

**RESTRAINT AND SECLUSION –  
A RISK MANAGEMENT GUIDE**

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## Executive Summary

Courts have long recognized that people with mental illnesses have the right to be free from the improper use of seclusion and restraint. In the landmark 1982 case Youngberg v. Romeo, the Supreme Court recognized that the use of restraint is a drastic deprivation of personal liberty, holding that “[t]he right to be free from undue bodily restraint is the core of the liberty interest protected by the Due Process Clause from arbitrary governmental action.” Youngberg v. Romeo, 457 U.S. 307, 316 (1982).

In that case, the Supreme Court noted that the use of restraint should reflect “the exercise of professional judgment.” At the time of the Youngberg decision, restraint and seclusion were often used to control the behavior of people with mental health conditions in a variety of settings, and a broad range of views regarding what constitutes “professional judgment” existed among clinicians.

Over the past decade, however, a clear consensus has emerged that restraint and seclusion are safety interventions of last resort and that the use of these interventions can and should be reduced significantly. In evaluating the potential legal risks associated with the use of restraint and seclusion, risk managers should understand this emerging consensus as critical to a determination about whether a particular use of these interventions reflects “the exercise of professional judgment.” This should be considered in the context of the following factors:

- (1) Each use of restraint or seclusion poses an inherent danger, both physical and psychological, to the individual who is subject to the interventions and, frequently, to the staff who administer them.
- (2) The decision to use restraint or seclusion nearly always is arbitrary, idiosyncratic, and generally avoidable.
- (3) Many inexpensive and effective alternatives to restraint and seclusion have been developed and successfully implemented across a broad range of mental health facility types.

Recent increased scrutiny regarding the use of restraint and seclusion has resulted in a legal and regulatory environment that discourages their use and increases the risks of litigation for clinicians and facilities that rely on these practices. The legal consequences of inappropriate use of restraint and seclusion can include civil damages, administrative sanctions (including the loss of Medicaid and Medicare certification), and criminal prosecution. Moreover, litigation about these practices invariably consumes the facility’s attention and resources, no matter what the ultimate outcome, with significant negative implications for the facility’s reputation and staff morale.

To minimize these risks, all mental health facilities should develop a risk management strategy that includes the following components:

- (1) Review your facility's current policies and practices regarding restraint and seclusion;
- (2) Advise top management that legal exposure is increasing and that reducing the use of restraint and seclusion demands their attention;
- (3) Establish a facility-wide task force including top management, staff, union representatives, and consumers to develop a plan to reduce restraint and seclusion that includes a public commitment to the goal of reduction, a strategy for workforce training, and the use of data to set outcomes targets and evaluate progress; and
- (4) Maintain the priority of constant reduction in the use and duration of restraint and seclusion.

## **RESTRAINT AND SECLUSION: *A Risk Management Guide***

*Wisconsin Mutual Insurance Company has learned a very serious lesson from this case . . . seclusion is a real issue that needs to be dealt with on a proactive basis in order to avoid another record verdict of \$400,000 in [compensatory] damages and \$5 million in punitive damages.*

Bisek, B., *Scott Lawson v. Monroe County - A Lesson Learned*,  
The Mutual Effort, Vol. 4.3 (Summer, 1999) at 1.

### **I. Introduction**

Restraint and seclusion historically have been used to control the behavior of people with mental health conditions in a variety of settings, including hospitals and psychiatric treatment facilities.

Over the past decade, however, these practices have come under intense scrutiny as researchers and clinicians have chronicled the significant physical and psychological risks – including death, disabling physical injuries, and significant trauma – inherent in each use of the interventions. Also during this time, many effective, inexpensive alternatives to restraint and seclusion were developed, demonstrating that their use can safely be reduced significantly and undermining their legitimacy in a treatment setting.

This attention to the use of restraint and seclusion has resulted in a legal and regulatory environment that discourages their use and increases the risks of litigation for clinicians and facilities that rely on these practices. The legal consequences of inappropriate use of restraint and seclusion can include civil damages, administrative sanctions (including the loss of Medicaid and Medicare certification), and criminal prosecution. Moreover, litigation about these practices invariably consumes the facility's attention and resources, no matter what the ultimate outcome, and the impact on the facility's reputation and staff morale linger long after the legal dust settles.

This paper is intended to assist the attorneys and risk managers who advise behavioral health facilities. In particular, this paper will:

- Provide background on the increased scrutiny of the use of restraint and seclusion, including a discussion of the political, legal, and regulatory context regarding the use of these interventions for people with mental illnesses;

- Provide a brief overview of factors explaining why the use of restraint and seclusion poses legal risks, including a description of the medical risks associated with the use of these interventions;
- Provide an overview of the constitutional, civil, and criminal claims that may arise when seclusion and restraint are used improperly, and review relevant case law;
- Provide examples of effective alternatives to the use of restraint and seclusion and related resources;<sup>1</sup> and
- Recommend practical strategies to reduce risks to providers and facilities.

## **II. Restraint and Seclusion Use in Mental Health Facilities Is Under Intense Focus**

Courts have long recognized that people with mental illnesses have the right to be free from the improper use of restraint and seclusion. In the landmark 1982 case Youngberg v. Romeo, the U.S. Supreme Court recognized that the use of restraint is a drastic deprivation of personal liberty, holding that “[t]he right to be free from undue bodily restraint is the core of the liberty interest protected by the Due Process Clause from arbitrary governmental action.” Youngberg v. Romeo, 457 U.S. 307, 316 (1982).

In light of the significant constitutional issues inherent in the use of restraint, a decision by clinicians or other staff to use these interventions must reflect “the exercise of professional judgment.” *Id.* at 323. Liability may be imposed when the decision by the professional is “such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.” As will be discussed, the standards governing professional judgment in this area have evolved considerably since Youngberg.

Although Youngberg articulated a constitutional right to safety and protection against “undue bodily restraint” more than 20 years ago, little consensus existed at that time within the legal or clinical communities concerning the appropriate duration, conditions,

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<sup>1</sup> The restraint and seclusion reduction interventions discussed in this guide have been developed and effectively implemented in inpatient facilities serving individuals with mental conditions that are amenable to recovery-focused treatment. The effectiveness of these interventions is not known when used with people with traumatic brain injury (TBI); people who present to care settings such as emergency rooms in an acutely intoxicated condition; or people who demonstrate criminal psycho-pathology such as the ability to plan aggressive attacks on others or who demonstrate low or no remorse for hurting others. For mental health facilities and state forensic mental health hospitals that serve the populations described above, these interventions will need to be carefully adapted for such individuals and other interventions may be necessary.

or the circumstances in which restraint and seclusion were inappropriate. In a 1985 report of the American Psychiatric Association's Task Force on the Psychiatric Uses of Seclusion and Restraint, the Task Force reported on a survey of state mental health directors regarding seclusion and restraint practices. The Task Force noted that it was "impressed by the variability in the length and specificity of written regulations." State regulations differed significantly regarding when seclusion and restraint could be employed and who could order their use. Most state regulations did not define seclusion or restraint, and only four specified who was responsible for ending seclusion and restraint episodes. At least eight states permitted the use of seclusion and restraint to prevent substantial property damage, two states permitted the use of these interventions to prevent disruption of the treatment environment, and four states allowed their use as part of a regular treatment plan. The Task Force concluded: "This survey further supports the national need for comprehensive, widely disseminated, and, hopefully, fully implemented guidelines for the seclusion and restraint of patients." American Psychiatric Association, *Seclusion and Restraint, The Psychiatric Uses*, Report of the American Psychiatric Association Task Force on the Psychiatric Uses of Seclusion and Restraint (1985).

Over the next 20 years, clinicians, researchers, consumers, and legal advocates increasingly identified the overuse of restraint and seclusion in psychiatric facilities as abuse and many advocacy and professional organizations worked to reduce the use of these interventions. However, there remained a lack of consensus within the field about the appropriate use of restraint and seclusion. In 1998, the *Hartford Courant* published a series of articles chronicling the many deaths of adults and children resulting from the improper use of restraint in mental health facilities. This groundbreaking investigative series identified 142 deaths across the country related to these procedures between 1988 and 1998, with one-fourth of those deaths children. Weiss, E., *et al.*, *Deadly Restraint: A Nationwide Pattern of Death*, *Hartford Courant* (Oct. 11, 1998). The *Courant* also retained a researcher from the Center for Risk Analysis at Harvard's School of Public Health who estimated that between 50 and 150 deaths occur each year from the use of restraint and seclusion. *Id.*

Following publication of the *Courant* series, Connecticut's Congressional delegation introduced legislation and held hearings to regulate the use of these dangerous interventions. The Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration, or HCFA) responded swiftly by publishing an Interim Final Rule governing the use of restraint and seclusion in hospitals, including psychiatric hospitals. That Interim Final Rule, published in 1999, remains in place today. It adopts a regulatory framework that distinguishes restraints used for behavior management from other kinds of restraints used in hospitals and provides the following principles:

- The patient has the right to be free from restraint and seclusion, in any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. 42 C.F.R. §482.13(f)(1) (1999).

- Restraint and seclusion can only be used in emergency situations if needed to ensure physical safety and if less restrictive interventions have been determined to be ineffective. 42 C.F.R. §482.13(f)(2) (1999).

The regulations define seclusion broadly to mean “the involuntary confinement of a person in a room or an area where the person is physically prevented from leaving.” 42 C.F.R. §482.13(f)(1) (1999). Restraint is defined to mean:

- Any manual method, or any physical or mechanical device, material, or equipment attached or adjacent to the patient’s body that he or she cannot easily remove, that restricts freedom of movement or normal access to one’s body; and
- A drug used to control behavior or to restrict the patient’s freedom of movement that is not a standard treatment for the patient’s medical or psychiatric condition.

*Id.*

Today, less than six years after publication of these requirements, most States and providers with laws, regulations, or policies governing the use of restraint and seclusion have adopted an approach that mirrors the minimum standards provided in the Federal regulations. Haimowitz, S. and Urff, J., *Ending Harm From Restraint and Seclusion: The Evolving Efforts* (submitted for publication). The basic tenets of these standards are also reflected in the Behavioral Health Standards of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and in policy statements adopted by many of the nation’s leading professional organizations.

The American Psychiatric Association, in a special publication devoted to the reduction of restraint and seclusion, notes that “what is clear in all of these standards is a national intent to see that restraint and seclusion are used appropriately, as infrequently as possible, and only when less restrictive methods are considered and are not feasible.” American Psychiatric Association, American Psychiatric Nurses Association, and the National Association of Psychiatric Health Systems, *Learning from Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health* (January, 2003) at 4.

Other Federal agencies and professional associations also have prioritized reducing the use of restraint and seclusion:

- The federal Substance Abuse and Mental Health Services Administration (SAMHSA) issued a *National Call to Action* in 2003 concerning restraint and seclusion. “SAMHSA is committed to work with States, communities, consumers, families, providers, and provider organizations to ultimately eliminate the use of restraint and seclusion. Individuals with mental illness should not be confined, restrained, or retraumatized by the persons and resources put in place to help them.” <http://alt.samhsa.gov/seclusion/SRMay5report4.htm>

- The National Association of State Mental Health Program Directors (NASMHPD) – representing state mental health agencies, which typically administer state psychiatric hospitals – adopted a formal position statement calling for the reduction and, ultimately, the elimination of the use of restraint and seclusion. The position statement provides that these practices, which include “chemical restraints,” are “safety interventions of last resort” and should never be used for the purposes of discipline, coercion, or staff convenience, or as a replacement for adequate levels of staff or active treatment. NASMHPD, *Position Statement on Seclusion and Restraint* (July 13, 1999).
- The California Service Employees International Union (SEIU), the largest labor organization of public mental health workers, and the California Network of Mental Health Clients adopted a joint position that the mental health system must undergo a fundamental change in culture, from top to bottom, in its attitude toward and use of restraint and seclusion, stressing the need for de-escalation training, individual crisis plans and peer support. California Service Employees International Union and California Network of Mental Health Clients, *Five Principles in Reducing the Use of Seclusion and Restraints* (2002).

Other national associations which have adopted standards, policies or guidance focused on the reduction or elimination of restraint and seclusion include the Child Welfare League of America, American Academy of Child and Adolescent Psychiatry, American Association of Community Psychiatrists, NAMI (National Alliance for the Mentally Ill), National Mental Health Association, and The Bazelon Center for Mental Health Law.

“[W]hat is clear in all of these standards is a national intent to see that seclusion and restraint are used appropriately, as infrequently as possible, and only when less restrictive methods are considered and are not feasible. ...Clear policies and procedures that are well-communicated, understood, consistently implemented and continuously re-evaluated can significantly reduce your economic exposure.”

American Psychiatric Association  
 American Psychiatric Nurses Association  
 National Association of Psychiatric Health Systems  
*Learning from Each Other: Success Stories and Ideas for  
 Reducing Restraint/Seclusion in Behavioral Health*

The use of seclusion and restraint creates significant risks for people with psychiatric disabilities. These risks include serious injury or death, retraumatization of people who have a history of trauma, and loss of dignity and other psychological harm. ... 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  
*Position Statement on Seclusion and Restraint*

Restraints and seclusion must only be used in emergency situations to ensure the physical safety of the child and all others and should never be used for purposes of discipline, retaliation and convenience. ... The use of chemical restraints and mechanical restraints should be prohibited.

Child Welfare League of America  
*The Use of Restraints and Seclusion in Residential Care Facilities for Children*

Overuse and abuse of restraints and seclusion are symptoms of poor quality care in facilities, poor state oversight, and misdirected public policy. State and federal agencies must take a greater role in assuring the safety and protection of children and adults who experience these interventions.

National Mental Health Association  
*Position Statement: The Use of Restraining Techniques and Seclusion For Persons with Mental or Emotional Disorders (NMHA Program Policy P-41)*

### **III. Many Factors Contribute to the Substantial Legal Risks Associated with the Use of Restraint and Seclusion**

In considering the risks associated with the use of restraint and seclusion, facilities should be aware of the following factors:

#### **A. Each use of restraint or seclusion poses an inherent danger, both physical and psychological.**

Restraint and seclusion are widely acknowledged to be violent, stressful, and humiliating incidents, both for patients and for the staff members imposing them. Never benign, the use of restraint and seclusion can be lethal.

People have died in restraints from many causes, including:

- Asphyxia – that is, suffocating, often while being held face down, with staff sitting or putting pressure on an individual's person's back or abdomen, or when staff have placed blankets or towels around the face;
- Aspiration – that is, swallowing one's own secretions, generally while being restrained face up; and
- Cardiac events brought on by exertion, medication interactions, and unknown cardiac anomalies.

These risks are elevated by numerous medical conditions (*e.g.*, obesity, asthma, bronchitis, intoxication) and by psychotropic medications that alone can lead to hyperthermia, a condition where the internal temperature rises without normal correction. The risk of death or injury also appears to be more significant for children and adolescents. Mohr, W.K., *et al.*, *Adverse Effects Associated with Physical Restraint*, 48 *Canadian J. of Psychiatry* 5 (2003) at 330-337.

In addition to the risk of deaths to patients described above, physical injuries to patients and staff are very common. Even when stitches, fractures, and fatalities are avoided, restraint and seclusion traumatize the person, damage therapeutic relationships, and can significantly impede recovery. Restraints are particularly traumatizing to people who have been victims of physical and sexual abuse. For patients who are deaf and use American Sign Language to communicate, restraints eliminate their ability to express physical or emotional distress, increasing the risk of disabling harm or death

**B. The decision to use restraint or seclusion nearly always is arbitrary, idiosyncratic, and generally avoidable.**

Any practice which is inherently dangerous and which denies liberty in the most basic sense warrants scrutiny. When the practices also are largely avoidable and imposed in an arbitrary and idiosyncratic manner, the risk of liability increases substantially.

Most research regarding the use of restraint and seclusion suggest that the use of these practices generally is not based on patients' clinical needs or characteristics. A review of the existing literature published in 1994 reached the following conclusion

Local non-clinical factors, such as cultural bias, staff role perceptions and the attitudes of hospital administrators, have a greater influence on the use of these practices than any clinical factors.

Fisher, W., *Restraint and Seclusion: A Review of the Literature*, 151 *Am. J. Psychiatry* 11 (1994) at 1584-1591. See also D'Orio, B.M., *et al.*, (2004); Duxbury, J. (2002); Hinsby, K. and Baker, M. (2004); Ilkiw-Lavalle, M. and Grenyer, B.F.S. (2003); and Morrison, E.F. (1989).

An assessment of data in New York also confirmed these findings. The New York Commission on Quality of Care for the Mentally Disabled, an independent state agency, reviewed inpatient use of restraint and seclusion in 1994 and found huge variations between state psychiatric centers that could not be explained by patients' demographic or clinical characteristics. Rather, the NYCQC report concluded, "low use" facilities were led by administrators who discouraged these practices, provided greater personal liberties to patients (such as time off the unit, telephone and visitor privacy, and the freedom to take unscheduled showers), and provided at least 50 percent of the patients 20 hours or more therapeutic activities per week. New York State Commission on Quality of Care, *Restraint and Seclusion Practices in New York State Psychiatric Facilities* (September, 1994).

An important finding of both these studies is that, while attitudes and practices of direct care staff may affect rates of utilization of restraint and seclusion, the driving factor is the organizational leadership's view about the use of these practices, the leadership's commitment to active programming within the facility, and the organizational culture.

**C. The standard of practice in clinical settings is moving toward the reduction and even the elimination of restraint and seclusion.**

The intense focus on preventing and reducing the use of restraint and seclusion has resulted in dramatic shifts in the way many facilities and professionals view these practices as well as in significant reductions in their use. For example, from 2001 until 2005, the number of hours that patients in State psychiatric hospitals spent in restraints decreased by 46 percent and the percentage of patients restrained decreased by about 12 percent. Similarly, the number of hours that patients spent in seclusion decreased by 36 percent and the percentage of patients secluded decreased by about 26 percent. Schacht, L., *Public Report: National Trend in the Use of Seclusion and Restraint Among State Psychiatric Hospitals*, NASMHPD Research Institute, Inc. (2006).<sup>2</sup> Several states and specific facilities – spanning geographic areas, socioeconomic and cultural environments, and demographic and clinical characteristics of patients -- report even more dramatic reductions. Specific examples include the following:

- **State mental health authority:** In 1997, Pennsylvania's state mental health authority became the first in the nation to publicly commit to significantly reduce and ultimately eliminate restraint and seclusion in its nine adult state hospitals. A comprehensive program was adopted providing clear goals, specific strategies, and ongoing monitoring. During the first five years of the initiative, restraint and seclusion episodes were reduced by 74 percent and the total number of hours spent by individuals in restraints or seclusion decreased 96 percent. Smith, G., Davis, R., and Bixler, E., *Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program*, 56 *Psychiatric Services* 9 (2005) at 1115–1122.

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<sup>2</sup> This report tracks 150 State psychiatric hospitals that reported seclusion and restraint data for at least 4 years during the period January, 2001 through June, 2005 as part of the NASMHPD Research Institute, Inc.'s Behavioral Health Performance Measurement System.

- **Urban state psychiatric hospital:** Creedmoor Psychiatric Center, a large, urban state psychiatric hospital in Queens, New York that serves highly disabled individuals from one of the most culturally diverse communities in the nation, initiated a program that reduced the combined restraint and seclusion rate by 67 percent between 1999 and 2001. Fisher, W., *Elements of Successful Restraint and Seclusion Reduction Programs and Their Application in a Large, Urban State Psychiatric Hospital*. 9 *Journal of Psychiatric Practice* 1 (2003) at 7-15.
- **Rural state hospital:** Western State Hospital, a rural, regional state hospital in Virginia, reduced the use of these interventions by 79 percent between 1997 and 2002. Donat, D., *An Analysis of Successful Efforts to Reduce the Use of Seclusion and Restraint at a Public Psychiatric Hospital*. 54 *Psychiatric Services* 8 (2003) at 1119-1123.
- **Privately-operated state hospital:** South Florida State Hospital, a 350-bed adult facility, prioritized reducing the use of restraint and seclusion when it became the nation's first privately-operated state hospital in 1998. The hospital's managers, Atlantic Shores Healthcare, Inc., undertook a total review of its practices and culture, relying a great deal on consumer input and focusing on the goal of recovery. As a result, restraint and seclusion episodes were reduced from more than 15 to less than 1 per month between 1998 and 2000. National Association of State Mental Health Program Directors (NASMHPD), *National Executive Training Institutes: Reducing the Use of Seclusion and Restraint -- Curriculum Training Manual* (2003).
- **Forensic hospital:** North Texas State Hospital's Forensic Unit, a 50-bed maximum security facility, reduced both the incidence of restraint and seclusion and the duration of these interventions by more than 50 percent between 1999 and 2001. Goodness, K. and Refro, N., *Changing Cultures: A Brief Program Analysis of a Social Learning Program on a Maximum-Security Forensic Unit*, 20 *Behavioral Sciences and the Law* 5 (2002) at 495-506. This facility, the only one of its type in Texas, serves individuals found Incompetent to Stand Trial and Not Guilty by Reason of Insanity. Most of its patients are transferred from civil hospitals after being determined to be "manifestly dangerous" and thus unable to be cared for in any other setting.
- **Statewide initiative:** In 2000, the Massachusetts Department of Mental Health implemented a statewide Child and Adolescent Initiative aimed at reducing the use of restraint and seclusion with youths in inpatient units at all public and private facilities under the agency's jurisdiction. Within 22 months, significant reductions in the use of restraint and seclusion were achieved in 80 percent of the units. At the same time, injuries to both patients and staff decreased, as did the use of involuntary medication. LeBel, J. and Goldstein, R., *The Economic Cost of Using Restraint and the Value Added by Restraint Reduction or Elimination*, 56 *Psychiatric Services* 9 (2005) at 1109-1114.

- **Private residential treatment facility:** Millcreek, a 204-bed private psychiatric residential facility for children and adolescents in Mississippi, achieved a 99 percent reduction in the use of restraint and seclusion over four years, including an 89 percent drop in the first year. In 2003, Millcreek received an Ernest Codman Award from the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) for sustaining restraint reduction through culture change and the treatment planning process. <http://www.jointcommission.org>
- **General hospital acute care psychiatric unit:** Salem Hospital, a general hospital in Salem, Oregon, “virtually eliminated” the use of seclusion and restraint from its acute care psychiatric unit when it refocused its treatment philosophy to a patient-centered approach in 2000. Bennington-Davis, M. and Murphy, T., *Eliminating Seclusion and Restraint*, 32 Clinical Psychiatry News 12 (2004). In addition to significant and measurable reductions in the use of restraint and seclusion, many facilities have documented the positive consequences of these efforts. For example, a recent study demonstrated that reduced use of restraint and seclusion leads to fewer injuries to patients and staff, better clinical outcomes, and significant cost savings in terms of staff time. LeBel, *supra*. Moreover, many mental health facilities comply with Occupational Health and Safety Administration’s guidelines on worker safety through programs to prevent the need for the use of restraint and seclusion. Occupational Health and Safety Administration, *Guidelines for Preventing Workplace Violence for Health Care and Social Workers*, OSHA 3148-01R (2004).

As a result of these changing practices and research findings, what constitutes professional judgment and reasonable practice has changed significantly. Uses of restraint and seclusion that may have been consistent with accepted medical practice only a few years ago would not be acceptable today.

#### **MYTHS AND REALITIES**

Efforts to reduce the use of restraint and seclusion invariably encounter a range of longstanding assumptions about these practices – assumptions that research has shown are erroneous. Examples of beliefs expressed by staff – and the “reality” associated with each of these myths – include the following:

**Myth:** Restraint and seclusion are used only to insure safety.

**Reality:** While the consensus in the field is that restraint and seclusion *should* be used only to ensure safety, they actually *are* used mostly for loud, disruptive, or non-compliant (but not violent) behavior.

<b>Myth:</b>	Restraint and seclusion are used only when there is no other alternative.
<b>Reality:</b>	In fact, although there is an emerging consensus in the field that these interventions should only be used if no other intervention is possible, restraint and seclusion often are staff's first, automatic responses to difficult behavior.
<b>Myth:</b>	Restraint and seclusion reduce patient and staff injuries.
<b>Reality:</b>	Decreasing the use of restraint and seclusion does not result in increased patient and staff injuries, and may actually reduce them.
<b>Myth:</b>	Restraint and seclusion help individuals feel secure, gain self control, and learn to follow rules.
<b>Reality:</b>	There is absolutely no evidence that these interventions have any therapeutic value.

For a discussion of these issues and the related research, see Mohr, Petti, Morh, 2003 and NASMHPD, 2003)

#### **IV. Overview of Legal Claims and Liability Risks Associated with Restraint and Seclusion**

Providers and facilities that use restraint and seclusion are vulnerable to litigation under several possible causes of action. In addition to constitutional claims first identified in Youngberg, plaintiffs may bring other civil claims (including common law tort claims) and civil rights actions. Prosecutors can bring criminal charges and are increasingly doing so. These are briefly summarized below.

##### **A. Basic Rules**

Federal regulations on the use of restraint and seclusion for behavior management in hospitals provide minimum standards related to the use of these interventions. The rules, which were developed in response to political and media attention following the *Hartford Courant* articles on the dangerousness of these interventions, were published as an Interim Final Rule in 1999. The rules are a Condition of Participation for all hospitals, including psychiatric hospitals, receiving Medicaid and/or Medicare reimbursement. 42 C.F.R. 482.13 (1999).

When the rules were published, hospital groups objected to the requirement that a physician or licensed independent practitioner conduct a face-to-face assessment within one hour of the intervention. These groups challenged in court the Federal government's ability to promulgate the rules as an Interim Final Rule. The court found that the Federal

government's actions did not violate the notice and comment period of the Administrative Procedures Act and upheld the Interim Final Rule. National Association of Psychiatric Health Systems, et al., v. Donna E. Shalala, Civil Action # 99-2025 (D.D.C., Decision September 14, 2000).

Additional regulations were adopted in another Interim Final Rule, later modified, regarding the use of restraint and seclusion in Psychiatric Residential Treatment Facilities for children. 42 C.F.R. Parts 441 and 483. Another set of regulations, required by the Children's Health Act of 2000, Pub. L. No. 106-310 (2000), regarding the use restraint and seclusion in non-medical, community-based facilities for children and youth are not yet published.

The Hospital Conditions of Participation focus principally on ensuring the physical safety of patients during a restraint or seclusion episode. These rules include the following basic tenets:

- Restraint and seclusion are safety interventions of last resort, to be used only when an individual poses an imminent danger to someone's safety.
- Restraint and seclusion may be ordered only by a physician or a licensed independent practitioner (such as a physician's assistant or nurse practitioner who is licensed to deliver medical services without oversight).
- Orders must be time-limited – 4 hours maximum for adults, 2 hours for adolescents ages 9-17, and one hour for children under 9 -- and the intervention must be ended as soon as it is safe to do so.
- Certain risky practices, such as "basket holds" and applying back pressure to a person who is prone, are prohibited.
- A physician or licensed independent practitioner must conduct a face-to-face assessment of the individual as soon as possible, which can not exceed one hour.
- Appropriately trained staff must continually assess, monitor, and reevaluate individuals who are restrained or secluded.<sup>3</sup>
- Debriefings with the individual and staff must occur as soon as possible after each use of restraint or seclusion.

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<sup>3</sup> According to Interpretive Guidance issued by CMS, the frequency of monitoring indicated by this requirement may vary according to the type and design of the restraint device or intervention, and the emotional, psychological, and physical needs, conditions, and symptoms of the individual.

- Staff must receive extensive, appropriate training, including all aspects of de-escalation.
- Deaths and serious injuries resulting from restraint or seclusion must be reported to governmental authorities.

Violation of these regulations can result in federal investigation and administrative sanctions, including the suspension of funding. They can also serve in some cases as the basis for civil and criminal liability.

## **B. Civil Litigation**

The use of restraint and seclusion creates a risk of litigation under such causes of action as deprivation of constitutional rights (in the case of state facilities), assault, battery, negligence, medical malpractice, wrongful death, failure to train staff, and failure to supervise staff. Such cases have been initiated by private attorneys and public agencies, and have focused both on single incidents and systemic patterns. Although there has been less litigation concerning restraint and seclusion than medication refusal, restraint and seclusion have been the subjects of numerous recent cases, including the following:

- The *pro se* complaint of a person found not guilty by reason of insanity, which alleged a failure to follow a state policy requiring physician reassessment of a person in restraint and seclusion, violated accepted professional judgment and thus stated a constitutional claim. Zigmund v. Foster, 106 F. Supp. 2d 352 (D. Conn. 2000).
- Placing a prisoner in restraint or seclusion without a physician's order in each instance states is clearly established law under both the 14<sup>th</sup> and 8<sup>th</sup> Amendments and thus obviates the qualified immunity defense. Buckley v. Rogerson, 133 F.3rd 1125 (8th Cir. 1998).
- An upset but not dangerous woman ordered into restraints and seclusion by an emergency room physician stated a claim for medical malpractice and battery. Threlkeld v. White Castle, 127 F. Supp 2d 986 (D. No. Ill. 2001).
- The civil rights and malpractice complaint on behalf of a woman who died in seclusion, which alleged that the physician signed the order in response to staff requests without conducting an examination and without a showing of an emergency, stated claims under professional judgment standards. Hopper v. Callahan, 562 N.E.2d 822 (1990)
- A hospital emergency room policy to place all persons seeking psychiatric treatment into seclusion is actionable under the American With Disabilities Act. Scherer v. Waterbury, 2000 Conn. Super LEXIS 481 (Conn. Super., February 22, 2000) .

- An excessive force and wrongful death case involving the use of a choke hold presents a “battle of experts” issue that must be tried. Unzueta v. Steele, 291 F. Supp. 2d 1230 (D. Kan. 2003).

Although most cases involve a lasting physical injury to the patient, this is not always a required element of a civil claim. Anyone closely involved in the operation of a mental health facility will likely recognize parts of the following scenario:

*An involuntarily committed man in his mid 20s, upset at not receiving any visitors on his birthday, left the state hospital grounds. He and another patient purchased alcohol and were found drinking in the woods near the hospital. Staff escorted the patients back to the hospital without incident. At the direction of the head nurse, who was responsible for 37 patients at the time, the patient was escorted to a medical evaluation. As he became boisterous, the staff and patient exchanged threatening words and gestures. When the head nurse ordered that he be placed in 4-point restraint, he physically resisted and kicked a staff member. During the takedown, one of the staff members punched him in the head 3-5 times. During an investigation of the incident, the head nurse stated that nothing untoward occurred.*

In this case, the individual sustained no serious physical harm as a result of the restraint episode. He filed a civil rights suit in federal court against the head nurse and five other staff members claiming excessive force, failure to protect, and a cover up. A jury awarded the patient \$100,000 in compensatory damages and over \$1 million in punitive damages. The First Circuit Court of Appeals rejected all defendants’ arguments, including challenges to the punitive damage award. Davis v. Rennie, 264 F.3rd 86 (1st Cir. 2000), *cert. denied*, 535 U.S. 1053 (2002).

The published decisions regarding restraint and seclusion do not capture the many cases resolved through negotiated settlement agreements which provide for monetary payments and/or the implementation of new procedures. A class action lawsuit against the Nebraska mental health agency, for example, resulted in a Consent Decree with detailed requirements concerning restraint and seclusion, such as admission assessments that ask consumers to identify calming methods that work best for them, staff consideration of the potential negative impact of restraint and seclusion, and debriefings after every use of these interventions. Caroline C. v. Dale Johnson, Case No 4:CV95-22 (D. Neb. 1998). Moreover, as is widely known, many settlements involving substantial payments to plaintiffs are subject to confidentiality agreements.

It is interesting to note that, even before the U.S. Supreme Court’s 1982 Youngberg decision, Federal and State courts expressed concern about the use of restraint and seclusion in psychiatric settings. Throughout the 1970’s, for example, the use of these interventions were central issues in the seminal civil rights class action challenging conditions and practices in Alabama’s psychiatric hospital system. Wyatt v. Sitckney, 325 F.Supp 781, 784 (M.D.Ala. 1971).

Following the detailed Wyatt rulings, many states adopted Patient Bills of Rights in the 1970's that included a prohibition on the use of restraint or seclusion for punishment or for the convenience of staff. In Alabama, non-compliance with the Wyatt Consent Order's provisions concerning restraint and seclusion was one of the reasons that court monitoring of the state's public mental health system continued throughout the 1990s. Wyatt v. Rogers, 985 F. Supp. 1356 (M. D. Ala. 1997).

In another pre-Youngberg case, Connecticut's Supreme Court upheld a judgment of \$3.6 million – four times the highest damage award in Connecticut's history at the time – in favor of a defendant who suffered neurological damage while in seclusion. Pisel v. Stamford Hospital, 430 A.2d 1 (1980). In that case, a hospital patient who was agitated and actively psychotic when placed in seclusion was found with her head wedged between the mattress and the steel bed frame, unconscious and without pulse, blood pressure, or respiratory function. The jury found that the defendant's conduct fell below the reasonable standard of care.

### **C. Criminal prosecution**

Most litigation regarding restraint and seclusion has occurred in civil courts. However, staff have also faced criminal charges, including prosecution for homicide, after incidents which resulted in tragedy. For example:

- An aide was convicted of manslaughter following the death of a 15-year-old, 100-pound boy hospitalized in Illinois. The boy had been ordered to write sentences as punishment and, when he failed to do so, three staff members tried to put him in restraints and he resisted. Placed in a "basket hold," he suffocated on his own vomit when staff failed to heed his gasping statements that he couldn't breathe. The conviction after a bench trial was upheld on appeal. People v. Harvey, 528 N.E.2d 1053 (Ill. App. 4 Dist. 1988).
- Staff members were convicted of manslaughter in the death of a 5-foot-tall, 90-pound woman who died in a mental health facility from asphyxiation due to compression of her neck while being restrained. A New York appellate court reviewed the factual record in detail and reinstated a jury conviction for manslaughter which the trial court had thrown out, finding that the patient's "erratic behavior appears to have irritated hospital staff rather than to have posed a threat . . . Defendants' violent reaction was an unwarranted response to what can essentially be characterized as annoying behavior." People v. Simon, 549 NYS 2d 701, 706 (A.D. 1 Dept. 1990).

Restraint and seclusion result in serious harm short of death in many cases. The growing concern about these practices generally, as well as advocates urging prosecutors to look into specific incidents, make it likely that criminal investigations in these cases will increase.

#### **D. Scrutiny from Civil Rights Agencies**

In investigating and prosecuting violations under the Civil Rights for Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997(a), the U.S. Justice Department has aggressively challenged facility and staff rationales for the use of restraint and seclusion. In an Investigative Findings letter issued in 2005 concerning the Vermont State Hospital, the head of the Justice Department's Civil Rights Division wrote:

We found numerous cases where the reason given for the use of seclusion or restraint was that the patient was "assaultive." However, no consistent picture ever emerged as to what was meant by that term. In several instances, "assaultive" appeared to mean "verbal assault," "loud and intrusive speech," "throwing milk and water at staff" and "spitting at staff." In several other cases "assaultive" was not specifically defined at all. In the above examples, patients were immediately placed in restrictive measures without attempts to use less restrictive measures and without consideration of whether the behavior was an immediate safety threat to the patient or others.

Our consultant found that: Far too often the documentation in the record is reflective of an automatic process in which certain patient behaviors appear to automatically lead to the application of the most restrictive measures. Similarly, the documentation of the reasons that lesser restrictive measures utilized to prevent an emergency situation were ineffective was often inadequate. [Vermont State Hospital] consistently uses seclusion and restraint as an intervention of first resort and fails to consider lesser restrictive alternatives.

Bradley J. Schlozman, Acting Assistant Attorney General, *Letter to Vermont Governor Jim Douglas, CRIPA Investigation of the Vermont State Hospital* (July 5, 2005) Another Justice Department CRIPA Investigative Finding issued in 2005 cited troubling restraint and seclusion practices at the Napa Hospital in California:

Multiple independent sources have alleged that staff at Napa goad patients into behaviors that are then punished with restraint or seclusion. More particularly, staff frequently provoke patients into verbal confrontations to justify placing the patients in seclusion. If a patient resists being placed in seclusion, the patient is then restrained.

Bradley J. Schlozman, Acting Assistant Attorney General, *Letter to California Governor Arnold Schwarzenegger, CRIPA Investigation of the Napa State Hospital* (June 27, 2005).

In addition to the Justice Department's CRIPA activities, the federal government also funds Protection and Advocacy for Individuals with Mental Illness (PAIMI) programs in every state and territory, 42 USC 10801 et seq. These programs focus on both individual and class action cases, often with the goal of achieving system-wide policy change.

PAIMIs across the country have identified the reduction of restraint and seclusion as a priority both for advocacy and litigation. The Center for Public Representation (CPR) in Massachusetts is perhaps the most active, conducting investigations, surveying consumers, advising PAIMIs on related issues, and consulting for and co-counseling with PAIMIs wishing to focus on restraint and seclusion as program priorities. Among the CPR's areas of particular focus are the use of restraint and seclusion in emergency rooms, including the development of model standards. CPR also collects information on criminal investigations of restraint and seclusion deaths and damage awards related to these practices. Other PAIMI activities include:

- Equip for Equality, the PAIMI in Illinois, has conducted a number of investigations into restraint and seclusion practices in the state. They found, for example, that no attempt at any use of alternative interventions occurred prior to the use of restraint in 60 percent of the episodes in Illinois. Koelliker, M., *et al.*, *State of Restraint Utilization in the New Millennium: Practical Recommendations for Positive Intervention* (2000), available at <http://www.equipforequality.org/publications/restraintreport.php>. In 2002, Congress appropriated \$1 million a year to Equip for Equality for a 5-year demonstration project to determine how independent investigations of the use of restraint and seclusion and other serious incidents could enhance the safety of consumers.
- Protection and Advocacy, Inc., a PAIMI program in California, published *Reforming Restraint and Seclusion Practices: An Advocacy Manual* in May 1992 and a 2002 report called *The Lethal Hazard of Prone Restraint: Positional Asphyxiation*. The latter report was a key factor in the state's enactment in 2003 of a statute specifically aimed at the reduction of restraint and seclusion. The law requires facilities to conduct a clinical and quality review of each use of restraint and seclusion, as well as centralized reporting of each episode and its duration. The law also mandates that aggregate facility data regarding restraint and seclusion be available on the internet and that agencies report progress in reduction to the legislature during annual budget hearings.

Additional legislation and regulation at both the state and federal levels concerning restraint and seclusion are likely, with mandates aimed at prevention through de-escalation training and accountability through the public availability of data on the use of these practices. In addition, investigation and litigation concerning specific facilities and incidents can be expected to increase. The success that many facilities have shown in reducing these practices and the inexpensive, easily replicated tools that are readily available are likely to fuel increasing scrutiny and challenge. These developments, discussed below, can elevate legal standards regarding professional judgment and reasonable and community practices, increasing exposure for facilities and staff. The risk management goal should not be "better restraint and seclusion," but exposing the underlying reasons for use of restraint and seclusion and seeking to predict, prevent and eliminate those issues in the future.

**V. Effective Tools to Reduce the Use of Restraint and Seclusion are Well-Established and Inexpensive**

Given the current state of affairs, issues that may arise in litigation concerning the use of these practices can be anticipated. For example, an episode of restraint or seclusion could result in judicial review of the staff determination that an emergency warranted such an intervention. Was there a risk of imminent, serious physical harm or was the goal to coerce the individual to comply with ward rules? Were such extreme actions necessary or could other options been employed? Were alternatives to restraint and seclusion considered? Could early intervention have prevented the incident?

These issues in turn focus attention on the facility's administration. Is the administration aware of the frequency and methods of restraint and seclusion use? Has a restraint and seclusion prevention program been established? Are individual risks factors related to restraint and seclusion systematically identified? What are the goals and efficacy of the training provided to staff? Does the training address de-escalation techniques? Is there an effective management system for supervising staff and reviewing use of restraint and seclusion?

Facility administrators and leaders need focused assistance to quickly identify and address legal and financial risks. As discussed in more detail below, these risks are manageable through the use of easily replicated and inexpensive strategies.

The prevention tools discussed below have been employed with great success at a broad range of types of mental health facilities. These achievements are not, however, easy; they require providers to examine basic assumptions and change long-standing behaviors, especially with respect to the coercion and conflict which characterize much of the mental health service delivery system today. Successful reduction of restraint and seclusion require leadership and a change in the culture of psychiatric inpatient care – from a culture that values control and order to one that believes in and promotes recovery.

**A. Six Core Strategies to Reduce the Use of Seclusion and Restraint in Inpatient Facilities**

The National Association of State Mental Health Program Directors (NASMHPD) is the national lobbying and technical assistance organization representing state mental health agencies, which, in most states, administer the state psychiatric hospitals. In 2002, NASMHPD reviewed the evidence and consulted with national experts on restraint and seclusion. Through this effort, NASMHPD identified a growing body of knowledge about reducing the use of restraint and seclusion, and determined that most of these strategies are readily available at low or no cost. NASMHPD published *Six Core Strategies*© to Reduce the Use of Seclusion and Restraint in Inpatient Facilities, outlined below. See Huckshorn, K.A., *Re-Designing State Mental Health Policy to Prevent the Use of Seclusion and Restraint*, 33 Administration and Policy in Mental Health 4 (2006) at 482-491; and Huckshorn, K.A., *Reducing the Use of Seclusion and Restraint in Mental*

*Health Systems: A Public Health Prevention Approach with Interventions*, 42 J. of Psychosocial Nursing and Mental Health Services 9 (Sept. 2004).

The public health prevention model, at the heart of the Six Core Strategies, is a disease prevention and health promotion approach. This model focuses on identifying risk factors for conflict and violence *before they occur*, along with early intervention strategies to immediately respond to conflict so that violence and the use of restraint and seclusion can be prevented. The model aims to transform treatment environments to minimize the occurrence of conflict and facilitate immediate resolution when conflict does occur. Similar models have been developed and promoted by the American Psychiatric Association, American Psychiatric Nurses Association, American Hospital Association, National Association of Psychiatric Health Systems, and the Child Welfare League of America.

The Six Core Strategies described by NASMHPD are:

**1. Leadership Toward Organizational Change.** To be successful, efforts to reduce the use of restraint and seclusion begin with clear leadership, generally at the level of the executive director or facility administrator and other executive staff. These leaders should take an active and routinely visible role in announcing and implementing a plan to reduce the use of restraint and seclusion. Leaders should prioritize the initiative within the facility and hold people accountable for all aspects of the plan.

Effective organizational leadership should include a specific plan that states the mission and outlines the roles and responsibilities of all staff. The development of the formal prevention plan is a leadership responsibility that requires full and consistent participation by a top facility administrator who is firmly committed to the project. The reduction plan should be presented in a continuous quality improvement framework that understands that culture change takes time and that staff at all levels “learn as they go.” *Id.* The plan should involve consumers, family members, and advocates in all aspects of the project and maximize the prospects that it will be understood by staff, and be viewed in a positive manner. Bluebird, G., *Redefining the Roles of Consumers: Changing Culture and Practice in Mental Health Settings*, 42 J. of Psychosocial Nursing and Mental Health Services 9 (2004) at 46-53. The plan should formally adopt the principles of trauma-informed systems of care and incorporate person-first language in all documents.

A key component of this strategy is the elevation of oversight of every restraint and seclusion event by executive management, including frequent communications and hospital rounds done by executives in an effort to change traditional staff practices. Hardenstine, B. (2001). Other components of the comprehensive strategy include the following:

- Develop a facility-wide policy statement that outlines for all staff the prevention/reduction approach to the use of restraint and seclusion;
- Identify data-driven goals to reduce use;

- Announce a “kick-off” event and routinely celebrate successes;
- Identify restraint and seclusion reduction champions at all horizontal and vertical organizational layers; and
- Assign these staff to specific prevention roles.

Some state mental health authorities and facilities have demonstrated their commitment by voluntarily lowering the number of hours allowed in restraint or seclusion orders.

**2. The Use of Data to Inform Practice.** Effective efforts to reduce restraint and seclusion use facility-generated data to inform practice and policies. It is essential that data be used in a non-punitive manner to facilitate health competition among facility units or wards and to elevate the general oversight and knowledge of the use of these interventions. Hardenstine, B., *Leading the Way Toward a Seclusion and Restraint-Free Environment: Pennsylvania’s Success Story*, Office of Mental Health and Substance Abuse Services, Pennsylvania Department of Public Welfare (2001). This strategy uses data in a way that encourages the administration to identify successful staff and treatment units so that successful restraint and seclusion prevention practices can be shared.

Facility utilization of restraint and seclusion should be collected by unit, shift, day, and by staff member involved, although this latter strategy should be recorded confidentially to identify individual staff training needs and not for disciplinary actions in general. This information should be graphed and posted in all areas of the facility so that it is clearly visible for staff and patients. This transparent use of data has been identified as one of the most important strategies used by successful projects, including the entire Pennsylvania state institutional system of care.

**3. Workforce Development.** Efforts to reduce restraint and seclusion are most successful in facilities where policy, procedures, and practices are based on the principles of recovery and the characteristics of trauma-informed systems of care. In selecting vendors to train staff on the use of restraint and seclusion, facilities should engage only vendors who have data demonstrating a reduction in the use of these interventions where their model has been implemented. The involvement of mental health consumers as trainers is essential, whatever the model.

This strategy assures that staff are given the opportunity to develop and practice individualized treatment planning and practice skills that integrate prevention strategies for specific high-risk individuals. Training should include activities that accomplish the following objectives: assure adequate staff education about the experiences of patients placed in restraint or seclusion; address the common myths associated with use; introduce the rationale and characteristics of trauma informed care; educate on the neurobiological and psychological effects of trauma; and describe a prevention-based approach to reduction. It is clear that de-escalation skills can be learned by all staff.

Staff training should also address the growing evidence that many restraint and seclusion events occur because of win-lose conflicts set up by the numerous rules that govern facility operations and the role of staff in enforcing these rules. Facility leadership need

procedures in place that provide guidance for staff to “suspend” institutional rules and procedures, when necessary, to avoid or resolve conflicts when addressing individual needs. Examples of this include rigid policies regarding attendance at activities, wake and sleep times, curfews, smoke breaks, meal times, and other rules designed to “keep order” and that do not take into account individual needs or the signs and symptoms of mental illness. Staff should be empowered to make decisions – in the moment – to avoid the use of restraint and seclusion through adapting rules in the face of real events, and then addressing repetitive issues in the treatment team.

Other important components of this strategy include discussing the facility’s reduction plan in interviewing potential new staff and incorporating expectations in job descriptions, performance evaluations, and new staff orientation activities. The use of mental health consumers, as consultants or staff, can be significantly informative when reviewing rules, staff training needs, and staff attitudes.

**4. Use of Prevention Tools.** Numerous clinical and other tools exist to prevent the use of restraint and seclusion, including the following:

- Patient assessments to identify the risk for violence (including previous restraint and seclusion history);
- Patient assessments to identify medical risk factors for death and injury, such as obesity, respiratory disease, cardiac anomalies, medication issues, recent ingestion of food, prone positioning, and past trauma histories;
- Patient assessments to identify psychological risk factors that suggest the need for a trauma assessment;
- The development, with patients, of de-escalation or safety plans (including psychiatric advance directives), which support the patient in learning illness self-management by identifying emotional triggers and environmental stressors that can lead to conflict or lack of emotional control;
- Creative changes to the physical environment, including comfort and sensory rooms; and
- Implementation of daily, meaningful, and engaging treatment activities.

These activities should be integrated into hospital policy and procedure, as well as each individual patient’s treatment plan.

In addition to these activities, staff should be provided with a behavior scale – a set of guidelines to ensure that staff responses are appropriate to the behavior being demonstrated by the patient and to help assess whether certain patient behavior meets the criteria of imminent danger prior to the implementation of restraint or seclusion. Many incidents involving the use of these interventions are initiated prematurely and before the level of “imminent danger” occurs, often due to staff not knowing any other approach to use.

## **5. Supporting Consumer and Advocate Roles in Inpatient Settings.**

Involving patients, other mental health consumers, family members, and external advocates in a variety of roles in the organization – as administrators, managers, direct service providers, and in other roles -- can have a powerful impact, particularly as a primary prevention strategy to reduce the use of restraint and seclusion. The presence of these stakeholders in an inpatient environment sends a strong message to both patients and staff that recovery is real, that recovery happens, and that living with a psychiatric disability need not be perceived as a reason to accept anything less than pursuing one's hopes and aspirations.

Successful integration of mental health consumers and stakeholders as staff in an inpatient setting can be challenging, and likely requires refinement of organizational structures and practices. Solomon, M.L., *et al.*, *Positive Partnerships: How Consumers and Nonconsumers Can Work Together as Service Providers*, University of Chicago at Illinois (1998). Administrators can facilitate integration by taking the following steps:

- Positions held by peers and advocates must provide equitable pay aligned with similar roles in the organization;
- Peer roles and their importance – including the efficacy of peer support, self-help, and the potential for reducing the use of restraint and seclusion – should be defined for all other staff; and
- Facilities should provide appropriate orientation and training for peers and advocates.

**6. Debriefing Tools.** Successful efforts to reduce the use of restraint and seclusion use event debriefing procedures to inform policy, procedures, and practices and reduce future use of these interventions. A secondary goal of this strategy is to mitigate the adverse and potentially traumatizing effects of a restraint or seclusion event for involved staff and consumers and for all witnesses to the event. Debriefing activities can be standardized through the use of a facility generated policy and procedure and we have provided you with one as a guide.

Debriefing activities are separated into two distinct but equally important activities that follow a restraint or seclusion event. The first activity is an immediate, post-event debriefing that is usually led by a nursing supervisor or other senior staff person who was not involved in the event. The purpose of this activity is to confirm the safety of all involved parties, review the documentation, interview staff and others who were present, and, as much as possible, return the unit to the pre-crisis milieu. The use of an interview or event guide and the documentation of activities immediately following the event are highly recommended.

The second debriefing activity is more formal, and often occurs a few days later. It includes the treatment team, the attending psychiatrist, and a representative from the facility's management team, and it uses rigorous problem-solving methods, such as root cause analysis procedures, to review and analyze the event. The purpose of this

debriefing is to identify what can be changed to avoid an event in the future, and to assure that, as much as possible, trauma is mitigated for all involved parties.

The inclusion of the patient's perspective is critical. Since attending a large meeting of staff can be intimidating for a patient who was very recently restrained or secluded, facilities should permit the consumer to appoint a staff advocate to present his or her perspective.

While documentation that debriefing occurred is needed, concerns may arise about creating detailed records that might be used in subsequent legal proceedings. Debriefing is focused on the future - the goal is preventing problems rather than placing blame. The discussion and documentation should address what can be learned from the incident and how staff and consumers can utilize that knowledge.

## **B. Roadmap to a Restraint Free Environment**

The *Roadmap to a Restraint-Free Environment*, developed by the National Association of Consumer/Survivor Mental Health Administrators (NACSMHA) and published by the Substance Abuse and Mental Health Services Administration is focused on a recovery based framework and was developed by consumers for training of direct care staff in inpatient facilities. This training curriculum explores sustainable solutions and strategies that support the elimination of the practices of seclusion and restraint in mental health settings. This training manual is intended to build bridges and increase the understanding among staff of what it is like to be a mental health consumer admitted to an inpatient mental health setting. It assumes the significant importance of direct care staff as being critical in developing seclusion and restraint free environments and is best used in conjunction with the training of senior and middle management leadership such as is done in the NASMHPD training curriculum. The Roadmap is available online at: <http://www.mentalhealth.samhsa.gov/publications/allpubs/sma06-4055/>.

## **C. Advance Crisis Management Program**

The Advance Crisis Management Program (ACM), developed at the National Research and Training Center on Psychiatric Disability at the University of Illinois, Chicago seeks to increase self-determination by helping individuals develop written plans that identify personal stress triggers and strategies to manage agitation and anger. See [www.psych.uic.edu/UICNRTC/dep-training.htm](http://www.psych.uic.edu/UICNRTC/dep-training.htm). The program is based on the idea that individuals' naturally-occurring crisis management techniques can be used during hospitalization if the techniques are documented before the crisis occurs. This approach makes self awareness and symptom management a central element in the treatment process. The individual and staff frequently review the plan and immediately consult it whenever either feels it is warranted. Afterward, the management of the situation is reviewed and the ACM is revised as needed. Preliminary research findings have been published. ACM training was provided to patients, and Nonviolent Crisis Intervention (NCI) training, developed by the Crisis Prevention Institute (see <http://www.crisisprevention.com>), was provided to staff, on three units of a university

hospital: an adult unit, an adult research unit and an adolescent unit. During the first two quarters following the training, restraint and seclusion declined significantly and remained low for the remainder of the year. Jonikas, J., *et al.*, *A Program to Reduce the Use of Physical Restraint in Psychiatric Inpatient Facilities*, 55 *Psychiatric Services* 7 (2004) at 818-820.

## **VI. Action Steps for Attorneys and Risk Managers**

Unlike many difficult problems in the mental health system, reducing the use of restraint and seclusion is not primarily a matter of funding. In fact, numerous examples exist in which the use of restraint and seclusion have been reduced without major expenditures when facility administrators publicly commit to doing so. Approaches that focus on “doing restraint and seclusion better” leave a facility exposed to major risks. The most effective risk management strategy is one that focuses on the constant reduction of the use of these interventions and includes the following action steps:

- ✓ **Review your facility’s current policies and actual practices regarding restraint and seclusion.**
  - Ensure that your facility’s written policies and actual practices comply with existing laws and regulations and its own internal policies. This analysis is especially important with respect to the following:
    - Who has the authority to order these interventions;
    - Whether face-to-face evaluations are performed by a physician or Licensed Independent Practitioner within one hour of initiating restraint or seclusion;
    - Whether debriefings occur after each episode; and
    - Documentation and review.
  - Review the staff training being provided as to frequency and content. Staff need to receive training pre-service, before they are placed in situations that may put them or others at risk, and have mentor supervision on shift for at least six months. The focus must be on de-escalation and conflict negotiation skills, with the objective preventing restraint and seclusion use, not principally their safe use or application. Other important issues include:
    - Training needs to be competency based, adapted to staff knowledge and responsibilities, and on-going.
    - Senior clinical and administrative staff must attend each training session to demonstrate its importance and to ensure the content reflects the agency’s values, especially when this training is provided through external contracts.
    - Training must go beyond the “usual” annual refresher course on “de-escalation” and restraint and seclusion application procedures, as this

kind of training falls short of effecting the knowledge, skills and competencies this kind of practice changes necessitates.

- This training should integrate trauma informed care, the development of therapeutic relationships, values clarification, cultural competence, the use of language, individualized care planning skills, and the importance of inclusion of service users in their care, in planning for restraint / seclusion reduction efforts, and as staff members.
- ✓ **Collect and use data to inform your ongoing risk management strategy. The use of restraint and seclusion should be an established performance measure for your facility.**
- Critical data points to review include the following:
    - Rates of restraint and seclusion use (episodes and duration) during the last six months, broken down by unit and patient characteristics.
    - Trends in restraint and seclusion use – Are your facility’s rates increasing or decreasing?
    - Comparisons in rates and trends between your facility and similar, “benchmark,” facilities.
  - On a regular basis, share data reports on use and trends with each unit in the facility and discuss the data reports at facility management meetings.
- ✓ **Advise top management that exposure related to the use of restraint and seclusion is increasing and engage their leadership in a strategy to reduce the use of these interventions.**
- Explain that compliance with Federal and JCAHO rules is essential but not sufficient because (1) evolving professional standards now place any use of restraint and seclusion under increased scrutiny; and (2) inexpensive, easily replicated tools to reduce restraint and seclusion are readily available.
  - Discuss incentives for staff to reduce their reliance on restraint and seclusion, including but not limited to data collection and feedback, recognition, and rewards.
  - Ensure that actions are taken to (1) address any problems in the physical environment; and (2) provide active treatment on and off the unit as part of the effort to reduce the use of restraint and seclusion.
- ✓ **Establish a facility Task Force, led by top management, as part of the effort to reduce restraint and seclusion.**
- Involve consumers, top management, staff, and unions in the Task Force.

- Invite managers and direct care staff from facilities with successful programs to make a presentation at your facility.
  - Keep staff abreast of developments regarding restraint and seclusion in the law and in clinical best practices
- ✓ **Maintain the priority of constant reduction in the use and duration of restraint and seclusion.**

## VII. Conclusion

*I can't bring myself to describe the moment-by-moment struggles and sheer gut-wrenching terror of being put into five-point restraint. 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.*

W. Pflueger, *NTAC Networks*, Special Edition/Summer/Fall 2002, 7

Every episode of restraint or seclusion is harmful to the individual and humiliating to staff members who understand their job responsibilities. The nature of these practices is such that every use of these interventions leaves facilities and staff with significant legal and financial exposure.

Public scrutiny of restraint and seclusion is increasing and legal standards are changing, consistent with growing evidence that the use of these interventions is inherently dangerous, arbitrary, and generally avoidable. Effective risk management requires a proactive strategy focused on reducing the use of these interventions in order to avoid tragedy, media controversy, external mandates, and legal judgments.

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