



MODULE 1

The Personal Experience of Seclusion and Restraint

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*“When I participated in my first restraint experience I vomited.”
—Mental health worker*

Learning Objectives

Upon completion of this module the participant will be able to:

- Outline the issues and concerns regarding the practice of seclusion and restraint.
- Describe the use of seclusion and restraint with special needs populations.
- Understand the personal experience of seclusion and restraint for people diagnosed with a mental illness.
- Understand the personal experience of seclusion and restraint for direct care staff.

MODULE 1: THE PERSONAL EXPERIENCE OF SECLUSION AND RESTRAINT

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BACKGROUND FOR THE FACILITATORS: THE PERSONAL EXPERIENCE OF SECLUSION AND RESTRAINT

Overview

This module covers three areas: (1) a brief overview of concerns and issues associated with the practice of seclusion and restraint; (2) providing staff an opportunity to hear from people diagnosed with a mental illness about what it is like to be secluded and restrained; and (3) providing direct care staff an opportunity to hear from each other about the personal effects of putting people in seclusion and restraints.

Module 1 is designed to enhance awareness of the personal experience of restraints and the devastating and dehumanizing reality that such traumatic experience brings to the lives of individuals. Direct care staff and consumers live with many assumptions about people diagnosed with mental illnesses. But each of these assumptions (e.g., “They are chronics,” “Seriously and persistent mental illness (SPMI’s),” “They are crazy and do not need to be listened to,” “We must decide what is best for them) is a cliché that could be discarded if there were openness to alternative ways of understanding. This is the first step in changing a culture. It is not easy. In general, people are not comfortable with change. But we all must begin to really understand the effect of the practice of restraints and challenge long held perceptions. It is about really hearing someone else—hearing the voice of the consumer. When we truly understand the experience, changes can begin within ourselves, as well as within the culture of the system.

Various requirements regarding seclusion and restraint continue to be issued. The Federal Government, Joint Accreditation Commission of Hospital Organizations (JACHO), consumer and family organizations, professional organizations, and State mental health authorities are all invested in the reduction and elimination of seclusion and restraint as a practice within treatment settings. Although regulations are critically important, in order for sustainable change to occur a shared vision must be present. In order for a shared vision and commitment to occur, we must begin by listening.

Key issues related to seclusion and restraints include deaths, physical injuries, lack of reporting, consumer complaints, use of seclusion and restraint with high-risk populations, and overuse of restraints. In addition, lack of uniform national standards, lack of adequate staff training, and fears related to staff safety also impact the practice of seclusion and restraint.

Safety

New and emerging treatment approaches and services make it possible to treat people with severe symptoms without resorting to coercive strategies. There is a significant gap between what we know about preventing violence and creating a safe clinical environment and what is practiced in many mental health settings.

In mental health treatment settings, it is very common for consumers and providers to see the world through different lenses and to have different meanings for common words. Much of the conflict that arises in these settings results from people operating from their own worldview without acknowledging that of another. Definitions of safety depend, quite often, on who is doing the defining. The information in this section comes directly from the National Technical Assistance Center's report on managing conflict cooperatively (National Association of State Mental Health Program Directors [NASMHPD], 2002).

Special Needs Populations

The use of seclusion and restraint with special needs populations needs to be critically examined. Children are twice as likely as adults to be restrained (Weiss, 1998). More than 26 percent of deaths reported in the *Hartford Courant* series in 1998 were children — almost twice the proportion of their population in psychiatric hospitals. A large percentage of women receiving treatment have a past history of trauma and/or abuse, and seclusion and restraint can cause further damage (NYS OMH, 1994; MA DMH, 1996). In one study, Caucasian hospital staff physically restrained non-Caucasian consumers nearly four times as often as they restrained Caucasian consumers (Bond et al., 1988). Persons who are hospitalized on an involuntary basis are more likely to be subject to seclusion and restraint than those hospitalized on a voluntary basis (Solof et al., 1989). The National Association of State Mental Health Program Directors (NASMHPD) has made several recommendations regarding special needs populations.

Personal Perspective: Consumers

A New York study indicated that 94 percent of consumers who had been restrained had at least one complaint with 50 percent complaining of unnecessary force and 40 percent indicating psychological abuse (Weiss, 1998). Research analyses by Ray and colleagues (1996) also indicated that consumers (1) had predominately negative reactions to seclusion and restraint, (2) did not know the reason for their seclusion, (3) felt that it was humiliating, punishing, and depressing, and (4) thought that staff control was a primary factor.

A powerful way to understand the personal experience of seclusion and restraint is to hear from people who have had this experience. Consumers and members of the professional mental health community are beginning to realize the importance of establishing and maintaining rapport as an effective means of developing productive communication. This increases the likelihood of understanding each other, promotes beneficial treatment outcomes, and decreases and/or eliminates the use of seclusion and restraint. Developing trust, mutual understanding, and respect are essential in building needed rapport and creating alliances for eliminating the use of seclusion and restraint.

Consumer Panel—Highlight of This Module

One of the activities in this module includes a panel presentation by consumers who have experienced either seclusion and/or restraint. This panel presentation is part of the uniqueness of this training, which is based on the consumer perspective. Consumers bring a wealth of knowledge through lived experience. Four panel members are strongly recommended: two adults who have experienced seclusion and/or restraint and two adults who as adolescents, experienced seclusion and/or restraint. It must be made clear that they cannot and do not represent all consumers. Your local Office of Consumer Affairs in the Department of Human Services should be able to help you locate panel members. Another good resource would be local or State consumer organizations. Compensation or a stipend for panel members is strongly recommended. This further validates the consumer experience and is a sign of respect.

Personal Perspective: Direct Care Staff

Participants will have an opportunity to hear their colleagues talk about the experience of putting people in seclusion and restraint. Most direct care staff members are dedicated, hard working people who have no malicious intent toward the individual people with whom they work. Direct care staffs are often shorthanded, underpaid and undervalued. They are professionals with minds, hearts and souls. Promising practices indicate that training direct care staff is a key to eliminating the use of seclusion and restraint. Direct care staffs possess the informal power to contribute to system changes that eliminate the use of seclusion and restraint.

PRESENTATION



As facilitators, you will set the tone for the entire training in this first session. Welcome participants and introduce yourselves as facilitators, including who you are and how you became interested in this work. The participants will get a chance to introduce themselves in the first exercise. It is important to create a respectful learning atmosphere where disagreement is welcomed and various viewpoints are heard. Also, the norms you set for coming back on time from breaks and participating in class will carry on throughout the training. Always make sure everyone has a nametag or name tent.

Begin by going over the learning objectives.

Learning Objectives

Upon completion of this module the participant will be able to:

- Outline the issues and concerns regarding the practice of restraint and seclusion
- Describe the use of restraint and seclusion with special needs populations
- Understand the personal experience of restraint and seclusion for people diagnosed with a mental illness
- Understand the personal experience of restraint and seclusion for front line staff

- *"The initiative to reduce the use of seclusion and restraint is part of a broader effort to reorient the State mental health system toward a consumer focused philosophy that emphasizes recovery and independence...Seclusion and restraint with its inherent physical force, chemical or physical bodily immobilization and isolation do not alleviate human suffering. It does not change behavior." Charles Curie, Administrator SAMSHA*

Overview

The issue of reducing/eliminating the use of seclusion and restraint is about a total shift to a recovery-based model.

- For a shared vision and commitment to occur, we must begin by listening. Some of the things you hear may be difficult and feel challenging. Some of the things you have to say may be hard to say. This training was designed to implement change—so please hear and say the difficult things.
- The goal is to create an environment where all viewpoints are heard, including ones that are not in agreement with the philosophy of this manual.
- What we are asking from each participant is a commitment to really listen and hear each other.
- As we conduct this training, we want to be sensitive to the language we use because it sends a message. Language can set up a barrier between people. We are trying to build bridges between people.
- In this manual, we have chosen to use “direct care staff” instead of “front line staff”. “Front line staff” suggests the experience of war. We are trying to create a healing environment, not a war zone.
- We have also chosen to use the word “consumer” or “person diagnosed with a mental illness” rather than “patient.” We will cover language more extensively later on.



Put up the Power Point of the "Listen" poem, and either read the poem yourself or ask different participants to read each section.

Listen

*When I ask you to listen to me and
You start giving me advice,
You have not done what I have asked.*

*When I ask you to listen to me and
You begin to tell me why I shouldn't feel that way,
You are trampling on my feelings.*

*When I ask you to listen to me and
You feel you have to do something
to solve my problem,
You have failed me. Strange as that may seem.*

*Listen: All that I ask you to do is listen.
Not talk or do—just hear me.*

*When you do something for me
That I can and need to do for myself
You contribute to my fear and inadequacy.*

*But when you accept as a simple fact
That I feel what I feel, no matter how irrational
Then I can quit trying to convince you
And get about this business of understanding what's behind them.*

*So please listen and just hear me.
And, if you want to talk, wait a minute for your turn
And I'll listen to you.*

—Anonymous

Exercise/Discussion—Module 1

Getting to Know You

- OBJECTIVE:** Give an opportunity for participants to get to know one another and begin discussing their own experiences related to seclusion and restraint.
- PROCESS:** Ask participants to pair up with a person they don't know very well. Have them introduce themselves to each other and share their first experience with seclusion and restraint. If time allows, also have them tell their most difficult seclusion and restraint experience. What was their most recent experience with seclusion and restraint? Have each participant introduce their partner and at least one feeling word (e.g., sad, elated, scared, frightened, powerful, repulsed) to describe their experience. On the chalkboard or dry erase board, keep a list of feelings expressed.
- DISCUSSION QUESTIONS:** What are the similarities you heard about first experiences of seclusion and restraint? Which feelings were most common? How has your experience of seclusion and restraint changed/stayed the same over time?
- MATERIALS REQUIRED:** Chalkboard or dry erase board and writing utensil
- APPROXIMATE TIME REQUIRED:** 15 minutes

Challenge Assumptions

- This training challenges the following assumptions that are often present in mental health:

Assumptions to be Challenged

- Seclusion and restraints are therapeutic
- Seclusion and restraints keep people safe
- Seclusion and restraints are not meant to be punishment
- Staff know how to recognize potentially violent situations

- Seclusion and restraints are not therapeutic. There is actually no evidence-based research that supports the idea that restraints are therapeutic.
- Seclusion and restraints do not keep people safe. The harm is well documented; not only the physical harm, but also the emotional and mental harm. Restraints actually harm and can cause death. Broken bones and cardiopulmonary complications are associated with the use of seclusion and restraint (FDA, 1992; NYS OMH, 1994).
- Even though most staff would say that seclusion and restraints are not used as punishment, 60-75 percent of consumers view it as punishment for refusal to take meds or participate in programs.
- Holzworth and Wills, 1999, conducted research on nurses' decisions based on clinical cues with respect to patients' agitation, self-harm, inclinations to assault others, and destruction of property. Nurses agreed only 22 percent of the time on what constituted a violent situation. The longer nurses have worked in mental health positively correlates with greater consistency in determining potentially violent situations.
- In 1998, the *Hartford Courant* completed a series of investigative reports concerning the use of seclusion and restraints and found an alarming number of deaths. The majority of deaths related to seclusion and restraint are a result of asphyxiation or cardiac-related issues.

- Even more disturbing was that many of the deaths were unreported. Few States require the reporting and investigation of a death in a private or State psychiatric facility. The Harvard Center for Risk Analysis at the Harvard School of Public Health estimated that the annual number of deaths range from 50 to 150 per year—which translates into one to three deaths every week (Weiss, 1998).

Consumer Complaints

A New York study indicated that 94% of consumers who had been restrained had at least one complaint with one-half complaining of unnecessary force and 40% indicating psychological abuse (Weiss, 1998).

- In prison, seclusion is seen as one of the worse punishments possible. Is it any different in a mental health facility?

Consumer Complaints Ray & Rappaport, 1993

Consumers who have been restrained or secluded indicate:

- Predominately negative reactions
- Did not know the reason for the restraint/seclusion
- It was humiliating, punishing, and depressing
- Staff control was a primary factor

Lack of Uniform National Standards

Lack of national standards has reportedly generated wide variability in the use of restraint and seclusion - including potentially dangerous and unsafe practices.

- National standards continue to evolve. However, there are no uniform national standards governing how and when to use seclusion and restraint in psychiatric facilities.
- The Joint Commission on Accreditation of Hospital Organizations (JCAHO) and the American Psychiatric Association (APA) have guidelines on this topic – but neither of these are mandated.
- Landmark patients’ rights legal findings (Wyatt v. Stickney, 1972; Younberg v. Romeo, 1982) set forth minimum legal requirements regarding seclusion and restraint, but do not address issues surrounding clinical standards.

Lack of Adequate Staff Training

- A lack of adequate staff training has been cited as contributing significantly to deaths, injuries, and other abuses (Weiss, 1998).
- Currently, there are no national uniform minimum training standards for the use of seclusion and restraint.
- Three States– California, Colorado, and Kansas – license aides in psychiatric facilities with required training.
- Decreases in staffing patterns may increase risk factors.

Safety

- The rate of injuries among mental health workers in hospitals is higher than the number of workers injured in the construction and lumber industries.
- Often times, one of the staff fears about eliminating seclusion and restraint is that there will be more staff injuries. Research indicates that the opposite happens. As the rate of seclusion and restraints decreases, so does the rate of staff injuries.
- In mental health treatment settings, it is very common for consumers and providers to see the world through different lenses and to have different meanings for common words.
- Much of the conflict that arises in these settings results from people operating from their own worldview without acknowledging that of another.
- “Safety” is often used in hospitals to justify the use of procedures such as seclusion and restraint and may mean very different things to consumers and staff. Laura Prescott initially developed the following chart and it was adapted at the National Technical Assistance Center for State Mental Health Planning (NTAC) Expert’s meeting.

Conflicting Definitions of Safety

SERVICE RECIPIENTS	SERVICE PROVIDERS
Safety = minimizing loss of control over their lives	Safety = minimizing loss of control over the environment and risk
<p>Safety Means</p> <ul style="list-style-type: none"> •Maximizing choice •Authentic relationships •Exploring limits •Defining self •Defining experiences without judgment •Receiving consistent information ahead of time •Freedom from force, coercion, threats, punishment, and harm •Owning and expressing feelings without fear 	<p>Safety Means:</p> <ul style="list-style-type: none"> •Maximizing routine and predictability •Assigning staff based on availability •Setting limits •Designating diagnoses •Judging experiences to determine competence •Rotating staff and providing information as time allows •Use of force (medication, restraint, seclusion) to prevent potentially dangerous behavior •Reducing expressions of strong emotion

Source: *The Critical Step: Seeing Different Perspectives* (from the National Technical Assistance Center's report on managing conflict cooperatively [NASMHPD, 2002])

- The chart illustrates how the word “safety,” which is often used in hospitals to justify the use of procedures such as seclusion and restraint, may mean very different things to consumers and staff.
- Understanding these different definitions is critical to seclusion and restraint reduction.
- New and emerging treatment and service approaches make it possible to treat people with severe symptoms without resorting to coercive strategies.
- There is a significant gap between what we know about preventing violence and creating a safe clinical environment and what is practiced in many mental health settings.
- In 2002, the National Association of State Mental Health Program Directors and the National Technical Assistance Center for State Mental Health Planning (NTAC) sponsored a national experts’ meeting on *Managing Conflict Cooperatively: Making a Commitment to Nonviolence and Recovery in Mental Health Treatment Settings*. The following section on safety is taken directly from their report.

Inappropriate Uses of Seclusion and Restraint

- Seclusion and restraint practices are sometimes used to:
 - Control the environment – to curtail a consumer’s movement to compensate for having inadequate staff on the ward, or to avoid providing appropriate clinical interventions.
 - Coerce – to force a consumer to comply with the staff’s wishes.
 - Punish – to impose penalties on consumer behaviors.

Inappropriate Uses of Seclusion and Restraint

- Control the Environment
- Coercion
- Punishment

Treatment Approaches to Reduce Seclusion and Restraint

- The Medical Directors of the National Association of State Mental Health Program Directors reviewed the literature and identified factors in their report (NASMHPD, 1999) that contribute to a safe environment in which the use of seclusion and restraint is minimized and factors that are present when seclusion and restraint are more likely to be used.
- The Medical Directors of the National Association of State Mental Health Program Directors report on restraint and seclusion (NASMHPD, 1999) indicates the following well-documented, effective practices exist to reduce violence and simultaneously reduce or eliminate the use of restrictive measures such as seclusion and restraint:

Treatment Approaches to Reduce Seclusion & Restraint

- Peer-delivered services
- Self-help techniques
- New medications
- Emphasis on recovery
- Understanding the relationship between trauma and mental illness

Special Needs Populations



Distribute participant handout on Preventing, Reducing, and Eliminating Seclusion and Restraint with Special Needs Populations.

Children

- More than 26 percent of deaths reported in the *Hartford Courant* series were children — almost twice the proportion of their population in psychiatric hospitals.
- Children are twice as likely as adults to be restrained (Weiss, 1998; Cooper, 1998; Milliken, 1998).
- Children are further traumatized by being restrained and most see this as a form of punishment (Mohr, 1999).

Women

- At least 70 percent of women in psychiatric facilities have a past history of trauma and or abuse, and seclusion or restraint can cause further damage (Craine et al., 1988).

People of color

- In one study, Caucasian hospital staff physically restrained non-Caucasian consumers nearly four times as often as they restrained Caucasians (Bond et al., 1988). Other studies have had similar results.

Geriatric mental health

- Geriatric mental health is defined as specialized services for individuals 65 years old or older
- Aging may cause changes in the ability to communicate. Individuals who are unable to communicate will be more likely to experience seclusion and restraint (NASMHPD, 1999).

Involuntary hospitalizations

- Persons who are hospitalized on an involuntary basis are more likely to be subject to seclusion and restraint (Solof et al., 1989).

CONSUMER PANEL (1 hour)



Please refer to Background for the Facilitators for advice on selecting the Consumer Panel.

Panel members should be asked to speak about seclusion and restraint from their experience. They should tell more than just what happened, but how it happened. What was the personal impact of seclusion and/or restraint upon each? What would have prevented the use of seclusion and restraint?

Sample ground rules for panelists and the audience

- *Listen to others and try to be open to their ideas.*
- *Share your ideas in order to learn from each other.*
- *Show respect for each other by not carrying on secondary conversations when someone else is talking.*
- *Respect one another by letting the other person have their say without interruption.*
- *Stay within predetermined time limit.*

Checklist of supplies for the panel

- *Table/chairs*
- *Microphones if needed (check to make sure they work)*
- *Water/glasses*
- *Paper/pens*

If possible conduct a rehearsal to predetermine and inform speakers of the following:

- *Time allowed for each speaker*
- *Subject matter*
- *Order of speaking*
- *Question-and-answer period at the end*

Exercise/Discussion—Module 1

Hartford Courant Articles

The Hartford Courant articles highlight the fact that 142 people, many of them children, died in one year as a result of improper or excessive use of restraints. These articles illustrate the need for the elimination of the use of seclusion and restraint. It often takes articles such as these to get systems and the general public to sit up and take notice.

OBJECTIVE: To review the information in *The Hartford Courant* articles concerning seclusion and restraint.

PROCESS: Permission to reprint or copy these articles must be obtained from *The Hartford Courant* at www.tmsreprints.com/forms/reprints/hartford.html or call (800) 661-2511.

Divide participants into six groups. Give each group a different *Hartford Courant* article and have them read it. Ask each group to develop some creative way to relay the information to the large group. They can talk, use the chalkboard, etc. Encourage creativity.

DISCUSSION QUESTIONS: How many of you had heard this information previously?
What did you learn from the articles?

MATERIALS REQUIRED: Copies of *The Hartford Courant* articles
Chalkboard, whiteboard, or flip chart and writing utensil

APPROXIMATE TIME REQUIRED: 20 minutes

Exercise/Discussion—Module 1

Personal Perspective: Consumers

OBJECTIVE: To give an opportunity for participants to discuss consumer experiences and feelings around the practice of seclusion and restraint.

PROCESS: Groups of no more than six participants each. Distribute the handout *Consumer Quotes*. Have each group facilitate a discussion about the quotes.

DISCUSSION QUESTIONS: What are the common themes among consumer experiences?
How are consumer experiences similar/different to the experiences of people diagnosed with a mental illness on the panel?

MATERIALS REQUIRED: *Consumer Quotes* handout

APPROXIMATE TIME REQUIRED: 15 minutes

Exercise/Discussion—Module 1

Personal Perspective: Direct Care Staff

- OBJECTIVE:** To give an opportunity for participants to discuss direct care staff experiences and feelings around the practice of seclusion and restraint.
- PROCESS:** Groups of no more than 6 participants each. Distribute the handout *Direct Care Staff Quotes*. Have each group facilitate a discussion about the quotes. Are their personal experiences similar or different to those of the people quoted? Why or why not?
- DISCUSSION QUESTIONS:** What are the common themes among direct care staff experiences? How are direct care staff experiences similar or different to the experiences of people who were on the consumer panel?
- MATERIALS REQUIRED:** *Direct Care Staff Quotes* handout
- APPROXIMATE TIME REQUIRED:** 20 minutes

*Reducing the Use of Seclusion and Restraint: Part II
Findings, Principles, and Recommendations for Special Needs Populations*

Preventing, Reducing, and Eliminating Seclusion and Restraint with Special Needs Populations

Participants in the August 2000 meeting hosted by the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council focused on five special needs populations: (1) children and adolescents; (2) older individuals; (3) individuals with mental illness and a co-occurring disorder of mental retardation and/or developmental disability; (4) individuals with co-occurring mental illness and substance abuse or dependence; and (5) individuals being served in forensic programs.

These populations offer valuable lessons for achieving NASMHPD's goal of preventing, reducing, and eliminating seclusion and restraint. Children and adolescents teach us that seclusion and restraint decisions must take into account the child's *physical and cognitive development*, rather than just his or her chronological age. Older individuals may be fragile and present with *complex medical, psychological, and physical conditions* best served from a multidisciplinary perspective (e.g., physicians, nurses, pharmacists). Individuals with co-occurring disorders of mental illness and mental retardation and/or developmental disability often *communicate by means of behavior* which must be assessed in context when considering the use of seclusion or restraint. Individuals with co-occurring disorders of mental illness and substance abuse or dependence must be assessed to determine their capacity for exercising self-control and taking personal responsibility in weighing the use of seclusion and restraint. Treatment of individuals in forensic psychiatric programs must balance *public safety* against therapeutic issues in the use of seclusion and restraint. Many issues and recommendations identified in this report apply equally to all special needs populations, while others may apply only to one or more, but not all.

Children and Adolescents

Findings

Treatment settings for children and adolescents are diverse. More children are served in residential and group treatment programs than in State hospitals or other inpatient settings. Others receive mental health services in detention centers and secure facilities for those adjudicated delinquent. Standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Health Care Financing Administration (HCFA) regarding seclusion and restraint apply to hospitals, including State psychiatric hospitals, serving children and adolescents. In addition, HCFA has developed regulations to address the use of seclusion and restraint in child and adolescent residential settings. Promising practices to reduce and eliminate seclusion and restraint may differ between hospital and residential settings.

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Special Needs Populations (continued)

Seclusion and restraint decisions for children and adolescents must be made using a developmental model, and not be based solely on chronological age. Such decisions must take into account children's physical, cognitive, and developmental age. For example, in any use of seclusion and restraint, program staff must take special care to avoid damaging the formative growth plates in children's long bones. Children's level of cognitive development governs the accuracy of their understanding of social interactions and situations. Children's sexual development also must be considered so as to avoid or minimize trauma when staff respond to crisis situations.

Staff of child and adolescent programs are at risk, in an especially immediate way, of confusing their own childhood experiences and child-rearing practices in their own families with their duties as professionals to the children they serve. Training and supervision that recognizes and addresses these tensions are important for maintaining clear professional boundaries.

Recommendations

- Families, custodians, and/or guardians should be informed of a program's seclusion and restraint policies and procedures when their children are admitted. Programs should provide timely notification to these parties if their children are secluded or restrained and give them an opportunity to participate in debriefing each event.
- Mental health programs should develop standardized assessment protocols to identify children who have experienced physical, psychological, or sexual trauma, including abuse, and those at high risk for seclusion and restraint events for any reason. Physical and psychological risk assessments should be completed within 24 hours of admission, and before any seclusion or restraint is used.
- Assessment should include a review of the child's medical condition and disability, if any. Substance abuse or dependence should be evaluated in the assessment process for individuals of all ages.
- Initial treatment plans should include positive interventions to avoid the use of seclusion and restraint, especially for children most likely to lose self-control.
- In the event a child is restrained, he or she must be continually observed to prevent physical harm. These observations should be included in debriefing the event with the child and with staff.
- Children who have experienced seclusion and restraint and who can articulate the effects of these experiences should be involved in shaping program policies and procedures and in training staff.
- Child and adolescent programs should involve consumers, families, and other advocates to improve all treatment services, and specifically to reduce and eliminate seclusion and restraint.
- Many State mental health agencies currently do not have Offices of Consumer Affairs specifically for child and adolescent treatment services. States should be encouraged to develop or support specialized advocacy programs for children and adolescents.

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Special Needs Populations (continued)

Older Individuals

Findings

Geriatric mental health is defined as specialized services for individuals 65 years old or older; this definition is found both in law and Federal and State funding decisions. However, age is not necessarily proportionally related to an individual's functional status and the kinds of interventions that may be therapeutic. Despite this, an older individual's functional level is often not a large factor in determining services or settings. Older individuals may present multiple, complex diagnostic issues, including medical, psychological, and physical needs calling for attention by a multidisciplinary team of physicians, nurses, and pharmacists.

Aging may cause changes in the ability to communicate, some obvious, others subtle. Dementia and delirium may profoundly compound loss of thinking and speaking ability. The effects of depression may be less dramatic, but may also seriously impair the ability to communicate. An individual unable to communicate will be more likely to experience seclusion and restraint.

Aging may lead to sensory impairments, incontinence, falls, and cognitive disabilities. Older individuals affected by degenerative brain disease may be unusually loud, may become combative when approached or touched, or may intrude upon others. In addition, older individuals served in combined, general adult mental health programs may be vulnerable to stronger, more aggressive younger individuals. The design of treatment spaces should contribute to safety and support.

Cultural and generational factors of staff and the individuals served may determine if and how programs use seclusion and restraint. Family dynamics also play a role in how older individuals are treated in mental health programs. Some research indicates that seclusion and restraint events with older individuals increase following family visits. Adult children who place elderly parents in treatment may react with grief or guilt and those placed may feel anger toward their adult children for being placed in unfamiliar situations.

Recommendations

- Individuals, families, custodians, or guardians should be informed of program policies and procedures for use of seclusion and restraint at the time older individuals are admitted. Programs should provide these parties timely notification and an opportunity to participate in debriefing sessions if their relatives or wards are secluded or restrained.
- A biological/psychological assessment should be conducted within 24 hours of an individual's being admitted to a mental health program. The assessment should pay special attention to the individual's medical condition and unusual fragility (e.g., possible swallowing difficulties). Restraints or PRN medications should not be administered until assessment is completed.

Special Needs Populations (continued)

- Staff should be trained to recognize and treat chronic and acute diseases, to understand the dynamics of control issues, and the effect of these issues on interactions with older individuals. Staff training should not be compromised by high employee turnover rates.
- Physicians and nurses should consult with qualified pharmacists to assess the effects medications may have on individuals (e.g., gait problems, incontinence), including the use of PRNs, psychotropic medications, and polypharmacy considerations.
- An older individual should never be restrained on his or her back due to risk of choking on aspirated material.
- Only soft restraints should be used with older individuals. Leather restraints should never be used as these may cause lesions or fractures, especially in cases of osteoporosis.
- Programs should encourage individuals and families to use advance mental health directives when feasible. Advance directives spell out treatment preferences and may include alternatives to seclusion and restraint that individuals believe are safer, more effective, and humane.
- Many States have ombudsmen for older individuals. Mental health programs should be open to working with older consumers, ombudsmen, and other advocates, particularly to reduce and eliminate seclusion and restraint.

Children and Adolescents

- Mental health programs for children and adolescents appear qualitatively different from other mental health settings. How is physical contact with children and adolescents distinguished from restraint? Can contact to prompt, guide, or console a child be clearly distinguished from restraint? Can “time-out” in the child’s room be defined and practiced so as not to constitute seclusion?
- Children and adolescents, as well as others, rely on learned behavior to cope with difficult situations. If children learn early to rely on seclusion and restraint imposed by others to help control their behavior, can they later learn other less restrictive and coercive means of regaining control? Can critical components of developmentally acceptable seclusion and restraint be identified and provided in staff training?

Source: National Association of State Mental Health Program Directors. (2001). *Reducing the use of seclusion and restraint. Part II: Findings, principles, and recommendations for special needs populations*. Alexandria, VA: National Technical Assistance Center.

Deadly Restraint — Day One

A Hartford Courant Investigative Report

A Nationwide Pattern of Death

By ERIC M. WEISS

With reporting by Dave Altimari, Dwight F. Blint and Kathleen Megan

This story ran in *The Courant* on October 11, 1998

Roshelle ██████ pleaded for her life. Slammed face-down on the floor, ██████ arms were yanked across her chest, her wrists gripped from behind by a mental health aide. I can't breathe, the 16-year-old gasped. Her last words were ignored.

A syringe delivered 50 milligrams of Thorazine into her body and, with eight staffers watching, ██████ became, suddenly, still. Blood trickled from the corner of her mouth as she lost control of her bodily functions. Her limp body was rolled into a blanket and dumped in an 8-by-10-foot room used to seclude dangerous patients at the ██████ Treatment Center in ██████, Texas.

The door clicked behind her.

No one watched her die.

But Roshelle ██████ is not alone. Across the country, hundreds of patients have died after being restrained in psychiatric and mental retardation facilities, many of them in strikingly similar circumstances, a *Courant* investigation has found.

They died pinned down on the floor by hospital aides until the breath of life was crushed from their lungs. They died strapped to beds and chairs with thick leather belts, ignored

until they strangled or their hearts gave out.

Those who died were disproportionately young. They entered our health care system as troubled children. They left in coffins.

All of them died at the hands of those who are supposed to protect, in places intended to give sanctuary.

If Roshelle ██████ death last summer was not an isolated incident, neither were the recent deaths ██████.

A 50-state survey by *The Courant*, the first of its kind ever conducted, has confirmed 142 deaths during or shortly after restraint or seclusion in the past decade. The survey focused on mental health and mental retardation facilities and group homes nationwide.

But because many of these cases go unreported, the actual number of deaths during or after restraint is many times higher.

Between 50 and 150 such deaths occur every year across the country, according to a statistical estimate commissioned by *The Courant* and conducted by a research specialist at the Harvard Center for Risk Analysis.

That's one to three deaths every week, 500 to 1,500 in the past decade, the study shows.

"It's going on all around the country," said

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Dr. Jack Zusman, a psychiatrist and author of a book on restraint policy.

The nationwide trail of death leads from a 6-year-old boy in California to a 45-year-old mother of four in Utah, from a private treatment center in the deserts of Arizona to a public psychiatric hospital in the pastures of Wisconsin.

In some cases, patients died in ways and for reasons that defy common sense: a towel wrapped around the mouth of a 16-year-old boy; a 15-year-old girl wrestled to the ground after she wouldn't give up a family photograph.

Many of the actions would land a parent in jail, yet staffers and facilities were rarely punished.

"I raised my child for 17 years and I never had to restrain her, so I don't know what gave them the right to do it," said Barbara ██████, whose daughter ██████ died in the ██████ Child Treatment Center in New Jersey.

The pattern revealed by *The Courant* has gone either unobserved or willfully ignored by regulators, by health officials, by the legal system.

The Federal government—which closely monitors the size of eggs—does not collect data on how many patients are killed by a procedure that is used every day in psychiatric and mental retardation facilities across the country.

Neither do State regulators, academics or accreditation agencies.

"Right now we don't have those numbers," said Ken August of the California Department of Health Services, "and we don't have a way to get at them."

The regulators don't ask, and the hospitals don't tell.

As more patients with mental disabilities are moved from public institutions into smaller, mostly private facilities, the need for stronger oversight and uniform standards is greater than ever.

"Patients increasingly are not in hospitals but in contract facilities where no one has the vaguest idea of what is going on," said Dr. E. Fuller Torrey, a nationally prominent psychiatrist, author and critic of the mental health care system.

Because nobody is tracking these tragedies, many restraint-related deaths go unreported not only to the government, but sometimes to the families themselves.

"There is always some reticence on reporting problems because of the litigious nature of society," acknowledged Dr. Donald M. Nielsen, a senior vice president of the American Hospital Association. "I think the question is not one of reporting, but making sure there are systems in place to prevent these deaths."

Typically, though, hospitals dismiss restraint-related deaths as unfortunate flukes, not as a systemic issue. After all, they say, these patients are troubled, ill and sometimes violent.

The facility where Roshelle ██████ died insists her death had nothing to do with the restraint. Officials there say it was a heart condition that killed the 16-year-old on Aug. 18, 1997. ██████ Medical Examiner ██████ ruled that ██████ died of natural causes, saying that restraint use was a separate "clinical issue." But that, too, is

Deadly Restraint—Day One (continued)

typical in restraint cases. Medical examiners rarely connect the circumstances of the restraint to the physical cause of death, making these cases impossible to track through death certificates.

The explanations don't wash with ██████ grandmother. "I'll picture her lying on that floor until the day I die," ██████ said. "Roshelle had her share of problems, but good God, no one deserves to die like that." With nobody tracking, nobody telling, nobody watching, the same deadly errors are allowed to occur again and again.

Of the 142 restraint-related deaths confirmed by *The Courant's* investigation:

Twenty-three people died after being restrained in face-down floor holds.

Another 20 died after they were tied up in leather wrist and ankle cuffs or vests, and ignored for hours.

Causes of death could be confirmed in 125 cases. Of those patients, 33 percent died of asphyxia, another 26 percent died of cardiac-related causes.

Ages could be confirmed in 114 cases. More than 26 percent of those were children—nearly twice the proportion they constitute in mental health institutions.

Many of the victims were so mentally or physically impaired they could not fend for themselves. Others had to be restrained after they erupted violently, without warning and for little reason.

Caring for these patients is a difficult and dangerous job, even for the best-trained workers. Staffers can suddenly find themselves the target of a thrown chair, a punch, a bite from an HIV-positive patient.

Yet the great tragedy is that many of the deaths could have been prevented by setting standards that are neither costly nor difficult: better training in restraint use; constant or frequent monitoring of patients in restraints; the banning of dangerous techniques such as face-down floor holds; CPR training for all direct-care workers.

"When you look at the statistics and realize there's a pattern, you need to start finding out why," said Dr. Rod Munoz, president of the American Psychiatric Association, when told of *The Courant's* findings. "We have to take action."

Mental health providers, who treat more than 9 million patients a year at an annual cost of more than \$30 billion, judge themselves by the humanity of their care. So the misuse of restraints—and the contributing factors, such as poor training and staffing—offers a disturbing window into the overall quality of the nation's mental health system.

For their part, health care officials say restraints are used less frequently and more compassionately than ever before.

"When it comes to restraints, the public has a picture of medieval things, chains and dungeons," said Dr. Kenneth Marcus, psychiatrist in chief at Connecticut Valley Hospital in Middletown. "But it really isn't. Restraints are used to physically stabilize patients, to prevent them from being assaultive or hurting themselves."

But in case after case reviewed by *The Courant*, court and medical documents show that restraints are still used far too often and for all the wrong reasons: for discipline, for punishment, for the convenience of staff.

Deadly Restraint—Day One (continued)

“As a nation we get all up in arms reading about human rights issues on the other side of the world, but there are some basic human rights issues that need attention right here at our back door,” said Jean [REDACTED], the adoptive mother of Tristan [REDACTED], a [REDACTED] teen who died after aides wrapped a towel and bed sheet around his head.

Others have a simple explanation for the lack of attention paid to deaths in mental health facilities.

“These are the most devalued, disenfranchised people that you can imagine,” said Ron Honberg, director of legal affairs for the National Alliance of the Mentally Ill. “They are so out of sight, so out of mind, so devoid of rights, really. Who cares about them anyway?”

Few seemed to care much about Roshelle [REDACTED] at [REDACTED], where she was known as a “hell raiser.”

But [REDACTED] had made one close friendship—with her roommate, Lisa [REDACTED]. [REDACTED] remembers showing [REDACTED] how to throw a football during afternoon recess on that summer afternoon in 1997.

“She just couldn’t seem to get it right and she was getting more and more frustrated. But I told her it was OK, we’d try again tomorrow,” said [REDACTED], who has since rejoined her family in Indiana.

Within three hours, [REDACTED] was dead.

She had attacked staff members with pencils. And staffers had a routine for hell raisers.

“This is the way we do it with Roshelle,” a worker later told State regulators. “Boom, boom, boom: [medications] and restraints and seclusion.”

After she was restrained, Roshelle [REDACTED] lay in her own waste and vomit for five minutes before anyone noticed she hadn’t moved. Three staffers tried in vain to find a pulse. Two went looking for a ventilation mask and oxygen bag, emergency equipment they never found.

During all this time, no one started CPR.

“It wouldn’t have worked anyway,” Vanessa [REDACTED], the licensed vocational nurse on duty, later declared to State regulators.

By the time a registered nurse arrived and began CPR, it was too late. [REDACTED] never revived.

In their final report on [REDACTED] death, [REDACTED] regulators cited [REDACTED] for five serious violations and found staff failed to protect her health and safety during the restraint. They recommended [REDACTED] be closed.

Instead, the State placed [REDACTED] on a one-year probation in February and the center remains open for business. In a prepared statement, [REDACTED] said it has complied with the State’s concerns—and it pointed out the difficulty in treating someone with [REDACTED] background.

“Roshelle [REDACTED], a ward of the State, had a very troubled and extensive psychiatric history, which is why [REDACTED] was chosen to treat her,” the statement said. “Roshelle’s death was a tragic event and we empathize with the family.”

With no criminal prosecution and little regulatory action, the [REDACTED] family is now suing in civil court. The Austin chapter of the NAACP and the private watchdog group Citizens Human Rights Commission of Texas are asking for a Federal civil rights

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investigation into the death of ██████.

Medications and restraint and seclusion.

██████ friend, Lisa ██████, knew the routine well, too.

For six years, ██████, now 18, lived in mental health facilities ██████, where her explosive personality would often boil over and land her in trouble.

By her own estimate, ██████ was restrained “thousands” of times and she bears the scars to prove it: a mark on her knee from a rug burn when she was restrained on a carpet; the loss of part of a birthmark on her forehead when she was slammed against a concrete wall.

Exactly two weeks after Roshelle ██████ death, Lisa ██████ found herself in the same position as her friend.

The same aide had pinned her arms across her chest. Thorazine was pumped into her system. She was deposited in the seclusion room.

“It felt like my lungs were being squished together,” ██████ said.

But Lisa ██████ was one of the lucky ones. She survived.

Additional research was contributed by Sandy Mehlhorn, Jerry LePore and John Springer

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Deadly Restraint — Day Two

A Hartford Courant Investigative Report

Little Training, Few Standards, Poor Staffing Put Lives at Risk

By KATHLEEN MEGAN and DWIGHT F. BLINT

With reporting by Dave Altimari

This story ran in *The Courant* on October 12, 1998

She was a 15-year-old patient, alone in a new and frightening place, clutching a comforting picture from home.

He was a 200-pound mental health aide bent on enforcing the rules, and the rules said no pictures. She defied him; the dispute escalated.

And for that, Edith ██████ died. She was crushed face down on the floor in a “therapeutic hold” applied by a man twice her size.

Shy and well-behaved as a girl growing up in ██████ California, Edith had problems as a teen. She ran away, took drugs, hung with the wrong crowd. Her family hoped treatment at the ██████ psychiatric center in ██████, would help.

But Edith ██████ died—as did Andrew ██████ and Roshelle ██████ and countless others—when a trivial transgression spiraled into violence. Too often, it’s a reaction built right into our system that cares for people with psychiatric problems and mental retardation.

The people who make and execute the critical decisions to use physical force or strap a patient to a bed or chair are often aides, the least-trained and lowest-paid workers in the field.

They must make instantaneous decisions affecting patients’ physical and psychological well-being against a backdrop of staffing cuts that result more in crowd control than in patient therapy.

“I can’t understand why patients don’t die more often with all the things that happen on a daily basis,” said Wesley B. Crenshaw, a psychologist who has conducted one of the few national surveys on restraint use. “You have people who are ‘cowboying’ it,” Crenshaw said, “people who really want to get in there and show they’re the boss.”

Yet only three States-- California, Colorado and Kansas—actively license aides in psychiatric facilities. Licensing of aides is nearly non-existent in the mental retardation field as well, although a handful of States do certify aides. So, while individual States and facilities may set their own standards, there is no uniform, minimum training for psychiatric or mental retardation aides nationwide—even in life-saving techniques such as CPR.

In the Edith ██████ case, aide Daniel ██████ successfully fought negligent homicide charges by arguing he had followed

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hospital guidelines. And the guidelines didn't say he needed to watch Edith's face for signs of distress, the judge found. "It was a tragedy that this girl died in our care," said Kirke [REDACTED], director of business development for [REDACTED]. "But I don't feel there was any wrongdoing on the part of our staff. They are all well-trained in physical control and seclusion."

Done correctly, a restraint can protect a patient and worker from harm. Done under the right circumstances, patients say, it can be beneficial. Yet too often, it is done badly and for the wrong reasons. Nowhere is this tragedy more apparent than in the deaths of children.

A *Courant* investigation has found more than 26 percent of restraint-related deaths over the past decade involved patients 17 and under. Yet children make up less than 15 percent of the population in psychiatric and mental retardation facilities, according to federal statistics. The death rate should come as no surprise.

"You can't believe how many times a kid gets slammed into restraints because an argument will ensue after calling a staff member a name," said Wanda Mohr, director of psychiatric mental health nursing at the University of Pennsylvania. She and other analysts say children disproportionately bear the brunt of the misuse and overuse of restraints. A 1995 New York study, for instance, found children almost twice as likely as adults to be restrained. "It's socially acceptable to spank and punish children," said Mohr, reflecting the responses of other experts who say our culture tolerates a physical response to unruly children.

Yet children are both a vulnerable and challenging population.

Firm diagnoses often cannot be made until late adolescence or early adulthood, so providers are less sure how to treat children. And many troubled children enter the mental health system with histories of physical or sexual abuse—so even the threat of physical force can be traumatizing.

For their part, many patients say improper or frequent use of restraints hurts their recovery and defeats the very reason they were admitted. In interviews with more than a dozen children and adults, *The Courant's* investigation found these patients were left confused, angry and afraid. They rarely felt better.

Researchers are finding the same. In a 1994 New York study, 94 percent of patients restrained or placed in seclusion had at least one complaint about the process. Half complained of unnecessary force, 40 percent cited psychological abuse. In a study published this year, Mohr interviewed children after their hospital stays and found many were further traumatized when they were restrained or secluded—or even watching others undergo the procedure. Usually, she found, children saw such treatment as punishment.

The leader of the nation's psychiatric association acknowledged the problem.

"It must be especially frightening for a child," said Dr. Rod Munoz, president of the American Psychiatric Association. "It's a struggle of wills where the most powerful win."

And troubled children are the ones who lose.

Deadly Restraint—Day Two (continued)

██████████, 17, of Conn., is still so disturbed by a restraint five years ago that she can barely speak about it. She was put in a “body bag,” a sort of neck-to-toe straitjacket. “They tie you in it. They pull it tighter and tighter. I couldn’t move to breathe,” ██████████ said. “I was screaming and pleading, ‘Somebody, please, somebody take me out.’ “It made you so much more suicidal,” she said.

As mental health aides take this step that can do such physical and psychological harm, they are poorly monitored much of the time. Although most institutions require a supervisor to oversee a physical restraint, *The Courant* found such rules are often ignored.

When 11-year-old Andrew ██████████ was restrained last March at ██████████ psychiatric hospital in ██████████, Conn., the duty nurse sat nearby eating breakfast. She ignored the initial cries of distress from Andrew, whose chest was crushed during the restraint.

The decision to strap a patient to a bed or chair, or cuff their hands, must be cleared by a doctor, according to many hospital and State policies. If a doctor is not available, efforts must be made to contact one as soon as possible. But in more than a dozen cases reviewed by *The Courant*, patients were tied to their bed or chair for several hours at a time without regular review by a physician. Mental health advocates say doctors must keep a closer eye on how long their patients are restrained. “The ultimate responsibility falls to the doctors, who are supposedly the kings in these places,” said Curtis L. Decker, executive director of an organization representing patient advocates nationwide. “They’re in

control and ought to exercise their authority.” Yet in certain facilities, physicians give staffers virtual carte blanche by issuing an order to restrain as needed. “It’s a go-ahead to slap restraints on a person without evaluating why the patient was acting up in the first place,” said Dr. Moira Dolan, a medical consultant in Texas, where standing restraint orders are allowed in certain facilities. “There’s no guidance on when to restrain someone.”

Despite such responsibility, minimum hiring standards are few and pay is typically low for aides. A survey by *The Courant* last spring, for example, found aides were paid as little as \$10 per hour in Connecticut. When federal investigators began looking into the quality of care at ██████████ State Hospital in ██████████, Va., last summer they found the \$15,000 starting pay was less than what an employee could make at the nearby department store. “When you can make \$10 an hour working at the new Target,” asked union representative ██████████, “what incentive is there to come here?”

Especially when the work can be demanding and dangerous. For every 100 mental health aides, 26 injuries were reported in a three-state survey done in 1996. The injury rate was higher than what was found among workers in the lumber, construction and mining industries. “Depending on the situation, it’s scary, it’s violent,” said David Lucier, a veteran mental health worker at Natchaug Hospital in Mansfield, Conn. “Oftentimes, patients are kicking and punching and spitting and verbally abusive.”

Over a 19-year career, Lucier said, he has developed communication skills that allow

Deadly Restraint—Day Two (continued)

him to rarely touch patients. The skills described by Lucier are gained by training and by understanding the patients.

At some hospitals, though, staff are moved about like pawns in a chess game, leaving them little chance to know their patients. To fill less-desirable shifts such as weekends, institutions use less-trained, part-time workers. When faced with wide fluctuations in the numbers of patients, they resort to shuffling workers from one unit to another.

A staff shortage landed aide Spero [REDACTED] on Andrew [REDACTED] unit March 22.

[REDACTED], who usually worked with adults, had never met Andrew before that morning at breakfast and had not read the child’s medical chart. Indeed, Andrew’s ward that Sunday was staffed largely with part-time workers. So when Andrew defied [REDACTED] instructions to move to another table at breakfast, the dispute escalated into a “power struggle.” Had workers known more about Andrew, had [REDACTED] been better-versed in ways to calm him, the boy would not have died, a State investigation concluded.

Better staffing also reduces the risk of a restraint, like the face-down floor hold in which Andrew died. The American Psychiatric Association recommends at least five people—one for each limb, plus someone to watch—be involved in any physical restraint.

That would have been nearly impossible in Andrew’s case. A total of five staffers were on duty in the unit that Sunday morning, overseeing 26 children. As it was, just two aides were involved in Andrew’s restraint.

“A takedown requires four staff members and, with staff cuts being made at many

institutions, they end up with only two people doing the work of four people,” said Tom Gallagher of the Indiana Protection & Advocacy Services office. “That’s when problems occur.”

At least six of 23 recent deaths reviewed in depth by *The Courant* occurred during a restraint executed by only one or two people. Another six patients died in seclusion or mechanical restraints after being left, unmonitored, for several minutes or more.

“Hospitals have cut their staffing to a bare minimum,” said Dr. David Fassler, a psychiatrist, author and chairman of the Council on Children, Adolescents and Their Families. The same fiscal pressures, he said, have led institutions to reduce training as well.

All this at a time when patients particularly need skilled help. As managed care limits access to hospitals, most analysts say patients are entering the system in more troubled conditions than ever before. In the wards, staffers feel the pressure.

Pausing during a recent double shift at [REDACTED] State Hospital in Virginia, a 375-bed facility for adults, nurse Judy [REDACTED] talked about the need to devote time to patients.

“Every time we’ve had a downsizing of staff we’ve had an increase in restraints and seclusions,” said [REDACTED], who has seen 23 years of trends at [REDACTED]. “When you have more staff you can intercede better and you don’t have to just place someone in restraints to calm them down.” But reducing the use of restraints requires a financial and philosophical commitment—a commitment to use force only as a last resort, and only by well-trained staff who care about the patient.

Deadly Restraint—Day Two (continued)

Across the nation, the commitment is too often absent.

Last summer, a staff shortage at [REDACTED] forced nurses to call on security guards to help perform restraints. One guard, who didn't want his name used, showed little interest in the patients he might forcibly restrain. Or much interest in doing it correctly.

"I didn't get hired," he said, "for all this bull-crap interacting with people or tackling psychotic patients."

Courant Staff Writer Eric M. Weiss contributed to this story.

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Deadly Restraint — Day Three

A Hartford Courant Investigative Report

Patients Suffer in a System Without Oversight

By ERIC M. WEISS and DAVE ALTIMARI

This story ran in *The Courant* on October 13, 1998

Had Gloria [REDACTED] been able to move, had she not been bound to her bed with leather straps for days on end, perhaps she would have tried to draw the attention of the inspectors who were conducting a three-day tour of [REDACTED] State Hospital. Had she been able to move, had she not been pinned down by the wrists and ankles, she might have held up a sign, as she had done before when a visitor came through [REDACTED]. Her handwritten plea was simple: “Pray for me. I’m dying.”

But the inspection team from the nation’s leading accreditation agency never noticed Gloria [REDACTED] before leaving the [REDACTED], [REDACTED], psychiatric hospital.

The three inspectors from the Joint Commission on the Accreditation of Healthcare Organizations issued [REDACTED] a glowing report card—92 out of 100 points. They also bestowed the commission’s highest ranking for patients’ rights and care when they concluded their review on June 28, 1996.

The next day, Gloria [REDACTED] died. She was 31. Her heart, fatally weakened by the constant use of restraints, had inflamed to 1 1/2 times its normal size. In her last two months, she’d been restrained 558 hours—the equivalent of 23 full days. Nine months later, the

Joint Commission gave [REDACTED] an even better score in a follow-up review—even though [REDACTED] treatment would ultimately be labeled “inhumane” by the Commonwealth of Virginia and condemned by the U.S. Justice Department.

“How could JCAHO give [REDACTED] the highest rating in human rights when they were killing people?” asked Val Marsh, director of the [REDACTED] Alliance for the Mentally Ill. The way the country’s health care system works, how could it not?

The Courant’s nationwide investigation of restraint-related deaths underscores just how faulty—how rife with conflicts of interest, how self-protective, how ultimately ineffective—the system of industry oversight and government regulation really is. The health care industry is left to police itself, but often doesn’t. Time and again, *The Courant* found, when it comes to the quality and safety of patient care, the interests of the industry far outweigh the public interest. “One reason you have overuse and misuse of restraints is because oversight is practically nonexistent,” said Dr. E. Fuller Torrey, a nationally prominent psychiatrist and author of several books critical of the nation’s mental health system.

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“And the health industry doesn’t want oversight.” The chain of agencies, boards and advocates that is supposed to provide oversight—the kind of oversight that might have prevented [REDACTED] death and hundreds like it—often breaks down in multiple places.

But the heavy reliance on the Joint Commission—an industry group that acts as the nation’s de facto regulator—lies at the core of the problem.

The federal government relies on the private nonprofit agency’s seal of approval for a psychiatric hospital’s acceptance into Medicare and Medicaid programs. And 43 States, including Connecticut, accept it as meeting most or all of its licensing requirements.

But the Joint Commission doesn’t answer to Congress or the public. It answers to the health care industry.

The Joint Commission was founded in 1951 by hospital and medical organizations, whose members still dominate the commission’s board of directors. The commission is funded by the same hospitals it inspects. How tough are its inspections? Of the more than 5,000 general and psychiatric hospitals that the Joint Commission inspected between 1995 and 1997, none lost its accreditation as a result of the agency’s regular inspections. None.

When extraordinary circumstances arise—a questionable death, for instance—the Joint Commission may conduct additional inspections. Even then, less than 1 percent of facilities overall lost accreditation. Central State was not among them.

Joint Commission officials are the first to say they are not regulators. Participation is voluntary, and 83 percent of hospitals in-

spected were found to have shortcomings that needed to be addressed. “Joint Commission accreditation is intended to say to the patient: This is a place that does things well and is constantly working to improve things,” said Dr. Paul M. Schyve, a psychiatrist and senior vice president of the Joint Commission.

If the industry is not adequately watching itself, neither is the government. The nation’s top mental health official says he has little latitude when it comes to tougher regulation and oversight. “Most rules governing health care have been left to the States,” said Dr. Bernard S. Arons, director of the U.S. Center for Mental Health Services. When it comes to mental retardation facilities, in fact, inspection is left largely to the States.

But their record is not much better.

The General Accounting Office, the investigative arm of Congress, has found that State regulators are loath to punish State-run facilities. In a study of State mental retardation centers, the GAO found “instances in which State surveyors were pressured by officials in their own and in other State agencies to overlook problems or downplay the seriousness of deficient care in large State institutions.” When State regulators do show up, their inspections are scheduled with such predictability that facilities can beef up staff, improve services and even apply fresh coats of paint. Often, only the new paint remains after the inspectors leave. “These visits provide only a snapshot,” said William J. Scanlon, director of health care studies for the GAO. “And it may be a doctored snapshot.”

It is only when the system utterly collapses, as in [REDACTED] Gloria [REDACTED] case, that the

Deadly Restraint—Day Three (continued)

federal government intervenes to set rules for patient care.

Justice Department abuse investigators, who have authority to intercede when civil rights violations are suspected in publicly run facilities, often find these same facilities were recently given clean bills of health by licensing agencies or the Joint Commission.

“The use of restraints is clearly a very big problem and a very significant issue in nearly all of the institutions we investigate,” said Robinsue Froehboese, the top abuse investigator at the Justice Department. But with a staff of 22 attorneys, Froehboese’s office can undertake only a handful of major investigations each year.

“Nineteenth-century England had a better oversight system than we have now,” said Torrey, describing an English system that used full-time government inspectors to check every psychiatric facility without prior notice.

At ██████ State, the warning signs should have been apparent. But Joint Commission inspectors review just a sampling of patient records—a sampling that may not include problem cases like Gloria ██████. Anyone who did look at ██████ records would have known her health was failing—and that heavy use of restraints was a primary reason. Two years before ██████ death, a doctor warned officials at ██████ State that she would die if they didn’t change her restraint plan. “Staff members should watch their conscience, and those in charge must always remember that following physical struggle and emotional strain, the patient may die in restraints,” stated the ominously titled “duty to warn” letter.

Even if the Joint Commission inspectors had missed ██████ in particular, there were other cases at ██████ that should have raised red flags. One patient was restrained for 1,727 hours over an eight-month period, yet another for 720 hours over a four-month period, according to a U.S. Justice Department report. So, in many respects, the investigation into ██████ death is most remarkable in that it happened at all. When she died on June 29, 1996, the police were never called. It took a hospital employee’s anonymous call to a citizens watchdog group, days after ██████ death, to tip off the outside world that she died while being restrained—and not in her sleep as hospital officials told family members.

The Courant’s investigation found at least six cases in which facilities, wary of lawsuits and negative publicity, tried to cover up or obscure the circumstances of a restraint-related death. “It’s sort of a secretive thing,” said Dr. Rod Munoz, president of the American Psychiatric Association. “Every hospital tries to protect itself.” “The incentive is to settle with the family, fix it internally and move on,” said Dr. Thomas Garthwaite, deputy undersecretary of health for the U.S. Department of Veterans Affairs.

Many States, including Connecticut, have laws that shield discussions among doctors that explore what went wrong. The laws are designed to promote candid discussions, but the solutions often don’t leave the closed hospital conference room. Garthwaite and other experts said hospitals need to share problems and solutions to prevent deadly errors from being repeated. Just a year ago, the

Deadly Restraint—Day Three (continued)

VA began a comprehensive system to track all deaths and mistakes. But a plan by the Joint Commission to do the same all across the nation has been stymied so far by the powerful American Hospital Association.

The AHA notified the Joint Commission in January that the proposal had created a “firestorm” among its members, who worried that they would have to turn over “self-incriminating” documents. “We’ve tried to make the program workable, so people would not be afraid to report on a voluntary basis,” said Dr. Donald M. Nielsen, a senior vice president of the American Hospital Association. He said the two groups agreed last month on some ground rules regarding the issue. With the industry failing to monitor itself, with government regulators unwilling to challenge the industry, uncovering abuse is left to “protection and advocacy” agencies established by Congress in each State. Despite \$22 million in federal funding this year and broad authority to root out and litigate cases of abuse, even some advocates turn a blind eye to investigating deaths.

Desperate for help, Gloria ██████ turned to one of these organizations in her last months of life. Not only was her complaint not investigated, but three weeks after her death ██████ was sent a letter saying the advocacy agency was dropping her case because it hadn’t heard from her in 90 days. The letter ends: “It was a pleasure working with you to resolve your complaint. I wish you the best of luck in your future endeavors.”

Advocates say they have too little funding for their broad charge, and are fought every step of the way by hospitals and doctor groups. Scarce money and staffing are used just to secure basic information. “It’s a David and Goliath battle,” said Curtis L. Decker, executive director of the group representing advocacy organizations nationwide. “And Goliath is winning.”

Hospitals see no need for drastic change, let alone more government intervention. “Given the speed of government, it is often better to allow the private market to work issues out,” said Nielsen of the AHA. “Joint Commission standards have been revised recently and are continually being improved.”

██████ family might take issue with that assessment. They have filed a civil rights lawsuit in federal court seeking \$2 million, and a wrongful death lawsuit in State court seeking \$450,000. “We knew from the get-go things weren’t right when they told us she died in her sleep,” said ██████ sister-in-law. “We thought she was being taken care of.”

Courant Staff Writers Kathleen Megan and Dwight F. Blint contributed to this story.

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Deadly Restraint — Day Four

A Hartford Courant Investigative Report

“People Die and Nothing Is Done”

By DAVE ALTIMARI

With reporting by Dwight F. Blint and John Springer

This story ran in *The Courant* on October 14, 1998

Sheriff ██████ remembers the first time staffers at the ██████ Developmental Center in ██████, N.Y., called his office for help last year.

A deer had been killed by a car in front of the center the evening of Nov. 24. The staff wanted it removed. But no one from the State mental health facility had called ██████ four months earlier when William ██████ fell to his side, vomited and died after being

about,” said ██████, who first learned about the death from a *Courant* reporter.

The Courant’s investigation has found the nation’s legal system falters time and again when it comes to restraint-related deaths. Just as the medical establishment fails to provide the kind of internal oversight that might prevent patients from dying, the legal system offers little hope for justice after they are dead.

Law enforcement officials, lawyers and mental health advocates say it isn’t always easy, or appropriate, to place blame on the ill-trained mental health aides who typically execute restraints. But without thorough investigation, the system too often fails to determine whether a death is a tragic accident or an act of criminal negligence. And whatever the circumstances, they say, patients’ families are entitled to answers.

Yet the normal investigative process falls apart at each step, *The Courant* found.

Hospital workers cover up or obscure the circumstances of a death. Autopsies are not automatically performed. Police are not routinely summoned. Investigators often defer to the explanations offered by the institutions

ALVINA ██████ and her family fought for a thorough investigation of the death of her daughter Sandra ██████ at the ██████ Care Center in ██████ in January. After an autopsy, the ██████ woman’s death—originally deemed an accident—was ruled a homicide. The State of Utah eventually closed the facility.

restrained in a timeout room. “I wonder how many of these deaths occur at that facility or others in this State that [police] never know

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Deadly Restraint—Day Four (continued)

involved. “It’s easier to just say it was an accident and forget about it,” said Michael Baden, a former New York State medical examiner who now serves on a State board that investigates deaths in institutions.

Thus, few are ever punished. Prosecutors rarely pursue arrests in restraint deaths and, when they do, they typically accept plea bargains to minor charges.

“The way the system runs, people die and then nothing is done about it,” said ██████, whose 15-year-old daughter, ██████, died while restrained in a dispute over a photograph. Hers was a rare case in which criminal charges were filed. But an Arizona judge found restraint deaths are such a “rarity” that it would have been unreasonable to expect the aide to notice Edith’s distress. He tossed the case out.

Families of dead patients, angry with the lack of accountability in the criminal justice system, then turn to civil court where they face one last obstacle to justice: jurors who must place a monetary worth on people at the bottom rung of society. “The law is not disability-friendly. If you’re disabled or mentally retarded, you don’t have any value,” said Pennsylvania attorney Ron Costen, who represents families in abuse cases.

A former prosecutor, Costen is familiar with the flaws of criminal investigations into restraint deaths. Among the common problems he cited: Scenes are not preserved because staff immediately clean up the room where the restraint occurred. Staffers develop a story emphasizing the patient’s existing physical problems. And workers say they were just protecting themselves or others from harm,

making it hard to prove criminal intent.

Others have found staffers reluctant to blow the whistle on colleagues.

“Despite the legal and ethical obligations to report and protect patients from abuse, a strong code of silence among direct care staff still exists,” California investigators found last year after an investigation into restraint abuses at Napa State Hospital. Two people have died in restraint-related incidents at Napa State in the past six years. The California report found a system rotting from within. It cited a survey in which two-thirds of psychiatric aides statewide believe there to be a “code of silence.” Workers, the report said, consider themselves victims of a bad and abusive system.

In Pennsylvania, Costen intends to propose legislation to put the system, corporations and administrators, on trial—and not simply the low-paid aides who work for them. “We have to make it possible to attack the corporate structure and hold them accountable for criminal actions,” Costen said. His proposal would carry no prison sentence, instead fining corporations or, in the worst cases, putting them out of business.

But punishment can only follow investigation. Police and prosecutors typically rely on medical examiners to trigger a criminal case by issuing a homicide ruling. The trigger is infrequently pulled.

In 23 recent deaths examined in depth by *The Courant*, only three were ruled homicides. In the other cases, including the Binghamton death, medical examiners ruled the deaths to be accidental or attributed them to the patient’s existing medical problems.

Deadly Restraint—Day Four (continued)

Baden, of New York, said these rulings fail to take into account the full context in which the patient died. “Positional asphyxiation has this very nice ring to it,” said Baden, referring to a common cause of death in restraint cases. “Like maybe somebody did it to themselves instead of their chests being compressed.” Most medical examiners say they struggle with restraint cases, but ultimately cannot issue a homicide ruling if staffers are working within the scope of their jobs. “It’s difficult to say whether a hold put on a person has any role in their death unless it’s clear-cut they were doing the hold wrong,” said [REDACTED], the Texas medical examiner who ruled that Roshelle [REDACTED] died of natural causes after being restrained in a [REDACTED], Texas, facility.

Such clarity is nearly impossible. Across the country, *The Courant* has found, there are no clear, uniform standards on restraint use, and no minimum training standards for staffers. So prosecution is rare, too. “If a medical examiner rules a death accidental or by natural causes, it does make getting a criminal indictment more unlikely than not,” said John Loughrey, a prosecutor in Monmouth County, N.J.

In June, Loughrey presented to a grand jury his case against two staffers at the [REDACTED] Child Treatment Center. Staffers said 17-year-old Kelly [REDACTED] hair was hiding her face during a restraint—so they didn’t notice that her lips were turning blue.

But the grand jury refused to issue indictments after hearing the death had been ruled accidental. Faced with unfamiliar cases that are difficult to prove, most prosecutors simply

shy away. “There’s enormous variability from State to State and even county to county on what the district attorney feels is a prosecutable offense,” said Robinsue Froehboese, the U.S. Justice Department’s top abuse investigator. “Unfortunately,” she said, “the jurisdictions that don’t prosecute these cases far outweigh those who do.”

Take the case of Melissa [REDACTED] of [REDACTED], Wash. [REDACTED], a [REDACTED] County prosecutor, would not pursue charges in [REDACTED] death—even though the State attorney general’s office urged criminal prosecution against the owner and a worker at [REDACTED] Adult Family Home. Tied to her bed in a makeshift restraint on the night of July 23, 1997, [REDACTED] managed to climb out a window before becoming entangled in the straps. The 19-year-old autistic woman had been dead six hours before workers finally noticed her—hanging from the window about 3 or 4 feet from the ground. “We don’t charge persons who had goodwill and were doing the best job they could,” [REDACTED] said.

“They didn’t have any intent to hurt anybody.”

But the staffer did put [REDACTED] in a restraint without a physician’s permission—a direct violation of Washington State law. The same staffer was not authorized to care for clients, did not check on [REDACTED] for several hours, and lied to investigators about the circumstances of the death, the attorney general’s office found.

When prosecutors do press charges or get indictments from grand juries, they rarely follow through and go to trial. More often

Deadly Restraint—Day Four (continued)

they settle for a plea bargain that calls for no jail time. Kimberlye ██████ was originally charged with involuntary manslaughter and gross negligence, a felony with a maximum 15-year sentence, in the restraint death of 9-year-old ██████ in Detroit in November 1995. ██████, ██████ ██████, sat on ██████ and ignored his pleas for air because it was “typical of the ruses used by children to get themselves released from restraints,” she said in a court deposition. ██████ eventually pleaded guilty to a misdemeanor and received an 18-month suspended sentence and 100 hours of community service.

Nancy Diehl, the ██████ prosecutor who handled the ██████ case, said she had little choice because many of the witnesses were other troubled children. “We gave her a great plea because we felt we might have some problems convincing a jury of the original charge,” Diehl said. “It certainly isn’t easy because your witnesses are other young kids who have various problems. That’s why they are in the home.”

After navigating the criminal justice system and ending up empty-handed, the ██████ family ended where many aggrieved families do—in civil court. Detroit attorney Julie Gibson, who represented the ██████, said her clients eventually realized it was best to settle the case.

In fact, few lawsuits involving restraint victims ever make it before a jury because they are settled quietly and out of court. In the mere handful of jury verdicts over the past two decades, awards typically fell under a half-million dollars, according to legal experts and a national tracking service. When a case does go to trial, families face a final, common hurdle. Take the case of Roshelle ██████. “What’s the life of a poor, black, mentally ill girl who has been institutionalized for several years going to mean to a jury?” said ██████, the ██████ attorney who represents ██████ family. “I think the answer,” ██████ said, “is not much.”

Courant Staff Writers Colin Poitras, Kathleen Megan and Eric M. Weiss contributed to this story.

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Deadly Restraint — Day Five

A Hartford Courant Investigative Report

From “Enforcer” to Counselor

By ERIC M. WEISS

This story ran in *The Courant* on October 15, 1998

Will ██████ used to be called “The Enforcer.” With 280 pounds of solid ██████ muscle wrapped around a 6-foot-3 frame, the ██████ was called in to help “shuffle” patients—slamming them to the ground face-down if they acted up or disobeyed. And the 30 mentally retarded and mentally ill patients—people accused of murder, rape and other crimes—often disobeyed. “I used to be a bad boy,” said Robert ██████, a short, wiry patient with the energy of a wound rubber band. “I was shuffled about every day.” Not anymore. Behind the ██████ center’s locked gates and razor wire a radical turnaround has occurred in the last year. Shuffling is now forbidden, staff has been increased and given intensive training.

Tennessee’s example shows that, with strong leadership, the physical restraint of patients can be minimized—indeed, nearly eliminated—safely and without exorbitant cost.

“If we could do it here,” said ██████ ██████, deputy superintendent of ██████ ██████, “it can be done anywhere.” But the routine and frequently dangerous use

of restraints persists elsewhere, even though the solutions are often simple and straightforward: better training, stronger oversight, uniform standards and the collection and sharing of information.

Federal officials and health groups say they are working on it. The U.S. Center for Mental Health Services has begun a five-state pilot program to collect restraint and seclusion data. The U.S. Department of Veterans Affairs is tracking deaths more closely.

The Joint Commission, the nation’s leading hospital accreditation organization, has strengthened its guidelines on restraint and seclusion. And the American Medical Association has begun studying the use of restraints on children. “Those steps sound pretty inadequate to me,” said Dr. Joseph Woolston, medical director for children’s psychiatric services at Yale-New Haven Hospital. “This sort of half-hearted patchwork approach will probably do more harm than good by giving an illusion that something is happening when it is not.”

So for now, it is left to individual hospitals to find their own way. Those committed to the task illustrate what can be done.

Riverview Hospital for Children and Youth, a State-run psychiatric hospital in

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Deadly Restraint—Day Five (continued)

Middletown, Conn., uses an intensive training program that emphasizes non-physical intervention when a patient loses control. “These situations are often chaotic and unpredictable, and without proper training, staffers are just winging it,” says Linda Steiger, executive director of Wisconsin-based Crisis Prevention Institute.

CPI, a leading private training company, provides instruction to Riverview workers. The cost is minimal: \$895 per person for a four-day program to teach a small number of designated staffers, who then instruct their peers. Tighter procedures also emphasize that every restraint is a major step—literally, a matter of life and death.

At Riverview, a staffer is required to constantly monitor anyone in mechanical restraints. That ensures a patient’s vital signs remain strong, and provides an incentive to end the intervention as soon as the patient regains control.

At ██████████ Center, patient treatment plans that include the use of restraint are, for the most part, rejected. And every use of emergency restraint is investigated and must be defended. “When forced to go through the self-analysis and justifications, they solve it at a lower level the next time and without restraints,” said Thomas J. Sullivan, who heads Tennessee’s Division of Mental Retardation Services. “Of course, this requires staff to give up total control.”

Emergency restraints are so infrequent now that Sullivan gets an e-mail message every time they are used. He’s gotten an average of just two to three e-mails per month since January. Accountability means staffers

share more information and learn from the mistakes of others. Techniques found to be dangerous, such as face-down floor holds and mouth coverings, have been outlawed in certain places as a result. But tough lessons learned by individual hospitals typically aren’t shared with facilities on the other side of town or 10 States away. Each hospital is left to reinvent procedures or learn the hard way—through the death of a patient. It doesn’t have to be that way.

New York State has reduced restraint use and the number of related deaths by requiring the reporting of usage rates and by investigating all deaths. After New York required all mental health facilities to say how often they use restraints—and published the numbers—the top three users revamped their policies and brought their numbers down.

When it came to deaths, the State used to allow each hospital to decide which ones were questionable enough to report. It was notified of 150 cases over three years. Once mandatory reporting of every death was instituted 20 years ago, the number of deaths requiring further investigation rose to 400 a year. “When people have a choice in classifying deaths—with one choice resulting in tremendous scrutiny, the other resulting in none, what do you think they’re going to do?” said Clarence Sundram, the former chairman of the independent New York agency that tracks and investigates deaths. Accountability has produced results. Restraint-related deaths in the past five years have been cut nearly in half as compared with the preceding five years, New York State records show. Nationwide accountability could accomplish the same.

Deadly Restraint—Day Five (continued)

“There needs to be some kind of State-by-State evaluation to gather comparative statistics and give an annual report to Congress,” said Dr. E. Fuller Torrey, a prominent psychiatrist and author. “Until you embarrass the individual States,” Torrey said, “nothing will be done.” The federal government has shown a willingness to intercede on this very issue—in response to charges that the elderly were being abused.

When the U.S. Food and Drug Administration estimated in 1992 that more than 100 people annually were killed through the use of mechanical restraints in nursing homes, the agency tightened rules on their use. “We also thought these cases were flukes,” said the FDA’s Carol Herman, “until we started digging.” The FDA now considers lap and wheelchair belts, fabric body holders and restraint vests to be prescription devices. Manufacturers are subject to FDA inspections to ensure quality control.

Such steps, advocates say, have both reduced and improved the use of restraints. In the mental health field, strong and independent government oversight can weed out bad practices and bad facilities as well, they say. “We can’t do it alone,” said Curtis L. Decker of the National Association of Protection and Advocacy Systems. “The only way to truly protect patients is through a large, comprehensive monitoring program.” That means a system where government regulators, not the industry, are charged with oversight, he said. An internal patient grievance system would be bolstered by a well-funded network of independent advocates trained in death investigations.

More than money, though, many analysts say a culture in which restraints are used too soon, too frequently and for the wrong reasons must be changed. “The single biggest prevention method is the avoidance of restraints to begin with,” Sundram said. “It is often the training and opinions of staff that dictate restraints, rather than patient behavior.”

In Tennessee, “the changes were top-down, bottom-up and a hard sell everywhere,” Sullivan said. Before taking the top Tennessee job, Sullivan spent 27 years as an official in Connecticut’s Department of Mental Retardation. Reducing restraint use was just one of many changes forced on Tennessee by two lawsuits filed by the U.S. Department of Justice and by patient advocates. “It was a system that was disintegrating,” said Ruthie Beckwith of People First of Tennessee, a patient advocacy organization that sued the State.

The State responded with new leadership, more money and staff and an intensive training regimen emphasizing calming words instead of brute force. The total cost for the Jordan Center: \$12,665 for training in restraint use and alternative methods; \$255,372 annually in additional staffing to address not only restraint issues but massive deficiencies in overall patient care. The changes in technique weren’t easy on staff. About a half-dozen aides quit. Others grouched. But most stayed and changed. “It was a rough couple of months,” said Robert ██████, an aide at ██████. “At first, they just told us we couldn’t put our hands on them. Everyone was like, ‘Oh, so all I can do now is run away?’ “

Deadly Restraint—Day Five (continued)

Bernard [REDACTED], the [REDACTED] superintendent who oversaw the transition, remembers a defining moment. He received a frantic call from staffers [REDACTED] saying a patient was smashing furniture and asking whether they could restrain him. “I said, ‘Let him break it,’” [REDACTED] said. “So you’re going to risk hurting yourself or the patient for a \$100 coffee table? The State will buy a new one.” The changes are both profound and surprising to staff and patients who remember the old ways. “Before, we weren’t earning their respect, it was just fear,” said [REDACTED], the burly aide who still wears a belt that says “Boss.” “Now, I’m

more of a counselor or big brother than an enforcer,” [REDACTED] said. Like a Cold War relic, he now uses skills other than just his brawn, such as his woodworking knowledge, which he passes on to patients in a new class he teaches. “I used to get shuffled a whole lot of times when I would go off and hit someone,” said David [REDACTED], [REDACTED], who has been at the [REDACTED] Center for 2 1/2 years. “Now, they give us a lot more time to chill out, calm down. It’s getting better each day.”

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How The *Courant* Conducted Its Investigation

The death of 11-year-old Andrew ██████ in a ██████ psychiatric hospital in March prompted a team of ██████ reporters and researchers to investigate the use of restraints and seclusion. The investigation began in May and concluded five months later. The team ultimately pored through thousands of pages of policy reports and academic studies, traveled to 10 States, surveyed federal databases and electronic news archives, and spoke to hundreds of regulators, industry officials, analysts, workers and patients.

As its first step, the reporting team conducted a 50-state survey to document deaths that occurred during or shortly after restraint or seclusion. The team concentrated on the period from 1988 to the present.

The reporters contacted officials in health care and licensing agencies, child fatality review boards and patient advocates in each State. In most States, many more calls were made to public officials and others. As part of its investigation, the team compiled a database of 142 patient deaths in psychiatric hospitals, psychiatric wards of general hospitals, group homes and residential facilities for troubled youths, and mental retardation centers and group homes. Deaths that were confirmed and fact-checked by *Courant* researchers were compiled in a database now available on our Internet site at www.courant.com. Throughout the report-

ing, though, it became clear that many deaths go unreported.

For example, only New York State requires the reporting and investigation of every death in a private or State facility to an independent State agency. New York found that 64 people died during or shortly after restraint or seclusion in targeted institutions from 1988 through 1997. In contrast, only 12 confirmed cases could be uncovered in California in the same period—because the State simply does not collect the data. “I hope [your story] doesn’t reflect that these are the only deaths in California,” said Colette Hughes, the State’s top abuse investigator for a patient advocacy group. “There is no doubt that this is the tip of a huge iceberg.”

To better determine the national death rate, *The Courant* hired statistician Roberta J. Glass. Glass is a research specialist for the Harvard Center for Risk Analysis at the Harvard School of Public Health. She has 14 years’ experience in the field of statistical projections.

In her projection, Glass used data from the State of New York, the U.S. Department of Health and Human Services and earlier academic studies on restraint use, among other sources. If facilities throughout the rest of the country used restraints as often as those in New York State, Glass found, there would be 50 deaths annually nationwide. But Glass noted the rest of the country was not necessarily like New York State. New

***How The Courant Conducted
Its Investigation (continued)***

York monitors restraint use more closely, and facilities in New York use restraints at a lower rate than national surveys have found elsewhere in the country. Thus, Glass projected the annual number of deaths could range as high as 150. “Admittedly, the estimates are only rough approximations,” Glass said. “The data needed for precise estimation are not collected in a systematic way nationwide. “But it is clear that greater attention should be paid to this issue, especially in light of the fact that it affects a particularly vulnerable patient population.”

*Project reporters: Eric M. Weiss,
Dave Altimari, Dwight F. Blint and
Kathleen Megan.*

*Additional reporting: John Springer,
Colin Poitras and Hilary Waldman.*

*Project researchers: Jerry LePore
and Sandy Mehlhorn.*

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HOSPITAL CITED IN RESTRAINT MISUSE

PSYCHIATRIC FACILITY BROKE NEW RULES

The [REDACTED] ([REDACTED])

Author: COLIN POITRAS; *Courant* Staff Writer

February 16, 2002

Federal inspectors have found that Connecticut's largest psychiatric hospital has been improperly restraining patients, even after the State led a national movement to restrict such techniques. The findings forced Gov. John G. Rowland last week to propose spending \$1.8 million for training and additional staff to prevent the loss of \$50 million in federal aid.

Staff members at [REDACTED] Hospital routinely violated patients' rights by tying them to their beds and placing them in seclusion to control their behavior, inspectors found during tours of the hospital and its [REDACTED] Forensic Division last October. Such measures are supposed to be used only in emergencies when patients pose a serious threat.

In one instance, inspectors noted, a potentially dangerous 22-year-old male patient was placed in four-point bed restraint at [REDACTED] for an entire month. Other [REDACTED] patients were placed in mechanical restraints for days and weeks at a time and remained in restraints even while sleeping, according to the inspectors' report.

The inspection was conducted by the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services, formerly known as the federal Health Care Financing Administration. It was the first time that the hospital had undergone such a com-

prehensive federal inspection in six years.

If the State didn't take immediate corrective action, the agency warned that it would no longer provide the hospital with millions in Medicare reimbursements.

[REDACTED] Hospital's chief operating officer, [REDACTED], said this week that the hospital has already changed its restraint and seclusion practices and that the \$50 million in federal reimbursement is once again ensured.

Rowland included \$1.8 million to address the issue in his amended budget proposal presented to legislators last week. The money will be used to hire 13 additional staff members, train existing staff in the new rules for restraint and create a special eight-bed housing unit for particularly difficult patients, officials said.

But the inspection's conclusions were potentially embarrassing for the State, whose two U.S. senators—Christopher J. Dodd and Joseph I. Lieberman—sponsored the landmark national legislation that led to tighter controls on the use of restraints in psychiatric hospitals two years ago. Dodd and Lieberman sponsored the bill after an investigation by *The Courant* documented that 142 people, many of them children, had died in psychiatric facilities throughout the country as a result of improper or excessive restraints.

[REDACTED] said that [REDACTED] was

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Hospital Cited in Restraint Misuse (continued)

proud of the fact that it had reduced restraint use by about 40 percent in the past two years. Yet he and others were not anticipating the strict interpretation of the new federal guidelines adopted by the inspectors from the Centers for Medicare and Medicaid Services, or CMS, during their unannounced visit on Oct. 4.

██████████ said the national Joint Commission on Accreditation of Healthcare Organizations, as well as State law, allows psychiatric hospitals to use restraints if a patient poses an “imminent” threat to himself or others. But the guidelines adopted by CMS permit mechanical restraints only in the most severe situations and require them to be removed as soon as a patient calms down.

Any impression that ██████████ is an archaic facility that punishes its patients by placing them in restraints would be wrong, ██████████ said.

“This is a very, very progressive facility,” ██████████ said.

██████████ said the 22-year-old patient who was restrained to his bed for a month was particularly aggressive and injured 44 staff members over the past year, ██████████ said.

██████████ said the hospital immediately adopted CMS’ interpretation of restraint guidelines after the inspection and is in the process of creating a new behavior management program that complies with federal rules. Inspectors returned to the hospital in late January and found no additional evidence of improprieties, federal authorities said.

Instead of placing inmates in seclusion or restraints when they pose a threat, staff is now being training in “de-escalation” techniques to help them recognize and address potential problems before they turn serious.

The hospital has also started using a “patient preference form” that asks patients what they feel will work best to help them calm down when their behavior becomes a concern.

In more serious instances in which restraints may have once been used, ██████████ said the hospital now relies on intense patient supervision—one-to-one, two-to-one and sometimes even three-to-one staff observations—to ensure both the patients’ and staff’s safety.

██████████, a forensic treatment specialist at ██████████, said the new requirements for supervision are driving up overtime costs and forcing staff to often work double shifts.

“We’re really working hard to keep within the guidelines,” ██████████ said. “But it’s very demanding to work with people in that way. And when people are understaffed and over-tired, it’s very difficult for them to do their best work.”

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Consumer Quotes

The big problem I have with restraints is that you start feeling vulnerable and you start thinking imaginary things like the people are going to hurt you, especially like the staff. Since they are required by law to always chart you, you are always seeing them staring at you through the window while you are lying there like, you know and it's scary. Very scary.

—Male

As an adolescent, age 12, I was put in a psychiatric unit for adolescents. I was there for abuse situations and the duration of my stay I was put into seclusion, which we called the padded room. I was put in there and stripped down, to nothing, and I was forced to stay there for 5 hours because I refused to watch a sexual assault video. Instead of letting me stay in my room and talk to my nurse at that time, they said if I don't follow the rules this is where I have to go.

—Female in seclusion and restraint as an adolescent

I think they should talk to you when you want them to talk to you. Basically you are a human being, not an animal. Even an animal being strapped down flat on the floor the Humane Society would have a fit with that.

—Male

They say act like an adult. If they want me to act like an adult, they should treat me like one. The way I should be treated and the way you would want to be treated.

—Female

I have been in seclusion about seven times. I've had experiences where I've had 7 or 8 people take me down and I've had experiences where I have had less. It's very degrading because when they put you there even as a girl or woman, all you're left is your underwear and a paper gown and a mattress that has nothing on it.

—Female

Fear basically is a big thing. You're vulnerable. Seclusion room is sometimes used as a punishment not as a therapy. I don't think treating someone like an animal is really a therapy. I think a lot of the staff are scared of the patients. And they react to that fear by controlling the patients and not trying to treat the patients.

—Male

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Consumer Quotes (continued)

The only way to survive in there is to turn inward and that just made me more angry.
—*Female in seclusion and restraint as an adolescent*

Then they have these restraints; they really are kind of sadistic in a way. You are spread-eagled so you really can't move. You can't have any circulation. You can't do anything. And they do and when they do it on your stomach lying down, you really can't even breathe. And the human instinct when you are spread-eagled is to get up so you are constantly fighting these things.
—*Male*

I've heard about people trying to pull their feet out of restraints and getting hurt. I've never tried that, my feet are too big and I was afraid I might lose them.
—*Male*

I usually would end up hurting myself more because of what they had done, instead of less.
—*Female*

It's the fear factor. I get paranoid and that's why I sign myself into a place like that. I get more paranoid while I go through the process cause basically because of my energy level I scare people. I'm not a mean person. I don't hurt people. I don't pull wings off flies. I'm a nice guy; I don't even hunt or fish. I don't even put worms on hooks; it's not my thing. But I am very loud and very energetic and it does frighten people. And I am fairly big and that also frightens people. But unless I want to go on a starvation diet and get my vocal chords cut, lose my legs just so they can treat me well at a State hospital when I am paranoid.
—*Male*

They said as soon as I stopped being angry, they would let me out. Meanwhile you are naked on your bed, strapped down with your door open and they wondered why you weren't mellowing out.
—*Female as an adolescent in restraint and seclusion*

Seclusion room, same thing with the people viewing you. They are always looking at you with them beady eyes. It's very frightening; it's very frightening.
—*Male*

Consumer Quotes (continued)

After they unlocked the door and they dragged me in there, they said, well you can't keep your clothes for danger issues. And they made strip me down. They kept a video on me the whole time. For a girl who is awkward and is in there for issues of abuse at home, all that did was extend my hate.

—*Female in seclusion and restraint as an adolescent*

When you're like this (head back, arms straight out) you want something to prop your head up. A little kindness. There was nurse that is now a doctor that talked to me once when I was really paranoid. If the staff is paranoid of you, what's the difference if the patient is paranoid? There are more staff than there are of you. They got you outnumbered and they got the keys. And if they are scared, why can't I be scared? I mean, isn't that fair?

—*Male*

I know it deepened my fear. I was in there to get help so I wouldn't injure myself anymore and become a better person. It just made me more angry and didn't help nothing.

—*Female in seclusion and restraint as an adolescent*

You are spread-eagled and on the floor and can't move. They are much happier. It's more convenient to restrain a patient or put him in the seclusion room.

—*Male*

From interviews with consumers in Minnesota.

Direct Care Staff Quotes

One of the things that doesn't get talked about very much is the trauma of the staff. We talk about the trauma paradigm for our clients or people in recovery. But not very often in my 20 years of work in the field of mental health have I heard much about what happens to us, the workers, and I think that's an area where we need to do some work. I've seen some pretty traumatic things from when I first started 20 years ago. Some of those things still haunt me.

I feel that it is overused and could be prevented a great deal of the time. I think that we got to train staff to avoid it where it's at all possible.

The first time that I helped with a restraint, a four-point restraint, I walked out of the room in tears because I thought it was one of the most horrible things I had ever seen. A lot of staff are really inflexible as to, I feel like they need to have the last word and then if the kid doesn't do exactly what they say, where they say, their alternative is that they need to go into seclusion.

I've had my peers report to me on particular event. I remember she had been monitoring a seclusion and I don't remember if the patient had cut himself or had a bloody nose or what and had smeared the blood all over and she said, "I smelled that, I smelled that all the time."

The problem I've seen through the years in this setting is depending on what staff is working. Sometimes it becomes more of a control issue than an issue of the best outcome or avoiding a seclusion.

I've been injured from time to time. Bruises, nothing severe. Yeah, sometimes I get headaches. I get shaky.

When you get to that point you feel as though you have failed. It seems like you've missed something when you could have prevented it beforehand. I never liked doing that (restraints), but it's about maintaining safety and you just never want that to happen. You feel like you have failed. There's always something you could have seen earlier if you had been there a little sooner, if you had know the client a little better. You could have prevented the situation.

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Direct Care Staff Quotes (continued)

I had an altercation in the past week with a patient that left some scratching on my face. The next day I woke up and was sick to my stomach and I couldn't come back to work.

Often what leads up to that is a manual escort. We frequently ask kids to go to a quiet area to calm down which is not too restrictive, just an area away from the group where they can take time to calm down and get back on track and re-join the activity. However, what I see a lot of the time is a kid will refuse to go to the quiet area or a kid will refuse to go to the quiet room and the staff will think, OK, if I don't follow up on this the other kids will see they don't have to listen to me and my authority will be challenged. So what they will do is manually escort them to the quiet room or area. At that point the kids will resist three-fourths of the time. When the kids resist they might end up just struggling and trying to get away and inadvertently bumping or hitting or shoving staff or they might actually bite or kick them or something like that which aggression toward staff is usually a justification for seclusion and they will end up in that seclusion whereas if that hands on escort to the quiet area or quiet room wasn't initiated that seclusion wouldn't happen. So that's my big beef.

I know that after a couple of difficult incidents on a unit, I certainly felt like I had symptoms of PTSD, about being hyper-aware when I walked to my car because some of the things I say and that I was involved with were very traumatic. And I think consumers talk about what it is like to be in restraints, it is also traumatizing to put people in restraints in the same way that I think it is traumatizing for soldiers to go to war and kill other people. We don't often talk about the impact of that either.

From interviews with direct care staff in Minnesota.

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