

# Promoting Alternatives to the Use of Seclusion and Restraint Issue Brief #1

## A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services



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### About the Series:

Promoting Alternatives to the Use of Seclusion and Restraint

*The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed, in collaboration with partners at the Federal, State, and local levels, consumers, and national advocacy organizations, a series of issue briefs on the use of seclusion and restraint. The purpose of this series is to provide information on the use of seclusion and restraint throughout the country, their impact at the individual/family, program, and system levels, and efforts to prevent their use in mental health and other service settings, including schools. Additional issue briefs in the series may be found at [http://www.samhsa.gov/matrix2/seclusion\\_matrix.aspx](http://www.samhsa.gov/matrix2/seclusion_matrix.aspx).*

### Introduction

In the United States each year, it is estimated that 50 to 150 individuals die as a result of seclusion and restraint practices in mental health inpatient residential facilities and many others are injured or traumatized by these events (Weiss et al., 1998). In fact, seclusion and restraint are dangerous and traumatic not only to the individuals subjected to these practices, but also for the staff implementing them. The Government Accountability Office (GAO; 1999a) noted that seclusion and restraint continue to be used in these facilities despite the psychological and physical harm they cause to consumers. The Cochrane Collaboration, which provides reviews of the evidence of health care practices, noted of seclusion and restraint: “few other forms of treatment which are applied to patients with various psychiatric diagnoses are so lacking in basic information about their proper use and efficacy” (Sailas and Fenton, 2000, p.4). In addition, surprisingly, there is no uniform method for tracking these injuries or deaths within States or across the country. The GAO (1999a) highlighted insufficient monitoring and reporting of the use of seclusion and restraint and inconsistent standards for using these practices and reporting their use.

The Substance Abuse Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services and the National Association of State Mental Health Program Directors (NASMHPD) have emphasized that the use of seclusion and restraint is a result of treatment failure (Curie, 2003; NASMHPD, 2001). SAMHSA further notes that with leadership, policy, and programmatic change, the use of seclusion and restraint can be prevented and in some facilities has been eliminated.

This issue brief is the first in a series on the use of seclusion and restraint with children, youth, and adults with mental health problems. The brief provides an overview of the history and context of a national focus on reducing or preventing the use of seclusion and restraint within mental health and addictions inpatient treatment settings.



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## Background and Literature

### Definitions

The Centers for Medicare and Medicaid Services (CMS), in their issuance of a final rule related to consumers rights in the hospital setting defined seclusion and restraint as follows:

**Restraint** is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a person to move his or her arms, legs, body, or head freely. 42 C.F.R. §482.13(e)(1)(i)(A). See also 42 C.F.R. §483.352.

**Seclusion** is the involuntary confinement of a person alone in a room or area from which the person is physically prevented from leaving. 42 C.F.R. §482.13(e)(1)(ii); See also 42 C.F.R. §483.352.

The definitions above relate to restraint, which should be distinguished from restraint used for medical purposes as part of medical treatment or a procedure, and from postural supports or orthopedic devices used to improve a person's mobility and independent functioning rather than to restrict movement. Clarity around the definitions will aid in this discussion.

### What the Research Shows

For many years, numerous misconceptions have supported the use of seclusion and restraints in mental health inpatient and outpatient facilities, addictions treatment centers and schools, etc. Although seclusion and restraint were long thought to create a safer and more secure environment for consumers and staff, research contradicts this. Studies have shown that psychological harm, physical injuries, and death can result from the use of seclusion and restraint to both the individual subjected to and staff applying these techniques (NASMHPD, 2009; Sailas & Fenton, 2000; Weiss et al., 1998). In fact, injury rates to staff in mental health settings where seclusion and restraint are used have been found to be higher than injuries sustained by workers in high-risk industries such as lumber, construction, and mining (Weiss et al., 1998; Love & Hunter, 1996).

In addition, the use of seclusion and restraint has often been perceived as therapeutic to consumers. This misconception has been challenged and refuted (Mohr & Anderson, 2001; NASMHPD, 2009). Increasing research has identified the role of trauma in mental and addiction disorders. Research into trauma<sup>1</sup> and trauma-informed care<sup>2</sup> identify common themes about the impact of trauma and how traumatic life experiences can impede an individual's ability to manage his or her own behaviors or engage in appropriate behaviors in the community (Fallot & Harris, 2002; Hodas, 2004; van der Kolk, 2007).

Subsequently, trauma-informed care has emerged as an approach to care that prevents the re-traumatizing of these individuals. Studies suggest that restraints and seclusion can be harmful and is often re-traumatizing for an individual who has suffered previous trauma (NASMHPD, 2009).

Further, there is a common misconception that seclusion and restraint are used only when absolutely necessary as crisis response techniques. In fact, seclusion and restraint are most commonly used to address loud, disruptive, noncompliant behavior and generally originate from a power struggle between consumer and staff. The decision to apply seclusion or restraint techniques is often arbitrary, idiosyncratic, and generally avoidable (Haimowitz, Urff, & Huckshorn, 2006; NASMHPD, 2003; SAMHSA, 2003). Moreover, some studies indicate that seclusion and restraint use leads to an increase in the behaviors that staff members are attempting to control or eliminate (Jones & Timbers, 2002; Magee & Ellis, 2001; Natta, Holmbeck, Kupst, Pines & Schulman, 1990).

Conversely, it is important to note that programs that have reduced or eliminated seclusion and restraint have realized a number of positive outcomes including reduced youth and staff injuries, reduced staff turnover, higher staff satisfaction, reduced lengths of stay, sustained success in the community after discharge, and significant cost savings (LeBel & Goldstein, 2005; LeBel, in press).

### Impetus for Change

In 1998, the *Hartford Courant* published a Pulitzer Prize-winning exposé on the use of seclusion and restraint in inpatient treatment facilities (Weiss et al., 1998). This series highlighted stories of injuries and deaths that occurred in these settings as well as some of the contributing factors, such as lack of training and inadequate staffing patterns. The influential series of articles served as a catalyst for a sequence of events focused on addressing this issue.

In 1999, the GAO began an investigation on consumer injuries, trauma, and deaths in inpatient treatment facilities. The GAO reports, entitled *Mental Health: Improper Restraint or Seclusion Use Places People at Risk* (GAO, 1999a) and *Mental Health: Extent of Risk from Improper Restraint or Seclusion is Unknown* (GAO, 1999b), and their corresponding Congressional testimony confirmed findings from the *Hartford Courant* series, noting that consumers were injured, traumatized, and dying as a result of seclusion and restraint practices. After the Congressional hearings on seclusion and restraint, the Health Care Financing Administration (now CMS) issued a guideline creating more stringent standards for the use of seclusion and restraint in residential facilities (please refer to 42 C.F.R. §482.13 for details).

Shortly thereafter, the Children’s Health Act of 2000 (Public Law 106-310) established standards for the use of seclusion and restraint in all public and private health care settings that receive Federal funding, such as hospitals, psychiatric facilities, and nursing homes.

Momentum to restrict the use of seclusion and restraint continued with the President’s New Freedom Commission report in 2003. Goal 2 of this report, “Mental health care is consumer and family driven,” emphasized that the use of seclusion and restraint poses a “risk for serious injury or death, re-traumatizing people who have a history of trauma, loss of dignity, and other psychological harm” (President’s New Freedom Commission on Mental Health, 2003, p. 34). The Commission further stated that these techniques should be used as a last resort, when there is “imminent risk of danger.” Thus, with increasing consensus of the urgent need to address seclusion and restraint use, several important initiatives developed.

## Key Initiatives to Prevent or Reduce the Use of Seclusion and Restraint

### Best Practices in Behavior Management

Shortly after the GAO report and Congressional hearings, SAMHSA collaborated with the Child Welfare League of America (CWLA) and the Federation of Families for Children’s Mental Health, to administer a 3-year grant program, entitled *Best Practices in Behavior Management*. The program was funded by SAMHSA, with the CWLA and the Federation of Families serving as the coordinating center for the project. The program was developed to reduce the use of restraint and seclusion in seven demonstration sites across the country, and focused on improving the training and supervision of staff who work directly with children and youth. The coordinating center provided technical assistance to the grantees, conducted evaluation on interventions used, and disseminated results of the project to promote best practices. For more information, visit <http://www.cwla.org/programs/behavior/default.htm>.



### A National Call to Action

In May 2003, SAMHSA and NASMHPD convened a national summit, *A National Call to Action: Eliminating the Use of Seclusion and Restraint*, with approximately 200 mental health consumers, providers, family members, advocates, researchers, State and Federal officials, and other concerned stakeholders. Summit participants shared information related to seclusion and restraint such as research findings, personal experiences, and consumers’ rights as well as legal issues related to the use of seclusion and restraint. This landmark event was the first time a Federal agency called for the end of the use of these practices.

Discussion about what has worked around the country in attempts to reduce seclusion and restraint use in inpatient mental health facilities was also a core component of the summit. Participants noted some keys to prevention of seclusion and restraint use: adequate and well-trained staff; a wide array of treatment options, including evidence-based practices; consumer involvement; performance measurement and a quality improvement process; a strong focus on consumer dignity; and consumer and staff debriefings.

Workgroups developed recommendations related to: promising practices and guidelines (having a national registry of effective practices and programs with a focus on recovery, consumer education, and consumer involvement), organizational leadership toward the reduction of seclusion and restraint use and development of partnerships, training and technical assistance, advocacy and rights protection, and data collection.

## National Action Plan

Following the Call to Action, SAMHSA and its partners developed the National Action Plan to Eliminate Seclusion and Restraint, noting that “sentinel events (e.g., deaths and injuries) from seclusion and restraint occur in many settings which have no national guidelines, such as schools and juvenile justice facilities” (see [http://www.samhsa.gov/seclusion/sr\\_handout.aspx](http://www.samhsa.gov/seclusion/sr_handout.aspx)). The Plan’s five domains of focus include:

1. Training and Technical Assistance
2. Data Collection
3. Evidence-based Practices and Guidelines
4. Leadership and Partnership Development
5. Rights Protection

Short-term objectives of the National Action Plan are: (1) increase knowledge, skills, and abilities of consumers, providers, facilities, States, and others to prevent and reduce seclusion and restraint use for all ages; (2) increase knowledge, skills, and abilities of Protection and Advocacy agencies to monitor seclusion and restraint issues; and (3) increase the number of States and facilities adopting and implementing evidence-based seclusion and restraint prevention and reduction guidelines and best practices. Long-term objectives include reduction in deaths and injuries resulting from seclusion and restraint, and reduction and eventual elimination of seclusion and restraint use. For more information, visit [http://www.samhsa.gov/matrix2/seclusion\\_NationalActionPlan.aspx](http://www.samhsa.gov/matrix2/seclusion_NationalActionPlan.aspx).

## Alternatives to Restraint and Seclusion State Incentive Grant Program

In 2004, SAMHSA launched a new grant program, Alternatives to Restraint and Seclusion State Incentive Grant (ARS SIG). The goal of this program is to implement and evaluate best practices in preventing and reducing the use of seclusion and restraint in mental health facilities. In the first grant cycle, the program awarded funding for 3 years to eight States: Hawaii, Illinois, Kentucky, Louisiana, Maryland, Massachusetts, Missouri, and Washington. A second cohort of grants was awarded in 2007: Connecticut, Indiana, New Jersey, Oklahoma, Texas, Vermont, and Virginia. (See issue brief #2 in this series for additional information on the grant program and preliminary evaluation results.) SAMHSA’s collaboration with NASMHPD has continued throughout this grant program, as NASMHPD’s Office of Technical Assistance serves as the Coordinating Center for the grant program. For more information, visit <http://www.ars.samhsa.gov>.

*“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.”*

—Consumer



*“The terror of confinement, the pain of 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 a part of the package.”*

—Consumer

## Roadmap to Seclusion and Restraint-Free Mental Health Services

In 2005, SAMHSA developed a training curriculum entitled *Roadmap to Seclusion and Restraint-Free Mental Health Services for Persons of All Ages*. The curriculum is organized in seven modules and emphasizes the importance of creating cultural change within organizations to impact seclusion and restraint reduction. Training modules for the curriculum include:

1. The Personal Experience of Seclusion and Restraint
2. Understanding the Impact of Trauma
3. Creating Cultural Change
4. Understanding Resilience and Recovery from the Consumer Perspective
5. Strategies to Prevent Seclusion and Restraint
6. Sustaining Change Through Consumer and Staff Involvement
7. Review and Action Plan

For more information, visit <http://mentalhealth.samhsa.gov/publications/allpubs/sma06-4055/>.

## The National Center for Trauma-Informed Care

The National Center for Trauma-Informed Care was created in 2005 and is funded through the Center for Mental Health Services, SAMHSA. The Center offers technical assistance, education, outreach, consultation, and resources on trauma-specific treatment and interventions with the goal to change the ways mental health services are organized, delivered, and managed while furthering the understanding of trauma-informed practices.

A trauma-informed approach to care is based on the recognition that many behaviors and responses expressed by consumers are directly related to traumatic experiences that often cause mental health, substance abuse, and physical health concerns. For many consumers, treatment facilities perpetuate traumatic experiences through invasive, coercive, or forced treatment that exacerbates feelings of threat, violation, shame, and powerlessness. The use of seclusion and restraint is considered coercive and is often retraumatizing for consumers. These practices are counter to the underlying premise of trauma-informed care that begins with “what has happened to you?” instead of “what is wrong with you?” Trauma-informed care represents an organizational shift from a traditional top-down environment to one that is based on collaboration with consumers. For more information on trauma-informed care, see <http://www.mentalhealth.samhsa.gov/nctic>.

## Ongoing SAMHSA Efforts

In addition to the work previously described, SAMHSA continues to develop collaborations with various stakeholder groups, working closely within and across Federal departments, States, providers, accreditation bodies, advocates, consumers, and families to address the issue of seclusion and restraint use. In addition, SAMHSA is working towards changing Request for Application (RFA) language to reflect an increased emphasis on the use of alternatives to seclusion and restraint by grantees. In 2008, SAMHSA facilitated a retreat to further work towards reduction of seclusion and restraint practices. *Advancing SAMHSA's Efforts to Promote Alternatives to Seclusion and Restraint: A Matrix Work Group Retreat* resulted in several activities, all of which are ongoing. The activities include:

1. A SAMHSA recognition award for programs/organizations that have effectively eliminated or reduced the use of seclusion and restraint and sustained the reduction.
2. A compendium of best practices specific to seclusion and restraint reduction.
3. A national campaign, including generation of key issue concept papers and briefs, to prevent the use of coercive interventions.
4. Partnerships and collaborations within the public and private sectors to further the culture of prevention, reduction, and elimination of the use of restraint and seclusion.
5. A virtual leadership institute to promote and sustain new strategies to prevent, reduce, and eliminate the use of seclusion and restraint in treatment environments.
6. Ongoing training, consultation, and sustainability efforts related to seclusion and restraint reduction.

For more information, visit [http://www.samhsa.gov/matrix2/seclusion\\_matrix.aspx](http://www.samhsa.gov/matrix2/seclusion_matrix.aspx).



## NASMHPD's Six Core Strategies®

With the support of SAMHSA, NASMHPD developed a training curriculum focusing on alternatives to the use of seclusion and restraint in mental health settings. NASMHPD Directors' *Six Core Strategies® Approach to Reduce the Use of Seclusion and Restraint* (Huckshorn, 2004; 2006) is based on the public health prevention model, and focuses on minimizing conflict and facilitating immediate resolution when conflict occurs. The *Six Core Strategies®* include:

1. *Leadership Toward Organizational Change*—Leaders who strongly support organizational change towards the use of alternatives to seclusion and restraint, have a clearly articulated plan, take an active role in the change process, and hold people accountable.
2. *The Use of Data to Inform Practice*—Accurate data is used to determine the scope of the issue, assess effectiveness of interventions, and allow for changes to the plan when interventions are not successful.
3. *Workforce Development*—Ensure that staff receive training and ongoing mentoring or coaching on prevention and intervention skills such as avoiding power struggles and de-escalating consumers when problems occur.
4. *Use of Prevention Tools*—Assess the risk of violence, identify medical risk factors and past trauma histories, develop de-escalation or safety plans in collaboration with the consumer and utilize creative environmental changes including calming rooms.
5. *Supporting Consumer and Advocate Roles in Inpatient Settings*—Involve youth, family members, and advocates in a variety of meaningful roles.
6. *Debriefing Tools*—Event debriefing should be used to inform policy, procedures, and practices and to reduce the future use of these interventions as well as to address any adverse or traumatizing effects of the event.

For more information, visit <http://www.nasmhpd.org/publicationsOTA.cfm>.

## Conclusion

Over the past decade, there has been a shift in attitude and practice regarding the use of seclusion and restraint in mental health and addictions treatment settings. Seclusion and restraint are being viewed as a crisis intervention technique to be used only as a last resort when less restrictive measures have failed. These practices are also no longer perceived as therapeutic for consumers, and there is a stronger emphasis not only on reduction of seclusion and restraint use but also prevention of these practices by anticipating the needs of individuals and actively engaging them in prevention efforts (NASMHPD, 2009). The purpose of this brief was to provide information on the history and context of an initiative towards the reduction and elimination of seclusion and restraint as well as a summary of recent efforts. Although there are many efforts to raise awareness of these issues and to reduce the use of these practices throughout the country, there is still much to be done to ensure a safe, secure, and therapeutic environment for some of our Nation's most vulnerable individuals.



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## Endnotes

<sup>1</sup> NASMHPD defines trauma as: “The experience of violence and victimization including sexual abuse, physical abuse, severe neglect, loss, domestic violence and/or the witnessing of violence, terrorism or disasters” (NASMHPD, 2009).

<sup>2</sup> In the mental health field, trauma-informed care is defined as: “Treatment that incorporates: an appreciation for the high prevalence of traumatic experiences in persons who receive mental health services; and a thorough understanding of the profound neurological, biological, psychological and social effects of trauma and violence on the individual” (Jennings, 2004).

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