publication No. 3148). Washington, DC: Author.
- Poster, E.C. (1996). A multinational study of psychiatric nursing staffs' beliefs and concerns about work safety and patient assault. *Archives of Psychiatric Nursing, 10*, 365-373.
- Poster, E.C. & Ryan, J. (1989). Nurses' attitudes toward physical assaults by patients. *Archives of Psychiatric Nursing, 3*, 315-322.
- Poster, E.C. & Ryan, J. (1994). A multiregional study of nurses' beliefs and attitudes about work safety and patient assault. *Hospital and Community Psychiatry, 45*, 1104-1108.
- Prescott, L. (2001). Defining the role of consumer-survivors in trauma-informed systems. In M. Harris & R. Fallot (Eds). *New Directions for Mental Health Services, Using Trauma Theory to Design Service Systems* (pp. 83-89). : Jossey-Bass.
- Regan, K., Curtin, C., & Vorderer, L. (2006). Paradigm shifts in inpatient psychiatric care of children: approaching child and family-centered care. *Journal of Child and Adolescent Psychiatric Nursing, 19*, 29-40.
- Richmond, I., Trujillo, D., Schmelzer, J. Phillips, S. & Davis, D. (1996). Least restrictive alternatives: Do they really work? *Journal of Nursing Care Quality, 11*, 29-37.
- Rogers, P.D. & Bocchino, N.L. (1999). Restraint-free care! Is it possible? *American Journal of Nursing, 99* (10), 26-33.
- Ryan, E.P., Hart, V.S., Messick, D.L., Aaron, J., & Burnette, M. (2004). A prospective study of assault against staff by youths in a state psychiatric hospital. *Psychiatric Services, 55*, 665-670.
- Ryan, J. & Poster, E.C. (1989). The assaulted nurse: Short-term and long-term responses. *Archives of Psychiatric Nursing, 3*, 323-331.
- Sailas, E. & Wahlbeck, K. (2005). Restraint and seclusion in psychiatric inpatient wards. *Current Opinion in Psychiatry, 18*, 555-559.
- Strumpf, N. & Tomes, N. (1993). Restraining the troublesome patient. A historical perspective on a contemporary debate. *Nursing History Review, 1*, 3-24.
- Substance Abuse and Mental Health Services Administration (SAMHSA) (2005). Transforming mental health care in America. The Federal Action: First Steps. Retrieved on September 1, 2006 from http://www.samhsa.gov/Federalactionagenda/NFC_intro.aspx.
- Walsh E. & Randell, B. (1995). Seclusion and restraint: what we need to know. *Journal of Child and Adolescent Psychiatric Nursing, 8*, 28-40.

Weiss, E. (October 11-15, 1998). Deadly restraint: A nationwide pattern of death.
The Hartford Courant.

Whittington, R. & Patterson, P. (1996). Verbal and non-verbal behavior immediately prior to aggression by mentally disordered people: enhancing the assessment of risk. *Journal of Psychiatric and Mental Health Nursing*, 3(1), 47-54.