

## **NASMHPD's POSITION STATEMENT ON SECLUSION AND RESTRAINT**

The members of the National Association of State Mental Health Program Directors (NASMHPD) believe that seclusion and restraint, including "chemical restraints," are safety interventions of last resort and are not treatment interventions. Violence free and coercion free mental health treatment environments can be accomplished using the Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool developed by National Technical Assistance Center (NTAC). Seclusion and restraint 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.

The use of seclusion and restraint creates significant risks for all individuals involved. These risks include serious injury or death, re-traumatization of people who have a history of trauma, and loss of dignity and other psychological harm. In light of these potential serious consequences, seclusion and restraint should be used only when there exists an imminent risk of danger to the individual or others and no other safe and effective intervention is possible.

It is NASMHPD's goal to prevent, reduce, and ultimately eliminate the use of seclusion and restraint and to ensure that, when such interventions are necessary, they are administered in as safe and humane a manner as possible by appropriately trained personnel. This goal can best be achieved by: (1) early identification and assessment of individuals who may be at risk of receiving these interventions; (2) high quality, active treatment programs (including, for example, peer-delivered services); (3) trained and competent staff who effectively employ individualized alternative strategies to prevent and defuse escalating situations; (4) policies and procedures that clearly state that seclusion and restraint will be used only as emergency safety measures; and (5) effective quality assurance programs to ensure this goal is met and to provide a methodology for continuous quality improvement. These approaches help to maintain an environment and culture of caring that will minimize the need for the use of seclusion and restraint.

In the event that the use of seclusion or restraint becomes necessary, the following standards should apply to each episode:

- The dignity, privacy, and safety of individuals who are restrained or secluded should be preserved to the greatest extent possible at all times.
- Seclusion and restraint should be initiated only in those individual situations in which an emergency safety need is identified, and these interventions should be implemented only by competent, trained staff.
- As part of the intake and ongoing assessment process, staff should assess whether or not an individual has a history of being sexually, physically or emotionally abused or has experienced other trauma, including trauma related to seclusion and restraint or other prior psychiatric treatment. Staff should discuss with each individual strategies to reduce agitation which might lead to the use of seclusion and restraint. Discussion could include what kind of treatment or intervention would be most helpful and least traumatic for the individual.

- Only licensed practitioners who are specially trained and qualified to assess and monitor the individual's safety and the significant medical and behavioral risks inherent in the use of seclusion and restraint should order these interventions.
- The least restrictive seclusion and restraint method that is safe and effective should be administered.
- Individuals placed in seclusion or restraints should be communicated with verbally and monitored at frequent, appropriate intervals consistent with principles of quality care.
- All seclusion and restraint orders should be limited to a specific period of time. However, these interventions always should be ended as soon as it becomes safe to do so, even if the time-limited order has not expired.
- Individuals who have been secluded or restrained and staff who have participated in these interventions should participate in debriefings following each episode unless contraindicated for a particular person. The debriefing includes reviewing the experience and planning for earlier, alternative interventions.

States should have a mechanism to report deaths and serious injuries related to seclusion and restraint, to ensure that these incidents are investigated, and to track patterns of seclusion and restraint use. NASMHPD also encourages facilities to conduct the following internal reviews: (1) quality assurance reviews to identify trends in seclusion and restraint use within the facility, improve the quality of care and patient outcomes, and help reduce the use of seclusion and restraint; (2) clinical reviews of individual cases where there is use of these interventions; and (3) extensive root cause analyses in the event of a death or serious injury related to seclusion and restraint. To encourage frank and complete assessments and to ensure the individual's confidentiality, these internal reviews should be protected from disclosure.

NASMHPD is committed to achieving its goals of safely preventing, reducing, and ultimately eliminating the use of seclusion and restraint by: (1) encouraging the development of policies and facility guidelines on the use of seclusion and restraint; (2) continuing to involve consumers, families, treatment professionals, facility staff, and advocacy groups in collaborative efforts; (3) supporting technical assistance, staff training, and consumer/peer-delivered training and involvement to effectively improve and/or implement policies and guidelines; (4) promoting and facilitating research regarding seclusion and restraint; and (5) identifying and disseminating information on "best practices" and model programs. In addition, NASMHPD supports further review and clarification of developmental considerations (for example, youthful and aging populations) which may impact clinical and policy issues related to these interventions.

- 1.) Approved by the NASMHPD membership July 13, 1999**
- 2.) Revision proposed by NASMHPD Forensic Division June 6, 2007**
- 3.) Approved and reaffirmed by the NASMHPD membership July 15, 2007**