



SPECIAL EDITION  
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# networks

## Violence and Coercion in Mental Health Settings: **ELIMINATING THE USE OF SECLUSION AND RESTRAINT**

The National Technical Assistance Center is proud to present this special double issue of *networks* on the topic of reducing and ultimately eliminating the use of seclusion and restraint techniques in behavioral health settings.

From mental health technician to hospital administrator, and consumer to psychiatrist, this issue features a spectrum of viewpoints on the topic. We believe these perspectives will help inform readers of the efforts to reduce seclusion and restraint from a variety of belief systems and theoretical frameworks. The following articles represent philosophical, clinical, neurobiological, legal risk management, administrative and personal arguments in favor of reduction. Also, please note that due to the amount of content included in this issue, we have placed each author's reference listings for the following articles on our Web site ([www.nasmhpd.org/ntac](http://www.nasmhpd.org/ntac)).

We sincerely hope that the information contained in this issue and on the NTAC Web site helps our readers move toward the creation of violence- and coercion-free mental health settings. ◆

### Creating Sanctuary

By Sandra L. Bloom, M.D.

*Dr. Bloom is CEO of CommunityWorks, a system consulting firm based in Philadelphia that specializes in developing methods for applying the Sanctuary Model to a variety of social service settings.*

In medical school I learned that the first rule of healing is to “do no harm.” And yet the history of medicine in general and psychiatry in particular is shamefully littered with examples of our capacity to excuse damaging behavior directed at patients in the name of treatment. It is time to revisit the issue of “systemic violence” reflecting the unintentional consequences of procedures implemented by well-meaning authorities in a belief that the practices are in the best interest of patients (Epp & Watkinson, 1996).

Over the last several hundred years in psychiatry there have been many legitimate critics of psychiatric care including those who targeted the dehumanizing aspects of institutionalization, the pejorative labeling of psychiatric patients, the

abuse of patients' rights, and the unnecessary restriction of liberty and choice. Most of these social and professional critics have had to appeal to moral justice and higher dictates of humane treatment and have lacked theoretical, evidence-based reasons for their appeals for better treatment.

Our growing understanding about the complex biopsychosocial impact of overwhelming experiences provides a different and important way of re-evaluating practices like seclusion and restraint and speaks to the importance of defining, creating, and maintaining safe environments that truly support the process of recovery from any serious mental or physical stress.

Child psychiatrist Lenore Terr studied child victims of trauma and defined psychic trauma as occurring “when a sudden, unexpected, overwhelmingly intense emotional blow or a series of blows assaults the person from outside” (1990). Psychiatrist and (continued on page 16)



## MESSAGE FROM NTAC

Greetings from the National Technical Assistance Center at NASMHPD and welcome to our first double issue of *networks*. In this issue we present perspectives on the subject of violence and coercion in mental health settings with a focus on the reduction and elimination of the use of seclusion and restraint.

I will be the first to tell you that the perspectives we present in these pages do not include arguments for the use of restrictive measure or for violence and coercion in any form. NASMHPD and NTAC have already made our stance clear on this issue.

We further believe that the driving force and the overall rationale for reducing the use of seclusion and restraint needs to be more than just meeting the JCAHO and CMS standards, or even because of potential legal liability. The elimination of coercive measures must become part of the behavioral health field's commitment to stop the cycle of violence in our own practice settings because it is the right thing to do—based on science and ethics. We now have both effective and efficient alternatives that will allow us to take a leadership role in the elimination of seclusion and restraint practices. In this issue we present a few of these promising alternatives, though they are only a sample of the many exciting projects occurring in the vast majority of states.

I would very much like to thank the dedicated folks who contributed to this issue. It is an honor to call these people colleagues and we salute their work, as well as the work of many of you out in the field who, daily, are pushing, dragging, coaxing and leading others to join the fight in eliminating violent and coercive practices while providing state-of-the-art treatment for those affected.

While I cannot mention everyone who has contributed to this *networks* issue by name, I would like to identify a few. These include all of the authors whose articles appear in this issue; the work of the participants in the NTAC/NASMHPD-sponsored experts meetings on trauma and violence, alternative dispute resolution and cultural competency; the NASMHPD Medical

Directors Council and all of the commissioners/directors and staff who responded overwhelmingly to our survey regarding the use of seclusion and restraint.

I would also like to thank Charles G. Curie, M.A., A.C.S.W., and Robert W. Glover, Ph.D., for their vision and leadership in this endeavor as well as Steven J. Karp, D.O., Noel A. Mazade, Ph.D., Lucille Schacht, Ph.D., Gail P. Hutchings, M.P.A., and Andrea Blanch, Ph.D., for their expertise, commitment and passion in helping to drive this initiative forward. Additionally, none of this could be possible without the strong and continued support and guidance from the Center for Mental Health Services, especially the work of Bernard S. Arons, M.D., Joyce T. Berry, Ph.D., J.D., Michael J. English, J.D., and Susan Salasin. And last, but certainly not least, I thank the NTAC staff for their hard work on this issue.

We would like to dedicate this edition of *networks* to the memory of Max Schneier, J.D., mental health advocate, who died in June. Mr. Schneier was a driving force in our field on many issues, including the elimination of the use of seclusion and restraint. His unending fight to bring state-of-the-art treatment to persons suffering from mental illness benefitted the entire field, and he will be missed.

My last comment is to my colleagues in treatment settings across the country where I have spent most of my 22 years in this field. We all were inculcated at some early point in our training with the doctrine that the use of seclusion and restraint was necessary, therapeutic at times, and an acceptable part of a treatment plan. This training dies hard for some of us. But I ask every one of you to think about the following three questions without defense or emotion, just knowledge, intuition, and logic.

*When does coercion beget anything but anger, learned helplessness or surface compliance? When does violence teach anything but passivity or more violence? How congruent is "recovery" with forced isolation or immobility?*

We know better and the time is now for change.

—Kevin Ann Huckshorn, R.N., M.S.N., I.C.A.D.C., NTAC Director

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## PERSPECTIVES FROM THE FIELD

# Legal and Regulatory Aspects of Seclusion and Restraint in Mental Health Settings

By Susan Stefan, M.Phil., J.D.

*Ms. Stefan is a senior staff attorney at the Center for Public Representation in Newton, MA.*

*“It is the Office of Mental Health and Substance Abuse Services’ belief that seclusion and restraint are not treatment but reflect treatment failure.”*

Pennsylvania Office of Mental Health and Substance Abuse,  
Policy on Use of Restraints, Seclusion and Exclusion  
in State Mental Hospitals (2001)

*“It is NASMHPD’s goal to prevent, reduce and ultimately eliminate the use of seclusion and restraint.”*

National Association of State Mental Health  
Program Directors (1999)

In the last three years, Congress has passed new legislation regulating the use of restraints in facilities receiving federal funds. Accreditation bodies such as the Joint Commission on Accreditation of Health Care Organizations and the Center for Medicare and Medicaid Services have promulgated new standards governing the use of restraints, and are enforcing them vigorously. Both civil suits and criminal prosecutions arising out of injuries and deaths in restraints are on the rise.

The increasing attention is due in part to recent publicity on deaths and injuries in restraints, (1) especially in light of evidence that most deaths and injuries were unnecessary and preventable. In the past, facilities responded to deaths and injuries by trying to “do restraints better.” However, the complexity of causes and factors relating to deaths and injuries in restraint make this difficult, and a growing recognition of the traumatic effects of restraint on both patients and staff led a number of facilities and state agencies to make efforts to dramatically reduce the use of restraints. Their success was substantial and was consistently accompanied by a reduction in staff and patient injuries.

It is now the professional consensus that the best way to reduce restraint deaths and injuries is to minimize restraint use to the greatest extent possible. Pennsylvania reduced restraint use by 90% in six years; staff and patient injury rates dropped by 74%. The Pennsylvania Office of Mental Health and Substance Abuse received an “Innovations in American Government” award of \$100,000 from the Ford Foundation, and Charles Curie, who led the effort to reduce restraints, is now head of the Substance Abuse and Mental Health Services Administration in Washington, DC, where he continues to be committed to reduction of restraints.

High restraint rates are now understood as evidence of treatment failure. The professional consensus that restraints can and should be reduced substantially has been accompanied by increasing legal and regulatory liability for deaths and injuries in restraints. One

reason for this is that the techniques that have been successfully used to dramatically reduce restraints and injuries are known, replicable, and relatively inexpensive.

### Deaths and Injuries in Restraints

Studies of restraint deaths point to asphyxiation during the restraint process as a leading cause of death related to restraints.(2) Some restraint holds, such as the chokehold or the basket hold, and restraint positions, including face-down, are particularly related to asphyxiation. Some facilities and states have banned the use of prone restraints altogether because they are so dangerous.(3)

Physical condition such as obesity, asthma or bronchitis, neurological conditions, and drug or alcohol intoxication also increase the chances of death during a restraint procedure. Persons with diagnoses of mental retardation or substance abuse in addition to psychiatric diagnoses are at particular risk of injury or death from restraints. In addition, the use of blankets or sheets or towels, either wrapped around the patient or especially in the patient’s face, increases the risk of asphyxiation.

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*The techniques that have been successfully used to dramatically reduce restraints and injuries are known, replicable, and relatively inexpensive.*

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Deaths that are not caused by asphyxia most often appear to be caused by a toxic interaction between restraint and medication in a variety of different ways. Some psychotropic medications impair an individual’s gag reflex, making aspiration more likely when restraints are used on a client taking these medications. Although the face down position makes asphyxiation more likely, the face-up position makes aspiration more likely.

Other restraint deaths appear to be related to cardiac arrest. Psychotropic medications in general, and many antidepressants in particular, have been associated with fast or uneven heartbeats leading to cardiac arrhythmias. Other drugs, such as Clozapine, (4) have been associated with cardiac arrhythmias during struggles and exertion, which frequently accompany the use of restraints.

The interaction of restraint and medications that are already in a patient’s system is dangerous enough; the addition of PRNs at the time of a restraint can be even more dangerous, and literature has cautioned against it for almost twenty years. (5) Nevertheless, in a recent patient death in restraints, *after* (continued on page 4)

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## Legal and Regulatory Aspects *(continued from page 3)*

the patient was restrained and reported to be “non-responsive and flaccid,” the attending psychiatrist ordered 100 mg. of Thorazine I.M., remarking that the patient was “playing possum.”(6)

Some antidepressants, such as imipramine, can cause metabolic problems if a person’s movement is restricted, which may lead to life-threatening hyperthermia. A significant number of restraint deaths over the years have been associated with heat stroke. These deaths often involve the interaction of restraints and medication, because a significant number of psychotropic medications interfere with individuals’ ability to regulate body temperature. In the summertime, rooms lacking appropriate ventilation are particularly dangerous. Sometimes psychotropic medication toxicity causes patients to be confused and agitated, and resulting use of restraints may combine with the toxicity to cause death. (7)

A majority of women who are institutionalized because of psychiatric disabilities have histories of abuse in childhood. For these women, being surrounded by a group of people (often primarily men), having their limbs seized and lowered to the floor, and then being carried to a room where they are restrained with legs apart—often after their clothing is taken from them—can be extraordinarily retraumatizing. Federal government and state government agencies, as well as accreditation agencies, have specifically noted the treatment risk of using restraints on clients with histories of abuse, and caution that such use should be minimized if not eliminated.

Although many clients and some staff members are injured during the process of being restrained, a surprising number of lawsuits are filed based on staff injuries to a client who has already been restrained. Many restraints involve fear, anger and use of force, especially if staff feel out of control of a situation. It may be difficult for a staff member to behave in a calm and detached way. This underscores the need to prevent restraints, to provide thorough training of staff in both de-escalation and restraint techniques, and to maintain adequate staffing patterns. Clinical supervision is also vital, as on-scene supervisors can be held legally liable for failure to protect a client from attack by staff members.

### Restraints as Treatment Failure

Researchers have documented a wide variation in use of restraint among facilities with similar kinds of clients. Research over the last 20 years, from Robert Okin’s pioneering study to the recent work of Crenshaw, Cain and Francis, has consistently shown that restraint is largely a matter of institutional culture, not patient demographics.(8) Demographically similar institutions have wide variations in use and duration of both seclusion and restraint. This research is confirmed by anecdotal evidence that when wards and facilities seriously commit to minimizing restraints, reductions of between 50-80% can be achieved. Staff and patient injury rates also tend to decrease when restraint usage decreases.

A facility can reduce episodes of restraints, without affecting duration of restraint once a client is restrained. Therefore, it is important to

measure the duration of restraint as well as episodes of restraint. Crenshaw, Cain and Francis provide good benchmarks to aim for: hospitals in the lowest 10% of duration of restraint recorded .07-.09 hours spent in restraint per 1,000 patient hours, with the first figure corresponding to larger hospitals and the second to smaller hospitals. This article also gives an idea of the variation between facilities: facilities in the highest 10% of restraint duration recorded 12.16-12.53 hours of restraint per 1,000 patient hours.

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*On-scene supervisors can be held legally liable for failure to protect a client from attack by staff members.*

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The continued use of restraint on patients who are described as chronically aggressive or suicidal may be an indication that facilities have given up trying to determine the cause of the difficulty or the appropriate treatment. Restraining the individual becomes the norm. Advocates and family members are extremely concerned about this, whether it involves creating special units for these clients or perpetual use of methods of restraint such as the so-called “suicide prevention garment”(9) or “walking restraints.”

Most facilities have “outlier” clients who account for a large proportion of restraint episodes or restraint hours in the facility. The failure of facilities to identify these clients and focus intensively on reducing restraint use for them (including inviting external consultants, identifying precursors, introducing new forms of therapy, and/or doing extensive medical and neurological examinations) is a major cause of regulatory and legal intervention.

Recently, the failure of a northeastern state hospital to respond appropriately to the concerns of advocates about an individual who was in continuous restraint for months caused the advocates to call the Center for Medicare and Medicaid Services, which made an unannounced visit to the hospital in October 2001. After the visit, the hospital was cited for failing to meet a number of “conditions of participation.” In their report, the team noted that certain patients had been in restraints for days, weeks, even months at a time. In order to avert a threatened loss of fifty million dollars per year in Medicare funds, the state governor appropriated additional money for training and staff.

### Legal and Regulatory Consequences of Misuse of Restraint

Tort litigation has been one traditional response to deaths and injuries in restraints. Such cases have been increasingly successful in the past few years. Not only are the mental health workers who actually injure the clients being sued, but nurses and other supervisors are being found liable for failing to intervene and protect clients. One injured client recently was awarded \$100,000 in compensatory damages and \$1.5 million in punitive damages.(10) Furthermore, the State Attorney General’s office refused to represent either the mental health workers or the nurse supervisor on *(continued on page 8)*

## Restraint and Seclusion: Iatrogenic Trauma Comes Out of the Closet

(excerpted from *Double Bind*, 1996).

By Linn Cohen-Cole

*Ms. Cohen-Cole is an independent scholar in neuropsychiatric theory.*

**R**estraint and seclusion, currently accepted methods for the management of psychiatric patients in this country, meet the DSM IV definition of human-induced traumatic stressors: both exert violent and absolute control while engendering utter helplessness and fear (p. 424). This author condemns both activities as psychiatric abuse and their negative effects as iatrogenic trauma, and calls for an immediate end to this centuries-old practice.

This demand is not made on the strength of previously futile moral pleadings or on law which has failed to provide universal human rights to mental health patients, but on evidence that the outside world can be, when it moves too far beyond neutral or stimulating, physiologically overwhelming.

Based on Eric Kandel's studies into anxiety (1983) and on the work of many who have followed, psychiatric patients can state unequivocally that restraint and confinement are wrong not just because on an ethical level they are unconscionable or on a legal level, barbaric, but because they are psychologically so intense as to be physiologically damaging. In polite terms, they are wrong because they are anti-homeostatic.

Homeostasis is central to psychiatry's mission as a field. In *Beyond the Pleasure Principle* (1959), Freud suggested that a "stimulus barrier"—the skin, the peripheral sense organs, and an internalized neuronal layer—worked to protect organisms from destructive external stimulation. He saw the function of defensive processes as helping to keep the mental apparatus at a steady low level of stimulation.

Bowlby (1973) concurred with Freud that excessive excitation to the mental apparatus was traumatic and used that physiologic view to explain how a child's loss of its mother would have significance beyond the apparent psychological loss. He asserted that the loss would be physiologic as well because the mother functioned to support homeostasis in the child. By her absence, physiologic homeostasis would be traumatically disrupted.

In this, Bowlby saw a complementary relationship between steady familiar relationships and an individual's maintenance of physiological steady states. He suggested that defenses that protect the organism from excessive excitation are integral, also, to neurologic homeostasis in that they maintain steady representational states.

Reiser (1984) suggested that homeostatic processes are controlled in the central nervous system by neuroendocrine and autonomic

mechanisms. Together, these processes regulate physiologic systems from the organs to subcellular elements, maintaining "a constant internal environment in the face of external environmental challenges."

The concern with homeostasis in psychiatry is, thus, about recognizing and protecting humans from the disruptive effects of excessive excitation, whether that is defined psychologically or neurophysiologically. In this context then, a traumatic stressor is something which causes excessive stimulation, and traumatic stress is the failure of the organism's various dynamic systems, whether internal or external, to maintain homeostasis in the face of that overload.

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*Restraint and seclusion, currently accepted methods for the management of psychiatric patients in this country, meet the DSM IV definition of human-induced traumatic stressors.*

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This author asserts that any physiologic view of restraint and seclusion will prove them to be not only excessive stimulation, but overwhelming at the level of a catastrophic event....

Psychiatric studies by Blake, Albano and Keane (1992) divide traumatic stress into two categories—that caused by accidents or natural disasters, and that caused by humans. The DSM IV's definition of Posttraumatic Stress Disorder (p. 424) indicts human-induced trauma, stating, "The disorder may be especially severe or long lasting when the stressor is of human design (e.g., torture, rape)."

The common traumatic element, whether in rape, torture, kidnapping, incest, sexual abuse, terrorism, POW settings, concentration camp settings, etc., is the massive control of one human being over another (van der Kolk, 1987; van der Kolk & van der Hart, 1989; Herman, 1992).

The common pathologic element inherent is the extreme powerlessness and fear of the victim. A consistent application of the DSM IV definition of traumatic stressor would clearly include restraint and seclusion yet neither is listed among the numerous traumatic stressors cited in the DSM IV....

That psychiatry credits itself for exposing diverse forms of trauma, and singles out human-induced harm as especially perilous while disregarding the violence of its own (*continued on page 6*)

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## **Iatrogenic Trauma** *(continued from page 5)*

authority should not be considered merely paradoxical. It constitutes a dangerous scientific vacuum within which the field operates daily.

How does a field that harks back with pride to Pinel's freeing the insane from their chains (Pinel, 1962), condone procedures which phenomenologically (Doerr-Zegers, Hartmann, Lira, et al., 1992) replicate the very abuses it categorically denounces? How does a profession designed to alleviate mental suffering maintain its denial of the powerlessness, terror, loneliness, and rage it sees in the faces of its restrained and confined patients? These are far from rhetorical questions.

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*The victim's task of establishing that restraint and seclusion constitute psychiatric abuse of traumatic proportions ... must occur against a backdrop of almost hopeless disparity of credibility.*

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The call for an end to restraint and seclusion rests upon incontrovertible arguments of inescapable physiologic harm to a particularly vulnerable population, but the actual end to restraint and seclusion must depend upon the collapse of ... denial and, thus, upon an understanding of how it could exist...

Herman (1992) speaks of formidable barriers to sustained recognition of any abuse ... [.] human and societal tendencies to deny and repress disturbing information, the perpetrator's power to discredit the victim, the difficulty naming the experience when it is not conventionally regarded as a violation, and the absence of human rights movements to bear witness. Then she stresses that the unfair fight between victims and their abusers worsens: '[w]hen the victim is already devalued (a woman, a child), she may find that the most traumatic events of her life take place outside the realm of socially validated reality. Her experience becomes unspeakable' ....

The degraded status of psychiatric victims multiplies each of Herman's obstacles to almost insurmountable dimensions. Psychiatric patients are discredited before even speaking; their ability to claim their own reality denied (Bowlby, 1973; Rabinow, 1984); their civil rights limited (Szasz, 1963). Those in power, by contrast, enjoy an unparalleled deference. Herman refers to the 'appalling disjunction between [the victims'] actual experience and the social construction of reality' ....

Thus, the victim's task of establishing that restraint and seclusion constitute psychiatric abuse of traumatic proportions ... must occur against a backdrop of almost hopeless disparity of credibility.

But psychiatric abuse offers one of the most complex circumstances possible for rupturing denial—an extraordinary blend of noble intent with harmful standard operating procedures, in which the procedures are viewed neutrally, to the point of simple functionality (Caley, Pinchoff, 1991), making it complicated to tease out any recognition of abuse....

...all that matters here are two simple statements:

- 1) The emotions of fear, terror, and helpless despair are followed by a number of constant yet repetitive behavioral, cognitive, and physiological processes (Kolb, 1987), and
- 2) The primary result of excessive emotional stimulation is its effect on the function, and perhaps the structure, of the cortical neuronal barrier, particularly as it concerns control of aggressivity (Jackson, 1958).

Multiple homeostatic systems are disrupted by excessive stimulation. Intense emotion has real physiologic sequelae that threaten self-regulating human functions....

In the past, its power to define the significance of emotions and behavior has allowed psychiatry unlimited, even extra-legal, freedom of action, but masses of sophisticated neuropsychiatric research now speak more authoritatively, and legally will soon threaten this hegemony. Protestations of positive psychiatric intent or of patient welfare are about to lose their force because 'the emerging evidence of the existence of psycho-physiological, neuro-endocrine, and neurochemical abnormalities in chronic posttraumatic stress disorder outruns the potential of the current psychological explanations derived from psychoanalytic or learning theories' (Kolb, 1987)....

There is incontrovertible evidence ... that these procedures qualify as catastrophic stressors and that psychiatric patients are, by every developmental or biological index, especially susceptible. This harm is real and lasting. It constitutes iatrogenic trauma. This is biopsychiatry and it's being ignored....

... [I]n some phenomenal way, these ethically indefensible acts can no longer be denied—they are silently, deeply and truthfully being registered in human and animal physiology as toxic.

Evidence, both physiologic and legal, is mounting. ♦

**For a complete reference listing,  
visit [www.nasmhpd.org/ntac](http://www.nasmhpd.org/ntac)**

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## PERSPECTIVES FROM THE FIELD

# Consumer View: Restraint is Not Therapeutic

By William Pflueger

*Mr. Pflueger is the treasurer of the Statewide Mental Health Consumer/Survivor Network of Minnesota.*

It is difficult to write about my experiences with seclusion and restraint. Someone who has experienced it wouldn't want to read any further, and for someone who hasn't, how can it be explained? A comparison that comes to mind is describing the practice of whipping as a control and conditioning mechanism for slaves to an audience from the 1850s. Depending on the sympathies of the reader, possible reactions could be, "How ghastly! How wrong! This practice must be ended!" or, "Understandably upsetting to the squeamish, but a necessary, albeit unpleasant, treatment to maintain control and safety for all involved."

Fortunately for me it has been a number of years since I was locked up and tied down. It always seemed like overkill. Here I am in a locked facility and I get put in a locked room and then strapped and locked to a bed. I was expecting that next a canvas bag would be put over me and I would be dropped into a river.

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*I don't feel comfortable wearing watches any more and for a long time belts were out of the question.*

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I can't bring myself to describe the moment-by-moment struggles and shear gut-wrenching terror of being put into five-point restraint. Tears well up in my eyes and I feel a dark hole opening below me. I don't feel comfortable wearing watches any more and for a long time belts were out of the question. Just the smell of leather and jingle of the hardware were enough to trigger memories of those horrible times. The faces of the people who put me in restraints are stamped in my mind as indelibly as members of my family. The whole experience made me feel ashamed and that my soul had been dishonored. I sensed that some of that shame rubbed off on the

people who were ordered to do that to me. The terror of confinement, the pain of the restraint, and the wound to my soul made me want to stay as far away from the mental health system as possible. It didn't matter that it might offer me something helpful; I didn't want any of it if that horrible experience was going to be part of the package. So then where does one go with the feelings that are swirling around in the aftermath of that experience?

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*The techniques normally don't leave any permanent physical scars, but if the practitioners could see the psychological damage done they would know that the treatment causes more harm than good.*

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The trauma of the treatment is not something that can be discussed with the person who ordered it. How can a doctor acknowledge that the first tenant of the Hippocratic Oath has been violated at his or her own hand? The standard professional response is, "Unfortunate but necessary. Let's not dwell on the past."

The techniques normally don't leave any permanent physical scars, but if the practitioners could see the psychological damage done they would know that the treatment causes more harm than good. It is like amputating someone's leg to deal with a broken ankle. The mental condition that you leave with shouldn't be worse than the one you arrived with, but when a human being is treated like a non-human, that insult and injury is added on to the diagnosis that you already have. However, it is not acknowledged by anyone but the person who experienced it.

If we could all just recognize and acknowledge that the ordeal of seclusion and restraint is harmful, it would be a wonderful beginning for creating a mental health system that is truly about recovery, wellness, and helping the whole person. ♦

### Coming Soon from NASMHPD ...

#### **Reducing the Use of Seclusion and Restraint: Lessons from the Deaf and Hard of Hearing Communities**

A NASMHPD Medical Directors Council publication that focuses on the special needs, issues, and vulnerabilities of persons who have mental illness and who are deaf or hard of hearing, with a focus on the reduction of seclusion and restraint. Recommendations are included for research, alternate treatment methods, and policy initiatives.

Call 703-739-9333, ext. 131 or e-mail [robert.hennessy@nasmhpd.org](mailto:robert.hennessy@nasmhpd.org) for more information.

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## Legal and Regulatory Aspects *(continued from page 4)*

appeal. A tort claim relating to a restraint resulting in a client's broken arm is currently pending against the same facility.

Tort claims can involve a number of different causes of action: excessive force, (11) medical malpractice, (12) failure to protect, (13) assault and battery, (14) and failure to maintain a safe environment. In addition, the attempts of administrators to cover up deaths or injuries related to restraints have resulted in awards of over \$1 million. (15)

Claims of constitutional violations were a common response to systemic overuse of seclusion and restraint, and are likely to reemerge now that professional judgment in the field strongly supports significant reduction in the use of restraint. (16) Constitutional claims include violations of the fourteenth amendment right to minimally adequate treatment, freedom from restraint, and also violation of the fourth amendment right to be free from unreasonable search and seizure.

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*Restraint use represents treatment failure,  
not on the part of direct care staff,  
but on the part of facility management.*

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Lawyers are also beginning to examine the application of the Americans with Disabilities Act to the use of seclusion and restraint. In *Olmstead v. L.C.*, the Supreme Court confirmed that unnecessary segregation was discrimination under the ADA: "unjustified isolation, we hold, is properly regarded as discrimination based on disability," 527 U.S. 581, 597 (1999). Certainly, seclusion or restraint for days and months at a time, a practice that continues in some places, constitutes unnecessary segregation.

In addition, advocacy agencies and district attorneys have been paying more attention to overuse of restraints. The use of excessive force when placing a client into bodily restraints or the use of restraint in violation of state and federal regulations constitutes "abuse" under the statute creating protection and advocacy agencies. Advocacy Inc., the Texas P&A, recently successfully sued for access to the records of a patient who died in restraint, arguing that a death in restraint created probable cause to believe that abuse had taken place. More recently, district attorneys have begun to criminally prosecute staff for manslaughter (death as a result of an individual's gross negligence or reckless disregard of the danger to life) in some deaths arising from misuse of restraints. (17)

In addition to litigation, regulatory enforcement has been more intense than in the past. Although one state hospital "was proud of the fact that it had reduced restraint use by about 40% in the past two years," when the Center for Medicare and Medicaid Services inspectors showed up to investigate allegations that a client had been restrained for months, "[the hospital director and staff] ... were

not anticipating the strict interpretation of the new federal guidelines adopted by the inspectors from the Centers for Medicare and Medicaid Services during their unannounced visit." (18)

## Reducing Restraint Use

The philosophy and leadership of management—whether facility-wide or agency-wide—is crucial to reducing the use of restraints. To succeed, restraint reduction programs must underscore that the use of restraints represents a failure, a mistake that must be investigated in order to prevent the same mistake in the future.

Restraint use represents treatment failure, not on the part of direct care staff, but on the part of facility management. The time to consider "less restrictive alternatives" to restraint is not at the instant a staff member is being physically assaulted, but in the days, weeks and months before that moment. The institution's responsibility for coming up with a less restrictive alternative to restraint does not begin at the moment that a frustrated client boils over; it begins with a facility-wide program aimed at reducing both the incidence and duration of restraints.

Any facility where a patient has died or has been seriously injured in restraints, or where the restraint rates are higher than the mean in the Crenshaw, Cain and Francis study, should have an active, ongoing program to reduce restraint use. The failure to do so in the face of these factors may indicate to a court a deliberate indifference or a substantial departure from professional judgment.

- ◆ It is absolutely clear that restraint reduction is proactive, not reactive; that it is planned by management and senior clinical staff. It cannot be the responsibility of an overwhelmed direct care paraprofessional at the last instant. Every report has emphasized the importance of staff training in both restraint prevention and proper use of restraints, including medical contraindications. Some training programs also require staff who use restraints to experience restraints themselves.
- ◆ It is clear that when administrators and leaders simply attend to and focus on the use of restraint as a treatment failure, restraint use drops. For example, one facility accomplished a 62% reduction in seclusion and restraint use by having its Behavior Management Committee review high usage of restraint, defined as six applications or 72 hours duration per month.
- ◆ A successful program in restraint reduction will be reflected in data regarding incidence and duration of restraint. This requires ongoing, careful documentation relating to the facility's use of restraint. It is important to keep records for weekly (or at the most monthly) review by a designated committee on the use of restraints and seclusion, the duration of restraints and seclusion, times when restraints are most often initiated, staff members associated with use of restraint and seclusion, and other data to help identify problem areas and to compare the facility with others in the state and across the country. The data should ideally be kept in a format to allow comparison with state and national performance *(continued on page 12)*

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## PERSPECTIVES FROM THE FIELD

# Education is Key to System-Wide Change

By Joyce Jorgenson, B.A. and Carol Geisler, Ph.D.

*Ms. Jorgenson is the project director of the National Association of Consumer/Survivor Mental Health Administrators and Dr. Geisler works with the Jorgenson Group.*

*Cowardice asks the question—is it safe? Expediency asks the questions—is it politic? Vanity asks the question—is it popular? But conscience asks the question—is it right? And there comes a time when one must take a position that is neither safe, nor politic, nor popular, but one must take it BECAUSE it is right.*

—Dr. Martin Luther King

In a world fraught with violence and terror there are many people who, through their example, help make our world a better place to be. Dr. Martin Luther King is one such example. His spirit and philosophy of non-violence and justice remains relevant today within the world of mental health practice, and if we dare to search our souls his questions may guide our journey. There is significant evidence to demonstrate that it is no longer safe, politic(al), popular, or right to engage in the practice of seclusion and restraints.

As a matter of fact, it never was. We remember reading the history of Fergus Falls Regional Treatment Center in Minnesota from the early 1900s in which the superintendent declared seclusion and restraint did not benefit the patients or the staff. He abolished the practice altogether during his tenure. That was then and here we are now, 100 years later still experiencing the horrors of restraint and seclusion.

In December 2000, the National Association of Consumer/Survivor Mental Health Administrators (NAC/SMHA) developed and sent out a survey to gather firsthand evidence from people who have experienced the practice of restraint and seclusion. Seventy-two percent of those responding reported being restrained or secluded.

Most of the responses were heart-wrenching. One consumer told us that he thought that “restraint” was too polite to describe his experience. He went on to say, “I was tied up and tied down. It was terrifying, dehumanizing, degrading, and painful. Along with the restraint was the forced injection of Haldol. Not only was the leather biting into my wrists, my body had been invaded by a substance that caused a feeling of intense internal violation.”

Education grounded in recovery, resilience, and self-determination is a cornerstone to changing the cultural environment that tolerates the practice of restraints and seclusion. As Charles Curie, the administrator for the Substance Abuse and Mental Health Services Administration (SAMHSA) suggested, “To reduce the use of seclusion and restraint is part of a broader effort to reorient the state mental health system toward a consumer-focused philosophy that emphasizes recovery and independence.”

NAC/SMHA, consumers, and a steering committee with broad participation from all stakeholders recently joined together to support the creation of a training manual with the intent of offering the service delivery system a toolkit as we move toward the elimination of seclusion and restraint. Final edits are now being made for a “Roadmap to Restraint- and Seclusion-Free Mental Health Services for Persons of All Ages.”

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*Education grounded in recovery, resilience, and self-determination is a cornerstone to changing the cultural environment that tolerates the practice of seclusion and restraint.*

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The Roadmap curriculum is grounded in the philosophy of recovery, resilience, and self-determination. The training is highly interactive and designed for front line staff as research-based evidence clearly shows a decrease in the use of seclusion and restraint when staff training is increased.

Jean Piaget said, “The principle good of education is to create people who are capable of doing new things, not simply repeating what other generations have done.” We urge you to *do new things*. ♦

### *Save the Date !!!*

**What:** NASMHPD/NRI Third National Summit of State Psychiatric Hospital Superintendents

**Who:** All Interested Stakeholders

**When:** May 11-13, 2003

**Where:** Washington, DC

This third biennial summit convenes the public state psychiatric hospital superintendents and other key stakeholders in a forum designed to share and disseminate information on evidence-based and promising practices, the reduction of seclusion and restraint, the use of performance indicators and outcome measurements, co-occurring disorders and other priority topics.

For more information, contact Kevin Ann Huckshorn, NTAC Director, at [kevin.huckshorn@nasmhpd.org](mailto:kevin.huckshorn@nasmhpd.org)

## Focus on the States

# Hospitals in Florida, Georgia and Utah Drastically Reduce Seclusion and Restraint

By Rob Hennessy

In late Fall 1999, officials from Atlantic Shores Healthcare, Inc. at the South Florida State Hospital set a goal of completely eliminating restraint usage by January 2001. Reducing the occurrence of restraint usage from an average of 20 per month to only four in the last 12 months, the hospital officials may not have technically accomplished their goal, but they made huge strides in the important effort to reduce the use of seclusion and restraint. Fortunately, this success story is not unique.

More than a decade ago, officials at Georgia's Central State Hospital started to track data on seclusion and restraint. After implementing their reduction system, officials say the numbers dropped from 90 occurrences per month to two or less per month, and seclusion has dropped from a maximum of 24 hours to only one hour per occurrence. At Utah State Hospital, restraint incidents dropped from 640 in 1998, to 211 in 2001. During the same time frame, seclusion incidents dropped from 921 to 184 per year.

### Follow the Leader

"The place to start is at the top," said Bob Quam, chief operating officer for Atlantic Shores. "The leadership of each hospital has got to be 100% on board. Not only does management have to support the plan, they have to believe in it," he added.

"Seclusion and restraint is something that is synonymous with public mental health care, so when we first discussed trying to reduce usage, I had my own reservations," said Sal Barbera, CEO at Atlantic Shores. "But, we decided to embrace the concept. As an administrator in a state hospital, the biggest risk factor I face is the use of seclusion and restraint. It has resulted in a lot of negative consequences across the country—including death—and so we are excited about our success in reducing usage."

### Back to School

To implement an alternative intervention process in the place of seclusion and restraint, those interviewed mentioned a need to overhaul the existing staff training program. Working with staff early and often during the transition will ensure consistency, state administrators say, while introducing a new overall philosophy will emphasize de-escalating situations before they turn violent. "When we began our training," said Dr. James Mimbs of Georgia's Central State Hospital, "we had to make it clear that seclusion and restraint interventions were never to be used as a convenience to staff—just as an extreme emergency intervention. Now the staff are the ones who never want to use seclusion and restraint."

"We trained staff how to diffuse situations by picking up on verbal and nonverbal cues from the patients," said Quam. According to

the administrators, this is a key effort that depends on the hospital staff's ability to become extremely familiar with each patient's needs, concerns and warning signs so that aggressive behavior can be neutralized before an incident. Staff must also quickly familiarize themselves with new patients.

A tip from Marvin Bailey, CEO of Georgia's Central State Hospital, is to carefully select the person to lead your in-house training program. "You need someone special—maybe from nursing—who can relate to each level of staff."

### Proven Alternatives

A common new initiative in each of these successful programs is the implementation of a de-escalation preference survey. During the admission process, patients are invited to fill out a new form that itemizes the patient's preferences for how staff should respond when he or she becomes agitated. "The forms really help because patients know in advance that we are trying to figure out different ways to work with them," said Quam.

Another successful de-escalation feature is the addition of "comfort rooms"—quiet, comfortable locations where patients can voluntarily go to calm down on their own (*for more info on these de-escalation techniques, see "Comfort and Communication Help Minimize Conflicts," page 18*).

An increased schedule of diversionary activities also helps to entertain patients during peak times of escalating behavior—nights and weekends. "Our Hopeway program allows patients to attend a variety of discussion groups that are tailored to clients' functionality and needs," said Dr. Mimbs. Discussions, which are sometimes led by a former client, include learning how to readjust to life outside the hospital.

Another common practice at each of these hospitals is a post-incident review session. Participants at these meetings vary within each hospital, with personnel including the actual unit teams involved, a risk manager, applicable upper management personnel and patient advocates. "These meetings were especially helpful in the beginning [of the system's implementation]," according to Dr. Debra Kirsch, clinical director for Atlantic Shores. "It was a great way to learn why the restraints happened, and to see what kind of interventions worked and didn't work."

### Side Effects

Skeptics of reducing physical interventions may fear unwanted side effects on the hospital culture—increases in intramuscular injections (IMs), assaults, and injuries. "Whenever you talk about

seclusion and restraint, you have to ask if you are substituting one improper method for another,” said Barbera. “We started tracking our data and while there was a minimal increase in IMs, there was no increase in assaults or injuries. In fact, we find that the more we use seclusion and restraint, the more assaults and injuries we experience.”

According to Dr. Richard Spencer, clinical director at Utah State Hospital, Utah officials noticed no increase in assaults or injections, and saw a decrease in staff injuries. “Before the effort to reduce seclusion and restraint, the hospital implemented a violence reduction program called ‘safety intervention techniques.’ It’s used to teach the staff verbal intervention skills in place of physical, and it has worked well for this purpose.”

Georgia’s Central State data showed that assaults by patients and injuries to patients and staff decreased after implementing their new techniques. However, the use of PRN medications did increase, so the staff began to scrutinize the use of medication during interventions until those figures decreased.

### Potential Obstacles

As with any new organization-wide system, there will be obstacles at the implementation stage such as “old-guard” thinking, personnel shortages, and time constraints.

Sometimes these factors combine to stall progress. “One of the obstacles we have faced is when a tech who has been around for a long time jumps to the conclusion of using seclusion and restraint without considering other options, and a new nurse who may be very busy may feel he or she has to support the decision. [This scenario] is part of the nursing shortage the whole country is facing,” said Dr. Spencer.

The good news is that implementing a new system does not have to affect your bottom line. “It’s more of a cost to not do anything, than to implement a new system. I could not tell you any change to our cost factors,” said Bailey. “Although, [reducing seclusion and restraint] does create a safer environment on the living unit and that’s a big plus that can’t be measured in dollars.”

“The resources needed to implement a reduction system would be in the form of training, monitoring and supervision,” said Barbera. “All state hospitals already have existing training resources, so there shouldn’t be an incremental increase in training costs...and the monitoring and supervision is already in existence...but just need to be focused on this issue.”

### Positive Feedback

Besides monitoring data, Georgia officials organized an extensive survey of patients, resulting in tremendous feedback and unique insight from the consumer perspective. Then, the survey

responses were shared with staff. According to Dr. Mimbs, the process was all about walking in someone else’s shoes. “Our view was that if you looked at what we were doing from the client perspective, you could see that it was time for a change. Our effort was truly a self-motivated, client-oriented endeavor.”

Feedback on the new system has been positive from both patients and staff at South Florida State Hospital. “The doctors especially have liked the new system, because when they used to get called to an aggressive situation, it was often too late to do anything but apply a restraint. Now we focus on the cues and try alternatives to prevent escalation—it works,” said Quam. “It really comes down to knowing your patients,” added Dr. Kirsch.

### Tips from the Field

According to each of the officials interviewed for this article, success in reducing seclusion and restraint is partially due to a variety of tangible steps such as the comfort rooms, increased patient feedback, and diversionary activities. But each official also placed strong emphasis on the more conceptual initiatives—the increased communication, the preemptive philosophy and focus on de-escalation, the inclusion of staff and consumers in all initiatives, and most importantly, the buy-in by top-level management at the hospital and state levels.

Taken together, these tangible and philosophical initiatives can be implemented most effectively by keeping the following three suggestions on management’s priority list.

**Develop a new staff training program, and use it early and often.** Don’t count on a quick fix say the experts. “Changing to this new system takes a lot of time and effort with your staff, especially to keep it going,” said Bailey. A thorough, consistent and regular training system can help speed effective implementation.

**Make changing the culture a team effort.** Get staff to “buy-in” to the new system by becoming your ambassadors for the project. “If you establish a goal and constantly work on changing the culture—to the point where staff become the ones who do not want to use it—you can achieve that goal,” said Barbera.

**Lead by example.** “Start with a unified stance on the part of the medical staff, and get everyone to come together on the concept that seclusion and restraint are not treatments, they are treatment failures,” said Dr. Spencer. “If doctors and administrators start to support it, then the change happens in the culture of the hospital.”

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*For more information on progress: in Florida, contact Dr. Debra Kirsch at [dkirsch@sfsh.org](mailto:dkirsch@sfsh.org), Bob Quam at [rquam@sfsh.org](mailto:rquam@sfsh.org), or Sal Barbera at [sbarbera@sfsh.org](mailto:sbarbera@sfsh.org); in Georgia, contact Marvin Bailey and Dr. James W. Mimbs at 478-445-4128; or in Utah, contact Dr. Richard Spencer at [rspencer@utah.gov](mailto:rspencer@utah.gov)*

# SUGGESTED READING

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Steel, E. (June 1999). *Seclusion and restraint practice standards: A review and analysis*. Alexandria, VA: National Mental Health Association.

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

For more information on this topic and additional mental health resources, please visit NTAC's Web site:  
[www.nasmhpd.org/ntac](http://www.nasmhpd.org/ntac)

## Legal and Regulatory Aspects (continued from page 8)

indicators, e.g. the Crenshaw, Cain and Francis study (see note 8).

Data collection also allows the facility to identify the clients who accounted for the greatest use of restraints (virtually every institution has "outliers" who account for a significant proportion of restraint use and duration). Then the facility can address reduction or elimination of restraints for these individuals, often women with histories of abuse who are particularly damaged and retraumatized by restraint use.

- ◆ The most successful internal mechanism to reduce restraint use is to require prompt and consistent involvement and responsibility on the part of the patient's psychiatrist. In Pennsylvania, physician's orders for restraint cannot exceed one hour, and face-to-face physician assessment of the restrained patient is mandatory within 30 minutes of the order. Requiring prompt, continuing medical or psychiatric involvement and documentation is key to reducing restraint use.
- ◆ Requiring continuous observation of an individual in restraints, as is required in Pennsylvania and Massachusetts, reduces duration of restraints and makes it less likely that an individual will die or be injured in restraints. Personal observation is more likely to produce these protective results than monitoring by video camera.
- ◆ Although internal review has been successful in reducing restraint, most reports and studies agree that external review seems to be even more successful. External review can take a number of forms. One hospital in Pennsylvania hired an external clinical consultant and required staff to call her within hours of instituting restraint; she came to investigate each incident. (19) One of the most successful initiatives in Utah involved asking ex-patients to come back and spend time with current clients, review incidents, and suggest ways of reducing restraints.

Restraint use is emotionally damaging and potentially dangerous for patients and staff. Every time restraint is used, a facility invites a set of risks, and in many cases the need to take those risks could have been prevented by planning and appropriate staff training and support. At some point, repeatedly allowing the risks associated with restraints becomes negligence without an initiative from management and quality assurance to reduce those risks.

Reducing the use of force and violence in a setting designed for treatment is an aspiration shared by all, but the aspiration can and must be realized in reality. Reduction of trauma for patients, stress and injury for staff, and risk of liability for the facility is a situation where everyone wins. ◆

For a complete reference listing,  
visit [www.nasmhpd.org/ntac](http://www.nasmhpd.org/ntac)

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## PERSPECTIVES FROM THE FIELD

# Coercive Tactics are No Longer Viable Treatment Methods

By Steven J. Karp, D.O.

*Dr. Karp is the chief psychiatric officer for the Department of Public Welfare in Harrisburg, PA.*

**W**ebster's *New World Dictionary* defines coercion as "the act, process, or power of coercing." Coerce is defined as "1.) To restrain or dominate by force; 2.) To compel to an act or choice; 3.) To bring about by force or threat." The mental health field in the United States as well as the world has used techniques that meet these definitions for many years.

This article is written in hopes of raising the awareness of the mental health treatment community so the professionals involved can examine their current practices and eliminate ways in which practitioners and administrators are using subtle, and not so subtle, forms of coercion to the detriment of the consumers they serve.

Three main areas will be covered: identification of the forms of coercion that exist in the system today; the impact of coercive practices on consumers; and ways in which current practice can be modified to reduce and eliminate the use of these control tactics in the recovery process of individuals receiving treatment.

Coercive behavior in mental health treatment exists on a spectrum from subtle to overt. There are many examples of subtle forms of coercive techniques. These forms can include telling a patient: that he can not participate in other parts of his treatment program if he doesn't take the appropriate medication; that refusal to participate in a modality to which he was assigned (therapy group) will result in a negative consequence; and that having a person sign a treatment plan when he did not participate in its creation and does not agree with it, or by breaking rules (such as the use of drugs or alcohol), will get the individual expelled from the program.

More extreme forms include involuntary inpatient and outpatient commitment, and the most extreme form is manifested by the use of restrictive procedures such as seclusion and restraint—methods which can be harmful, traumatizing and in rare instances life-threatening. In addition, there are numerous other examples including the use of depot antipsychotic medications.

Even the most seriously ill individuals can sense the coercive strategies of a treatment staff. These strategies can even reinforce a delusional system of someone who already, as a result of their illness, believes he or she is being targeted or controlled. Subtle coercion disengages the person, and rather than welcoming them into treatment it leads to mistrust of providers, creates a "learned helplessness," and disregards the recovery process.

Coercion also fosters dependency on the system for those who passively accept the process and prevents the individual from reaching his or her potential for self-management and maximum

independence. As a result, subsequent clinicians are placed in a position where they have to undo damage by coercion before they can develop a trusting relationship and proceed with treatment.

All this leads to increased financial cost to the system as consumers use acute services as crises occur. It also leads to increased human costs in prolonged suffering and increased morbidity and mortality.

It is difficult to imagine a system that does not require involuntary inpatient commitment when a person is acting in a manner that is deemed dangerous to himself or others, when the person is unwilling or lacks the capacity to make this decision for himself. This procedure should be available when needed but it must be used judiciously because it essentially takes away the rights of the individual, although appeal processes do exist. Commitment can be made less coercive with the use of psychiatric advance directives—created during a period of stability—that allow the person to designate how he or she wants to be treated during a period of destabilization.

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*The use of coercion, no matter how subtle, will usually undermine the engagement process and prevent the development of trust.*

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Involuntary outpatient commitment is much more controversial and is driven by the need for public safety. Laws regarding outpatient commitment are often enacted after a high-profile tragedy occurs involving a mental health consumer. If these cases are examined closely, it is often discovered that the person had been seeking treatment but the system did not respond quickly enough to meet the needs of the individual, or that the person did not feel welcomed by the system. A broad-based dialogue between all stakeholders is suggested as individual states make these decisions.

Most mental health professionals would support the notion that a healing relationship that promotes trust and autonomy is the most effective way to support patients in their individual recovery process. Engaging the individual in his or her own treatment is the first step in establishing this relationship. The use of coercion, no matter how subtle, will usually undermine the engagement process and prevent the development of trust. This can have a tremendous negative impact on the person seeking treatment, often alienating him or her from the system that has been designed to help.

It is critical in the continued development of treatment models to make the models welcoming to all consumers who need them. Solutions that lead to the elimination (*continued on page 15*)

# www.seclusion and restraint

American Academy of Child and Adolescent Psychiatry (AACAP): Presents issue briefs on the use of seclusion and restraint with children and adolescents and summarizes proposed legislation. Describes a variety of publications that address the use of coercion in the psychiatric treatment of children and adolescents. [www.aacap.org](http://www.aacap.org)

American Academy of Physician Assistants (AAPA): Features a position statement on reducing seclusion and restraint usage. [www.aapa.org/gandp/restraint.html](http://www.aapa.org/gandp/restraint.html)

American Nurses Association (ANA): Offers a detailed position statement on reducing seclusion and restraint usage from the nursing perspective. [www.nursingworld.org](http://www.nursingworld.org)

Centers for Medicare and Medicaid Services: Offers information on restraint reduction and other issues from the senior perspective, including archive copies of the HCFA National Restraint Reduction Newsletter. [www.hcfa.gov/publications/newsletters/restraint](http://www.hcfa.gov/publications/newsletters/restraint)

Judge David L. Bazelon Center for Mental Health Law: Provides current information on legislation and court decisions affecting the use of seclusion and restraint in psychiatric facilities. Includes an in-depth discussion of the use of advance directives in stating a consumer's preferences during times of incapacity, including a series of advance directive templates. Also contains information on the proposed Patients' Bill of Rights, Americans with Disabilities Act (ADA) and *Olmstead v L.C.* [www.bazelon.org](http://www.bazelon.org)

National Alliance for the Mentally Ill (NAMI): The non-profit support and advocacy organization's site features a position statement on seclusion and restraint as well as a chart that summarizes abuse of restraint usage across the country from October 1998 (the month that *The Hartford Courant* story was published) through March 2000. [www.nami.org](http://www.nami.org)

National Association of Consumer/Survivor Mental Health Administrators (NAC/SMHA): Features a modern history of abuse in mental health settings and contact information for national consumer affairs officials. [www.nasmhpd.org/consurdiv.htm](http://www.nasmhpd.org/consurdiv.htm)

National Association of Protection and Advocacy Systems (NAPAS): Offers information on federally mandated Protection and Advocacy (P&A) programs that protect the rights of persons with disabilities, including psychiatric disabilities. Contains a special report on seclusion and restraint. [www.protectionandadvocacy.com](http://www.protectionandadvocacy.com)

National Association of Psychiatric Health Systems (NAPHS): Offers guidelines on the use of seclusion and restraint in psychiatric facilities. Provides information on advocacy projects, news releases, upcoming events and links to related Web sites. [www.naphs.org](http://www.naphs.org)

National Association of State Mental Health Program Directors (NASMHPD): Features a position statement, legislative updates, and several free online publications including two NASMHPD Medical Directors' special reports and an archive copy of the summer 1999 *networks* issue on reducing seclusion and restraint. [www.nasmhpd.org](http://www.nasmhpd.org)

National Council for Community Behavioral Healthcare (NCCBH): Includes legislative information on the effort to reduce seclusion and restraint, as well as a variety of other public policy initiatives in the field of mental health. [www.nccbh.org](http://www.nccbh.org)

National Mental Health Consumers' Self-Help Clearinghouse: Includes information on restraint reduction and other issues from a consumer advocate perspective. [www.mhselfhelp.org](http://www.mhselfhelp.org)

Pennsylvania Department of Public Welfare: A wealth of information on this state's efforts to drastically reduce seclusion and restraint usage includes data, charts and exemplary state hospital guidelines. [www.dpw.state.pa.us/omhsas/omhleadingway.asp](http://www.dpw.state.pa.us/omhsas/omhleadingway.asp)

U.S. General Accounting Office: The complete September 1999 report to Congressional requesters entitled, *Improper Restraint or Seclusion Use Places People at Risk*. [www.psych-health.com/restrnl2.pdf](http://www.psych-health.com/restrnl2.pdf)

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## Coercive Tactics *(continued from page 13)*

of coercion in mental health treatment are both simple and complex. The simple answer is to listen to the patient. Multiple surveys have shown that mental health consumers want the same things as most people: a nice place to live, a job, a significant other, and good healthcare. As the medical treatment of serious mental illness has improved over the last decade, it has become clear that these goals are achievable for people who may not have been able to get there in the past. Combining these treatments with a trusting, empathic healing relationship can result in successful treatment and continued recovery.

The complex answer involves confronting “practice as usual” as unacceptable and replacing a culture of control with a culture of caring.

Making the cultural shift identified above results in a welcoming treatment environment that meets the individuals where they are and assists them in attaining the goals they set for themselves. When a psychiatrist asks questions like, *What do you want to get out of treatment and how can I help you achieve it?* and *What bad experiences have you had in treatment settings in the past, and how can we avoid them?*, it helps engage the person quickly.

It is also important to give the consumer the permission to disagree with the proposed treatment and the opportunity to safely tell the clinician. Realistically, if the person disagrees they are not likely to adhere to the plan the moment they walk out of the office. If the consumer is allowed to express his or her disagreement there is a much better chance that a reasonable alternative can be negotiated that both the clinician and consumer can feel comfortable with.

Cultural change can be difficult, but there are examples in the mental health field that can be used to illustrate this point. The drive to reduce and potentially eliminate the use of restrictive procedures in mental health facilities is an example of the importance of culture change in accomplishing a goal. Many facilities and systems have substantially reduced the use of these procedures. When you look for the common themes that contributed to these facilities’ successes, a significant cultural change—one that moved the system from a philosophy of control to empowerment—is often noted.

Strong leadership was also critical. Top management needs to be accountable for this type of change to occur and must hold the whole staff accountable as well. Values of respect and dignity must permeate the system and disrespectful behavior by staff must be confronted and changed. No longer can providers pick and choose who they serve or have rules for the convenience of the organization that result in coercive tactics. There should be standard “No reject, no eject” policies in place and staff should learn to negotiate with consumers to reach a mutually agreeable plan. If compromise does not occur, they can agree to disagree in all but the most critical or dangerous situations. Since the consumer is the one with the disease it must be his decision to accept treatment in the non-emergency

situation. If they refuse medication it is up to the psychiatrist to continue to educate consumers so they can make informed, non-coercive decisions on how they want to be treated. The relationship, if it is based on trust and caring, will result in the consumer making the best decision for himself. The consumer is ultimately responsible for his or her recovery.

These solutions are important ones since they represent the clinician-patient interface where the work has to happen. The larger system can respond by enacting laws or regulation that push it forward but this response is difficult to enforce and regulate. It has been important to regulate life-threatening coercive procedures such as seclusion and restraint, but even with regulation, if a facility has not made the cultural shift it will continue to struggle with the issue.

A more practical approach would be to implement a cultural change early in training programs for mental health professionals. Facility staff need to treat people with respect and dignity and encourage trainees to avoid control tactics at all cost, using them only in the most extreme situations. Also, facility staff should develop the habit of regularly self-examining their practice styles to make sure they are not inadvertently pushing a consumer to do something they do not agree with in treatment.

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*Policies that make the patient the center of the plan and the most important member of a treatment team can encourage respect and dignity.*

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Outside the realm of regulation, each facility can establish clinical policies (or guidelines) that do not allow for coercive strategies. Policies that make the patient the center of the plan and the most important member of a treatment team can encourage respect and dignity. The organization can establish a vision statement that raises these values to the forefront and that can be referenced when questionable practices occur. Of course, if the words are not followed by vigilance and action it will not be successful.

In conclusion, coercion continues today despite advances in the advocacy movement and treatment technology. It is hard to give up the old ways of doing business especially when the system seems to move so fast that there is not enough time to reflect on how far it has come, or how much better the tools of today allow us to let consumers make their own choices. Mental health practitioners need to explore their feelings of responsibility in controlling a consumer treatment recovery process. Mental health consumers must be allowed to make their own mistakes if they are to reach their full potential in life. Our role is to support and facilitate that process. ♦

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## Creating Sanctuary *(continued from front cover)*

trauma specialist Bessel van der Kolk has pointed out that traumatization occurs when both internal and external resources are inadequate to cope with external threat” (1989). When understood broadly, the concept of trauma can refer to any event or sequence of events that overwhelms the person’s physical, psychological, social, or spiritual capacity to cope.

Traumatic events are real and unfortunately common. In the most recent study, 60% of men and 51% of women in the general population reported at least one traumatic event at some time in their lives. Almost 17% of men and 13% of women who had some trauma exposure had actually experienced more than three such events (Kessler, et al., 1995).

At least 3.3 million children between the ages of 3 and 17 years witness parental abuse annually (Campbell & Lewandowski, 1997). The number of abused and neglected children in the U.S. grew from 1.4 million in 1986 to over 2.8 million in 1993. During that same period, the number of seriously injured children *quadrupled* while child protective services only investigated 28% of the cases. The number of sexually abused children rose by 83% in that period (NIS-3, 1996).

In America today, almost 9 million adolescents have witnessed serious violence, and among them, at least 15% have developed Posttraumatic Stress Disorder (PTSD) compared to 3.3% of surveyed youths who had not witnessed violence (Kilpatrick & Saunders, 1997). In a research study on the prevalence and consequences of child victimization, published in 1997, it was reported that approximately 3.9 million adolescents have been victims of a serious physical assault and an estimated 8% have been victims of serious sexual assault (Kilpatrick & Saunders, 1997).

Five out of six people will be victims of violent crimes at least once in their lifetimes (National Victim Center, 1993). One out of every eight adult women or at least 12.1 million American women will be the victim of forcible rape sometime in her lifetime (Kilpatrick, Edmunds, & Seymour, 1992). It has been estimated, based on probability sampling, that from 2 to 3 million women are assaulted by male partners each year in the U.S. and that from 21-34% of all women will be assaulted by an intimate male during adulthood (Gelles & Straus, 1988).

At least 8% of these will suffer significant distress or impairment as a result of their exposure (Friedman, 2000) and this rate will vary depending on the type of trauma. For instance, rape victims are 6.2 times more likely to develop PTSD than women who had never been victims of crime (Kilpatrick, et al., 1992), and studies have shown that 70% of rape victims may develop PTSD (De Girolamo & McFarlane, 1996). Forty percent of those who develop PTSD will suffer from chronic, severe, even permanent symptoms. The people who will have the most difficulty recovering from a traumatic event are those who have the most exposure, the greatest loss, the greatest

amount of other physical and psychological vulnerabilities, the least social support, and the greatest amount of previous trauma (Yehuda, Hallig, & Grossman, 2001).

Exposure to childhood trauma is particularly problematic because so much active physical and psychological growth is occurring during childhood and therefore a traumatic event can profoundly influence developmental pathways. There is strong evidence that trauma that is prolonged, first occurs at an early age, and is interpersonal can have pervasive effects on the totality of people’s personality development (Roth, et al., 1997).

The result of these pervasive effects can be a syndrome called “complex PTSD,” which is characterized by 1) alterations in regulating affective arousal; 2) alterations in attention and consciousness; 3) somatization; 4) alterations in self-perception; 5) alterations in perception of perpetrator; 6) alterations in relations to others; and 7) alterations in systems of meaning (Herman, 1992; Roth, et al., 1997). From the point of view of complex PTSD, many of the individuals and families who end up becoming high utilizers of psychiatric, social service, and criminal justice services could be described in this way.

There is a very high rate of comorbidity between PTSD and many other physical, psychological, and social problems (Bloom, 2002). In fact, people suffering from PTSD are two to four times more likely than those without PTSD to have virtually any other psychiatric disorder (Solomon & Davidson, 1997), and are almost eight times as likely to have three or more disorders—88% of men and 79% of women with PTSD have a history of at least one other disorder. Women with PTSD are four to five times more likely to also suffer from an affective disorder than those without PTSD and two to four times more likely to have another anxiety disorder (Kessler, et al., 1995). People with PTSD are eight times more likely to have three or more psychiatric disorders (Kessler, et al., 1995).

Despite the obvious enormity of the problem, little was recognized about the multilevel impact of trauma until the last two decades. Inhumane and humane treatment of the mentally ill has followed a cyclically recurring course and so has the recognition of trauma (Herman, 1992). The connection between exposure to trauma and psychological distress goes back many centuries and was written about by authors as diverse as Homer and Shakespeare. But it wasn’t until 1980 that psychiatry formally recognized the impact of traumatic experiences on mental health, and established the diagnosis of PTSD.

It has taken another two decades for us to begin to understand the implications of this knowledge for the mentally ill in general, and for the inpatient treatment of the mentally ill specifically. Even though studies dating back a decade and a half have demonstrated that a high proportion of psychiatrically hospitalized patients are trauma survivors (Carmen, Rieker, & Mills, 1984; Jacobson, Koehler, & Jones-Brown, 1987), the impact of that trauma *(continued on page 19)*

## Replacing Control with Empowerment is a Proven Solution

By W. Russell Hughes, Ph.D., M.B.A.

*Dr. Hughes is the chief executive officer of the Columbia Behavioral Health System, a division of the South Carolina Department of Mental Health, in Columbia, SC.*

Seclusion and restraint are among the interventions that include forced medications, physical measures by uniformed security officers, and “whenever necessary” orders for psychoactive medications. This class of interventions, which is marked by force, coercion, and violence and often results in trauma, has been accepted for decades as legitimate in behavioral health settings and derives from the erroneous belief that “We must control the patients.”

In past years, the critical incident reviews in the major state acute care program of South Carolina indicate that in over 50% of the occasions when coercive measures were deemed necessary, there had been a preceding act of control by one or more staff members which led to escalating behavior by the consumer, followed by more intrusive intervention by staff. More detailed reviews indicated that forced control was the preceding factor in even significantly more cases.

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Behavioral health has control as its heritage with a genesis in the days when medications, treatment techniques, and knowledge were much more primitive than today. The state hospitals of 50 years ago resembled manufacturing plants more than hospitals where thousands of employees reported to work and set about herding large groups of patients into medication lines, through showers, into day rooms, and to meals. Control was seen as necessary given the limited alternatives for addressing disruptive or violent behaviors. This philosophy of control also dictated how employees were supervised with strict schedules, time clocks, discipline for minor policy violations, and punishment of initiative. In short, the hierarchical control of a strict medical model was the rule.

When South Carolina adopted the goal of eliminating coercive measures in 1999, we identified that no one likes to be controlled by another and that reactions to such ranged from the visceral “knot in the stomach” to physical violence among those with limited

impulse control. Thus, we set about to create an environment where employees were valued and empowered and where consumers would be treated with the same courtesy and respect.

All staff, including mental health aides, were included on decision-making task forces and encouraged to communicate ideas and take initiative. Consumers were included in debriefings and were empowered in their ability to provide a valuable perspective that staff could utilize. Plans were developed and discussed to eliminate time clocks, allow self-scheduling, and provide for flex time, all of which were viewed as shifting control, responsibility, and accountability from management to each individual staff member.

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*Consumers were included in debriefings and were empowered in their ability to provide a valuable perspective that staff could utilize.*

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Education proved to be both simple and effective. Sensitivity training helped staff visualize the terror someone felt while being placed in four point restraints when that person had a history of sexual abuse, or of being “taken down” by large security officers when that person had suffered physical abuse in childhood. Staff could appreciate how the coercive events could be re-traumatizing and lead to flashbacks, a reliving of the previous abuse, and even extremely violent behavior. With this awareness, staffers were more open to training in methods of de-escalation of behaviors. Utilization of restraint and seclusion started to be viewed as treatment failures.

Previous management action had effectively lowered average monthly seclusion hours from 695 in 1993 to 70 in 2000 and average monthly restraint hours from 24 in 1992 to 2 in 2000. The philosophy that empowered both staff and consumers to control their own lives lowered average monthly seclusion hours to 21 and average monthly restraint hours to .35 in 2001. Data for the period May 2001 through April 2002 indicate that for every 1,000 inpatient hours, the number of hours clients spent in restraint were .006 compared to the national measure of .913, and that the number of hours clients spent in seclusion were .183 compared to the national measure of .876.

These results are convincing evidence—seclusion, restraint, and other coercive actions can be eliminated through continued commitment to do so. To attempt anything less is inexcusable. ♦

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## PERSPECTIVES FROM THE FIELD

# Comfort and Communication Help Minimize Conflicts

By Gayle Bluebird, R.N.

*Ms. Bluebird is a national consumer consultant.*

The Comfort Room Project was devised to create an environment of comfort rather than control, based on the fact that patients/consumers/clients in inpatient settings generally know best what prevents them from crisis. The guiding philosophy of this project is that rather than waiting for crises to happen, helpful, pro-active steps can be put in place.

The project was implemented at Atlantic Shores/South Florida State Hospital in 2001 where rooms formerly used as “quiet rooms” were reassigned to become “comfort rooms”—comfortably furnished, visually appealing rooms for people to voluntarily choose to enter when in distress.

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*It is important to make clear that the Comfort Room is not an alternative to seclusion and restraint; it is a preventive tool that may help to reduce the need for seclusion and restraint.*

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The first component of the Comfort Room Project is the use of the de-escalation preference form, which is filled out by the patient shortly after the time of admission to a facility. The form was designed to identify helpful prevention measures when a person is in stress and subsequently to help eliminate the need for seclusion and restraint. (*Editor's note: A sample de-escalation form is available on the NTAC Web site at [www.nasmhpd.org/ntac/networks/index.html](http://www.nasmhpd.org/ntac/networks/index.html)*)

Initially, persons admitted to the hospital were given the form in focus groups and asked to add to the list of diversions while ranking the diversions they would likely use. The findings indicated that most people would choose to exercise, go for a walk, talk to a friend or listen to music. They also liked the idea of the blanket wrap. Some noted that they would prefer to talk to a friend or peer, and some stated they would like to read the Bible. Other suggestions were added to the list, such as drinking coffee or other beverage.

Questions were added to the form regarding the consumer's preference for male or female assistance, whether or not he/she minds being touched or hugged, whether he/she had been a victim of sexual abuse, and whether he/she had been in seclusion and restraints before.

The form is best utilized if introduced after the time of admission and not when required forms are presented for signatures. It is helpful to introduce the form in small groups—perhaps during an

orientation group when discussion is encouraged. After the form is completed, it is integrated into the treatment plan.

One of the things communicated to a person during admission is the availability and location of the Comfort Room. A Comfort Room (formerly called the “Quiet” or “Time-Out” room) provides sanctuary from stress, while it can also be a place for persons to experience feelings within acceptable boundaries. The South Florida State Hospital is one of the first to implement such a room, while other hospitals, such as Allentown State Hospital (PA), have created similar programs as part of their seclusion and restraint reduction initiatives.

The Comfort Room is set up to be physically comfortable, including a recliner chair (experience shows that a special sturdy chair that can be bolted to the floor may be necessary), walls with soft colors, and murals with images chosen by consumers on each unit. The first Comfort Room was designed with palm trees—the image requested by the persons served on that unit. Colorful curtains were added but were required to be fire-resistant and placed high in the room to prevent them from being pulled down. Experience shows that despite some occasional abuse of the privilege, the majority of people using the comfort room abide by the guidelines.

A Comfort Box can also be placed in the room. The box could contain stuffed animals, a soft blanket or comforter, inspirational reading materials, a large stuffed animal for hugging, and other small, appropriate comfort items. Headphones can be made available with tapes (these can be kept in the nurses' station).

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*Even the most creative approaches will fail without top-level support for the initial start-up, and at every stage of continuation.*

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It is important to make clear that the Comfort Room is not an alternative to seclusion and restraint; it is a preventive tool that may help to reduce the need for seclusion and restraint. It is not used for a person who is unable or unwilling to use the room voluntarily.

In addition, success is not possible with any of these approaches unless staff are trained and open to using them and consumers are included as integral parts of planning and implementation. Most importantly, there must be a buy-in by administration and supervisory staff. Even the most creative approaches will fail without top-level support for the initial start-up, and at every stage of continuation. ♦

## Direct Care View: *Restraint is Avoidable*

By Rob Hennessy

With more than 20 years of direct care experience working with adolescents in mental health settings, Ron Kowalczyk has witnessed his share of seclusion and restraint incidents. The former technician has applied restraints, and has even been injured in the process during his career, but his opinion on the issue may surprise some readers.

“A huge number of seclusion and restraint incidents that occur are unnecessary and avoidable, and that makes me madder than hell,” he said. “Frequently, we have written and unwritten rules, and we have a lot of staff who are inflexible and unwilling to negotiate with patients. [These staff members] have a need to be in control, and that typically leads to problems.”

While he does not believe seclusion and restraint techniques should be completely abolished, he says the violent interventions, especially restraint, should be avoided at all costs. According to Kowalczyk, there’s multiple means to avoid seclusion and restraint usage, and in his current role as a behavior analyst/case coordinator, he works to teach staff to find acceptable outcomes to potentially violent situations without acting too quickly.

“The first thing is to step back, take a moment to think about what you are doing next. Even if the patient is breaking furniture, or scratching himself with a paperclip, these things aren’t life threatening, and don’t require restraint. If the situation is not life-threatening, there is always time to evaluate,” he said.

“It’s also better to ask the patient what he needs you to do, rather than telling the patient what you need him to do. It always helps to negotiate because time usually diffuses the situation. Finally, if there are options, such as offering the patient to go to his room and calm down, or talk to the staff member he trusts, or listen to music, you can have the patient help you,” said Kowalczyk.

“I personally don’t like using physical restraints, because it’s human nature for the person to try to escape it, and that will have the patient trying to bite and kick his way out. Using restraints builds the adrenaline in the staff and the patient, and staff can act inappropriately in those situations,” he said.

“When we instituted the reduction effort, there was a lot of talk that the kids would be more out of control, and that has not happened at all. If anything it’s been the opposite,” said Kowalczyk. “Our program has made big strides. We had an intense effort this past year especially, reducing restraint and seclusion incidents by about 75%—partially through training, and partially by saying, *That’s just not the way we do things anymore.*”

## Creating Sanctuary *(continued from page 16)*

is only now beginning to play a role in treatment formulation and approaches (Bloom, 1997, 2000).

What are some of the implications for hospitalized patients of our understanding the impact of trauma? Until proven otherwise, we must assume that hospitalized psychiatric patients have had exposure to violence, especially if they are women (Goodman, et al., 1997). They may indeed have a biologically-based, genetically influenced mental disorder and therefore a “sickness,” but they are also *injured*, and paying attention to the nature and alleviation of suffering secondary to these injuries may profoundly determine the outcome of treatment for their *illness*.

As in the treatment of any physical or psychological injury, it is critical that we *do no harm*. To accomplish this, we must immediately focus attention on safety and ask searing questions of ourselves and of our patients about what makes a treatment environment truly safe. In an interconnected social setting like a hospital, if anyone is unsafe, all are unsafe. The environment cannot be safe for patients unless it is also safe for staff. The staff cannot create an environment of safety without the active participation of the patients. These are the fundamental principles behind the ideas of the therapeutic community and they are as valid today as they were fifty years ago, only now our understanding of trauma explains the reasons behind these principles.

For an environment to be truly safe it must be physically, psychologically, socially, and morally safe for everyone in the community and the achievement of that level of safety must be a shared and sustained process (Bloom, 1997). For the inpatient trauma survivor this requires that the staff fully understand the dynamics of trauma and traumatic reenactment, including the unnecessary use of seclusion and restraint.

Coercion and force retrigger the survivors’ previous experience with profound helplessness and can therefore result in retraumatization. It means that the patients must be active participants in their own recovery and must take responsibility for committing themselves to safety and recovery.

A fundamental goal of treatment should be to prevent *sanctuary trauma*, defined as expecting a protective environment and finding only more trauma (Silver, 1986). “Creating Sanctuary” instead refers to the shared experience of creating and maintaining safety within any social environment and that sense of safety must be total and all-inclusive. Only then can we create a “trauma-sensitive culture,” a culture within which it is understood that most human behavioral pathology is related to overwhelming experiences of exposure to abusive power, disabling losses and disrupted attachment. Therefore, behavior on the part of staff and clients must be understood and addressed within the context of these dynamic forces. ♦

For a complete reference listing,  
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