



## RESOURCES

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## WEB SITES

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<p><b>Advocates, Inc.</b>                  27 Hollis Street                  Framingham, MA                  Phone: 508-620-0024                  Fax: 508-626-0356  <a href="http://www.advocatesinc.org">www.advocatesinc.org</a></p>	<p>Advocates mission is to help people with psychiatric illness, chemical dependency, developmental disabilities, or other problems in living. They provide community-centered services that empower people to deal effectively with their difficulties, to pursue their own individual aspirations, and to realize satisfaction in their relationships, their work, and their communities.</p>
<p><b>American Academy of Child and Adolescent Psychiatry (AACAP)</b>                  3615 Wisconsin Avenue, NW                  Washington DC 20016-3007                  Phone: 202-966-7300                  Fax: 202-966-2891  <a href="http://www.aacap.org">www.aacap.org</a></p>	<p>AACAP assists parents and families in understanding developmental, behavioral, emotional, and mental disorders affecting children and adolescents.</p>
<p><b>American Nurses Association (ANA)</b>                  8515 Georgia Avenue                  Suite 400                  Silver Spring, MD 20910                  1-800-274-4ANA  <a href="http://www.ana.org">www.ana.org</a></p>	<p>ANA is the only full-service professional organization representing the Nation’s entire registered nurse population. From the halls of Congress and Federal agencies to board rooms, hospitals, and other health care facilities, ANA is the strongest voice for the nursing profession and for workplace advocacy.</p>
<p><b>American Psychiatric Association</b>                  1000 Wilson Boulevard                  Suite 1825                  Arlington, VA 22209-3901                  Phone: 703-907-7300                  E-mail: <a href="mailto:apa@psych.org">apa@psych.org</a>  <a href="http://www.psych.org">www.psych.org</a></p>	<p>The American Psychiatric Association is an organization of psychiatrists working together to ensure humane care and effective treatment for all persons with mental illnesses, including substance use disorders. It is the voice and conscience of modern psychiatry. Its vision is a society that has available, accessible quality psychiatric diagnosis and treatment.</p>
<p><b>The American Psychiatric Nurses Association (APNA)</b>                  1555 Wilson Boulevard, Suite 602                  Arlington, VA 22209                  Phone: 703-243-2443                  Fax: 703-243-3390  <a href="http://www.apna.org">www.apna.org</a></p>	<p>APNA provides leadership to advance psychiatric-mental health nursing practice, improves mental health care for culturally diverse individuals, families, groups, and communities, and shapes health policy for the delivery of mental health services.</p>
<p><b>American Psychological Association</b>                  750 First Street, NE                  Washington, DC 20002-4242                  Phone: 800-74-2721 or                  202-336-5500  <a href="http://www.apa.org">www.apa.org</a></p>	<p>The American Psychological Association is a scientific and professional organization that advances psychology as a science and profession and as a means of promoting health and human welfare.</p>

*Resources (continued)*

<p><b>Bazelon Center for Mental Health Law</b>                  1101 15th Street, NW                  Suite 1212                  Washington, DC 20005-5002                  Phone: 202-467-5730                  Fax: 202-223-0409                  TDD: 202-467-4232  <a href="http://www.bazelon.org">www.bazelon.org</a></p>	<p>The Judge David L. Bazelon Center for Mental Health Law is a nonprofit legal advocacy organization based in Washington, DC. The Center's name honors the Federal appeals court judge whose landmark decisions pioneered the field of mental health law, and its advocacy is based on the principle that every individual is entitled to choice and dignity.</p>
<p><b>Bluebird Consultants</b>                  Gayle Bluebird, R.N.                  110 SW 8th Avenue                  Fort Lauderdale, FL 33312                  Phone: 954-467-1431  <a href="http://www.contac.org/bluebird">www.contac.org/bluebird</a></p>	<p>Bluebird Consultants, an innovative "traveling technical assistance program," comes to you with years of expertise in the mental health field. Each program is designed to your specific needs providing a diverse array of services, such as the development of new consumer-run programs, troubleshooting, trainings for professionals as well as consumers, conference planning, or assistance with the development of policies and procedures.</p>
<p><b>Centers for Medicare &amp; Medicaid Services (formerly Health Care Financing Administration)</b>                  7500 Security Boulevard                  Baltimore, MD 21244-1850                  Phone: 877-267-2323 or                  410-786-3000  <a href="http://www.cms.hhs.gov">www.cms.hhs.gov</a></p>	<p>The Centers for Medicare and Medicaid Services (CMS) is a Federal agency within the U.S. Department of Health and Human Services. CMS runs the Medicare and Medicaid programs. In partnership with the Health Resources and Services Administration, CMS runs the State Children's Health Insurance Program (SCHIP).</p>
<p><b>Center for Mental Health Services Office of Consumer Affairs</b>                  1 Choke Cherry Road                  Rockville, MD 20857                  Phone: 800-789-2647                  Fax: 240-276-1340  <a href="http://www.mentalhealth.samhsa.gov">www.mentalhealth.samhsa.gov</a></p>	<p>The Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration is charged with leading the national system that delivers mental health services. The goal of this system is to provide the treatment and support services needed by adults with mental disorders and children with serious emotional problems.</p>
<p><b>Center for Psychiatric Rehabilitation at Boston University</b>                  930 Commonwealth Avenue, W                  Boston, MA 02215                  Phone: 617-353-3549                  Fax: 617-353-7700  <a href="http://www.bu.edu/cpr">www.bu.edu/cpr</a></p>	<p>This Center is a research, training, and service organization dedicated to improving the lives of persons who have psychiatric disabilities by improving the effectiveness of people, programs, and service systems.</p>

**Resources (continued)**

<p><b>Child Welfare League of America</b>                  Headquarters—                  440 First Street NW, 3rd Floor                  Washington, DC 20001-2085                  Program Office—                  50 F Street NW, 6th Floor                  Washington, DC 20001-2085                  Phone: 202-638-2952                  Fax: 202-638-4004  <a href="http://www.cwla.org">www.cwla.org</a></p>	<p>The Child Welfare League of America is the oldest and largest national nonprofit organization developing and promoting policies and programs to protect America’s children and strengthen America’s families. The League is committed to engaging people everywhere in promoting the well-being of children, youth, and their families, and protecting every child from harm.</p>
<p><b>Consumer Organization and Networking Technical Assistance Center (CONTAC)</b>                  P.O. Box 11000                  Charleston, WV 25339                  Phone: 888-825-Tech or                  304-346-9992                  Fax: 304-345-7303  <a href="http://contac.org">http://contac.org</a></p>	<p>A national technical assistance center, CONTAC serves as a resource center for consumers/survivors/ex-patients and consumer-run organizations across the United States, promoting self-help, recovery, and empowerment. CONTAC was developed utilizing research on ideal consumer self-help programs, successful consumer-run programs, community support service philosophy about service delivery, descriptions of mature mental health systems, and management and leadership skills.</p>
<p><b>Connecticut Department of Children and Families</b>                  Office of Public Relations                  505 Hudson Street                  Hartford, CT 06106  <a href="http://www.state.ct.us/dcf">www.state.ct.us/dcf</a></p>	<p>The mission of the Connecticut Department of Children and Families is to protect children, strengthen families, and help children and youth reach their fullest potential.</p>
<p><b>Federation of Families for Children’s Mental Health</b>                  1101 King Street, Suite 420                  Alexandria, VA 22314                  Phone: 703-684-7710                  Fax: 703-836-1040  <a href="http://www.ffcmh.org">www.ffcmh.org</a></p>	<p>The Federation is a parent-run organization focused on the needs of children and youth with emotional, behavioral, or mental disorders and their families.</p>
<p><b>Joint Commission on Accreditation of Healthcare Organizations (JCAHO)</b>                  One Renaissance Boulevard                  Oakbrook Terrace, IL 60181                  Phone: 630-792-5000                  Fax: 630-792-5005  <a href="http://www.jcaho.org">www.jcaho.org</a></p>	<p>The Joint Commission, an independent, non-profit organization, evaluates and accredits health care organizations and programs in the United States. JCAHO’s mission is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.</p>

**Resources (continued)**

<p><b>Mental Health Recovery Self-Help Strategies</b>                  Mary Ellen Copeland, M.S.,M.A.                  P.O. Box 301                  West Dummerston, VT 05357                  Phone: 802-254-2092                  Fax: 802-257-7499  <a href="http://www.mentalhealthrecovery.com">www.mentalhealthrecovery.com</a></p>	<p>Mary Ellen Copeland is a mental health recovery educator and author. Her focus is on self-help. She has learned the concepts, skills, and strategies she teaches from her own personal experience with extreme mood swings and from her ongoing studies with people who experience psychiatric symptoms.</p>
<p><b>National Alliance for the Mentally Ill (NAMI)</b>                  Colonial Place Three                  2107 Wilson Boulevard                  Suite 300                  Arlington, VA 22201                  Phone: 703-524-7600;                  NAMI Help Line: 1-800-950-NAMI [6264]  <a href="http://www.nami.org">www.nami.org</a></p>	<p>NAMI is a nonprofit, grassroots, self-help, support and advocacy organization of consumers, families, and friends of people with severe mental illnesses, such as schizophrenia, major depression, bipolar disorder, obsessive-compulsive disorder, and anxiety disorders.</p>
<p><b>National Association of Consumer/Survivor Mental Health Administrators (NAC/SMHA)</b>                  Karen Kangas, President                  CT Department of Mental Health and Addiction Services                  410 Capitol Avenue                  P.O. Box 341431, MS 14CED                  Hartford, CT 06134-1431                  Phone: 860-418-6948                  Fax: 860-418-6786                  E-mail: <a href="mailto:Karen.kangas@po.state.ct.us">Karen.kangas@po.state.ct.us</a></p> <p>Dan Powers, Vice President                  Consumer Liaison                  Office of Community Mental Health                  Division of Health and Wellbeing                  Department of Health and Human Services                  POP Box 94728                  Lincoln, NE 68509-4728                  Phone: 402-479-5193                  Fax: 402-479-5162                  E-mail: <a href="mailto:Dan.Powers@hss.state.ne.us">Dan.Powers@hss.state.ne.us</a>  <a href="http://www.nasmhpd.org">www.nasmhpd.org</a></p>	<p>NACS/MHA represents State mental health department senior managers who are current or former recipients of mental health services. The Association provides a forum for members to develop strategies for balancing the often disparate demands and expectations of the two constituencies they serve: consumers/survivors and mental health bureaucracies. The organization serves as a vehicle for networking and peer support, and is committed to expanding the participation of consumers/survivors in all aspects of the public mental health system. The Association offers technical assistance to State mental health departments who are interested in developing offices of consumer/ex-patient relations.</p>

**Resources (continued)**

<p><b>National Association of Protection and Advocacy, Inc.</b>            900 Second Street, NE, Suite 211            Washington, DC 20002            Phone: 202-408-9514            Fax: 202-408-9520            E-mail: <a href="mailto:napas@earthlink.net">napas@earthlink.net</a>  <a href="http://www.napas.org">www.napas.org</a></p>	<p>The Protection and Advocacy (P&amp;A) System and Client Assistance Program (CAP) comprise the nationwide network of congressionally mandated, legally based disability rights agencies. P&amp;A agencies have the authority to provide legal representation and other advocacy services, under all Federal and State laws, to all people with disabilities (based on a system of priorities for services). All P&amp;As maintain a presence in facilities that care for people with disabilities, where they monitor, investigate, and attempt to remedy adverse conditions. These agencies also devote considerable resources to ensuring full access to inclusive educational programs, financial entitlements, health care, accessible housing, and productive employment opportunities.</p>
<p><b>National Association of State Mental Health Program Directors (NASMHPD)</b>            66 Canal Center Plaza            Suite 302            Alexandria, VA 22314            Phone: 703-739-9333            Fax: 703-548-9517  <a href="http://www.nasmhpd.org">www.nasmhpd.org</a></p>	<p>NASMHPD organizes to reflect and advocate for the collective interests of State Mental Health Authorities and their directors at the national level. NASMHPD analyzes trends in the delivery and financing of mental health services and builds and disseminates knowledge and experience reflecting the integration of public mental health programming in evolving healthcare environments.</p>
<p><b>National Council for Community Behavioral Healthcare</b>            12300 Twinbrook Parkway            Suite 320            Rockville, MD 20852            Phone: 301-984-6200            Fax: 301-881-7159  <a href="http://www.nccbh.org">www.nccbh.org</a></p>	<p>The National Council for Community Behavioral Healthcare, a nonprofit trade association, is the Nation's oldest and largest membership organization dedicated to ensuring that appropriate and affordable community-based mental health and substance abuse services are available for all individuals.</p>
<p><b>National Empowerment Center, Inc.</b>            599 Canal Street            Lawrence, MA 01840            Phone: 800-769-3728 or            978-685-1494            Fax: 978-6816426  <a href="http://www.power2U.org">www.power2U.org</a></p>	<p>The mission of the National Empowerment Center (NEC) is to carry a message of recovery, empowerment, hope, and healing to people who have been diagnosed with mental illnesses. NEC carries the message with authority because it is a consumer/survivor/ex-patient-run organization. Each member is living a personal journey of recovery and empowerment that is not just the privilege of a few, but possible for each person who has been diagnosed with a mental illness.</p>

**Resources (continued)**

<p><b>National Institute of Mental Health</b>          6001 Executive Boulevard,          Room 8184, MSC 9663          Bethesda, MD 20892-9663          Phone: 301-443-4513 or          866-615-6464          Fax: 301-443-4279          TTY: 301-443-8431  <a href="http://www.nimh.nih.gov">www.nimh.nih.gov</a></p>	<p>The mission of the National Institute of Mental Health (NIMH) is to diminish the burden of mental illness through research. This public health mandate demands that powerful scientific tools be harnessed to achieve better understanding, treatment, and, eventually, prevention of mental illness.</p>
<p><b>National Mental Health Association</b>          2001 N. Beauregard Street          12<sup>th</sup> Floor          Alexandria, VA 22314-2971          Phone: 703-684-7722          Fax: 703-684-5968          Resource center: 800-969-NMHA          TTY: 800-433-5959  <a href="http://www.nmha.org">www.nmha.org</a></p>	<p>The National Mental Health Association (NMHA) is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. NMHA works to improve the mental health of all Americans, especially the 54 million individuals with mental disorders, through advocacy, education, research, and service.</p>
<p><b>National Mental Health Consumers' Self-Help Clearinghouse</b>          1211 Chestnut Street          Suite 1207          Philadelphia, PA 19107          Phone: 800-553-4539          Fax: 215-636-6312          E-mail: <a href="mailto:info@mhselfhelp.org">info@mhselfhelp.org</a>  <a href="http://www.mhselfhelp.org">www.mhselfhelp.org</a></p>	<p>The National Mental Health Consumers' Self-Help Clearinghouse provides consumer information and referrals, on-site consultation, training events, teleconferences and national conferences, a consumer library, a newsletter, and a consumer and consumer-supported nationwide database.</p>
<p><b>PACER (Parent Advocacy Coalition for Educational Rights)</b>          8161 Normandale Boulevard          Minneapolis, MN 55435          Phone: 952-838-9000          Fax: 952- 838-0199  <a href="http://www.pacer.org">www.pacer.org</a></p>	<p>The mission of PACER is to expand opportunities and enhance the quality of life of children and young adults with disabilities and their families, based on the concept of parents helping parents. With assistance to individual families, workshops, and materials for parents and professionals, and leadership in securing a free and appropriate public education for all children, PACER's work affects and encourages families in Minnesota and across the Nation.</p>
<p><b>Pennsylvania Department of Public Welfare – Office of Mental Health and Substance Abuse Services</b>          Health and Welfare Building          Room 502, P.O. Box 2675          Harrisburg, PA 17105-2675          Phone: 717-787-6443          Fax: 717-787-5394  <a href="http://www.dpw.state.pa.us">www.dpw.state.pa.us</a></p>	<p>Pennsylvania's mental health services range from community to hospital programs with emphasis on helping people to remain in their communities. Community services are emphasized, with the aim to develop more services to help people who have serious mental illnesses break the cycle of repeated hospital admissions.</p>

**Resources (continued)**

<p><b>Research and Training Center on Family Support and Children’s Mental Health</b> Portland State University Portland, OR 97207 Phone: 503-725-3000 <a href="http://www.rtc.pdx.edu">www.rtc.pdx.edu</a></p>	<p>The Center’s activities focus on improving services to children and youth who have mental, emotional, or behavioral disorders and their families.</p>
<p><b>U.S. Psychiatric Rehabilitation Association</b> 601 N. Hammonds Ferry Road Suite A Linthicum, MD 21090 Phone: 410-789-7054 <a href="http://www.iapsrs.org">www.iapsrs.org</a></p>	<p>This organization is dedicated to promoting, supporting, and strengthening community-oriented rehabilitation services and resources for persons with psychiatric disability.</p>

## POLICIES AND POSITION STATEMENTS

### American Nurses Association Position Statement

### **Reduction of Patient Restraint and Seclusion in Health Care Settings**

#### **Summary**

Dilemmas in patient care situations are an inevitable consequence of professional accountability. With regard to use of restraints, nurses struggle with conflicts stemming from patients' rights of freedom, nurses' feelings of obligation to "protect" patients, and family and peer pressure to use restraints. ANA believes *only when no other viable option is available should restraint be employed*. In those instances where restraint, seclusion, or therapeutic holding is determined to be "clinically appropriate and adequately justified," registered nurses, who possess the necessary knowledge and skills to effectively manage the situation, must be actively involved in the assessment, implementation, and evaluation of the selected intervention.

#### **Background**

Nursing has a history of being involved with attempts at reduction in the use of restraint going back well over one hundred years. Frequently, when restraint was employed it was in the belief that such action would promote patient safety. It was this belief, in part, which led to the increase in restraint use in the nursing home population. As concern about the quality of patient care in that setting rose, the Nursing Home Reform Act (a part of the Omnibus Reconciliation Act of 1987) was adopted into law. The results of this law, which greatly affected the quality of care received through increased assessment of and care planning for the patient as well as through reduction of both physical and chemical restraint, have implications for individuals with mental illness as well. The patient populations affected are the elderly, psychiatric patients (adults and children), and disoriented or physically aggressive patients. The settings of restraint use include psychiatric facilities and residential sites for those with mental illness, developmental or behavioral problems; general hospitals, emergency departments, and nursing homes (Sullivan-Marx & Strumpf, 1996).

## Definitions

### *Restraint is...*

any involuntary method (chemical or physical) of restricting an individual's freedom of movement, physical activity, or normal access to the body.

### *Chemical restraint is...*

the use of a sedating psychotropic drug to manage or control behavior. Psychoactive medication used in this manner is an inappropriate use of medication.

### *Physical restraint is...*

the direct application of physical force to a patient, without the patient's permission, to restrict his or her freedom of movement (JCAHO, 2000). The physical force may be human, mechanical devices, or a combination thereof. This definition does not apply to (1) interactions with patients that are brief and focus on redirection or assistance in activities of daily living, such as hygiene, and (2) the use of any psychoactive medication that is a usual or customary part of a medical diagnostic or treatment procedure, and that is used to restrict a patient's freedom of movement (JCAHO, 2000).

### *Seclusion refers to...*

the involuntary confinement of a person in a locked room (JCAHO, 2000).

### *Therapeutic holding is...*

the physical restraint of a child by at least two people to assist the child who has lost control of behavior to regain control of strong emotions (American Academy of Pediatrics, 1997).

In the past, when restraint was employed, it was in the belief that such action would promote patient safety and without effective restraint and seclusion practices, patients were considered to be in danger of injuring themselves or others, including nursing staff, or being injured by other assaultive patients. The danger of employing such restraint, however, has been demonstrated to be problematic. There is a need for additional research to explore patient safety factors related to restraint and seclusion and the role of the registered nurse in their elimination.

A 50-State survey by a Connecticut newspaper (*Hartford Courant 1998*), revealed at least 142 deaths related to the use of physical restraint or seclusion since 1988. The report also noted that the true number of deaths is much higher since data about many such deaths is not public information. In one case, a patient at Virginia's Central State Hospital died after being restrained for 300 hours, including two intervals of approximately 110 hours each. Young men in a residential treatment facility in Pennsylvania and at a private psychiatric hospital in North Carolina died shortly after being physically restrained by personnel who were caring for them. According to statistical projections commissioned by *The Courant* and conducted

by the Harvard Center for Risk Analysis, between 50 and 150 such deaths occur every year across the country due to improper restraint procedures. The National Alliance for the Mentally Ill (NAMI, 1999) has received reports from 15 States about 24 incidents related to the use of restraints and/or seclusion, ranging from a 16-year-old in California who died while restrained by four staff members to an Ohio man who died in restraints running a temperature of 108 degrees. Situations such as these can not be allowed to continue. There is a critical need for mandated monitoring of the use (frequency, methods, etc.) of restraint and seclusion.

ANA supports the rights of patients of all ages and in all settings to be treated with dignity and concern, and to receive safe, quality care. Developmentally appropriate methods of restraint must be used in the least restrictive manner. The family members, guardians, or significant others of individuals placed in restraint must be informed immediately.

ANA recognizes that seclusion and/or restraint may be more likely to be employed inappropriately—that is, for nonemergency situations and/or for circumstances where no significant risk of harm exists—when hospital unit staffing is inadequate or staff is inappropriately trained to provide less restrictive interventions. Where the hospital cannot provide for an assessment by a physician or other appropriately licensed health care professional within an hour, ANA supports that all the following requirements should apply: (1) a registered nurse shall confer by telephone with a physician or other health care professional permitted by the State and hospital to order restraint or seclusion within an hour after the restraint or seclusion is initiated. (This requirement is also consistent with ANA’s proposal on obtaining telephone orders within an hour after instituting the procedure if an order cannot be obtained beforehand). (2) The reasons for a patient not being seen within the hour shall be documented in the patient record. (3) The patient must be physically assessed by a registered nurse hourly until a physician or other appropriately licensed health care professional arrives to see the patient. (4) The patient must be seen by an R.N. or physician or other health care professional permitted by the State and hospital to order restraint or seclusion within one hour after being placed in restraint or seclusion. Adding such language to the current requirements assures that the patients’ safety is not compromised by delay in assessment.

To achieve reduced restraint care, formal mission statements and policies that clearly state the intent to promote a reduced restraint environment for patients must be adopted. Such statements must include a focus on (1) intention to comply with policy standards; (2) environmental designs to facilitate restraint reduction; and (3) implementation of an individualized approach grounded in the following principles: 1) all behavior has meaning; 2) patient needs are best met when behavior is understood; and 3) a systematic approach of assessment, intervention, and evaluation is the best means to respond to behavior.

When instituting change toward reduced restraint care, initial educational efforts must address fundamental components of such care. Open communication and dialogue at board

and highest administrative levels, and including staff from all disciplines, as well as community representatives, are essential to implementing change. Early success with less complex problems, such as eliminating restraints for positional support with substitution of wedge or roll cushions, fosters confidence for handling more difficult situations. If systems lack internal resources to provide education and specialist intervention, independent nursing consultation services can be contracted to provide for these needs.

Targeting specific units or groups of patients, such as all new admissions, and then identifying those who are restrained (and why) lays the groundwork for interventions aimed at eliminating restraints. Interventions may take the form of actions categorized as pharmacologic, physiologic, psychosocial, activity, or environment.

Physiologic approaches include such efforts as pain relief, comfort measures, or investigating symptoms indicative of developing complications, such as hypoxia or fever. Psychosocial interventions focus on the meaning of patient behavior and address that need, e.g., is the agitated patient fearful of impending surgery? Activities can include talking with the patient, physical exercise/therapy, involvement in activities, meaningful distraction, or contact with familiar persons or places, even by telephone. Environmental adjustments may range from simple use of light to facilitate vision or relocation of the patient to another bed or room, to specifically designed units that reduce the hazards of falling. To foster transition to reduced restraint care and sustain lasting change, beliefs must be altered and knowledgeable practice enhanced through education, intensive clinical evaluation, and consistent reinforcement of standards and policy (Sullivan-Marx & Strumpf, 1996).

Finally, it must be recognized that psychotropic medications are not merely “chemical restraints” but treatment strategies which can result in a decreased need for therapeutic holding and/or physical restraint. However, there must be an adequate number of professional nurses available to provide the necessary care. Staff must be educated in the use of alternatives to restraint, and such alternatives must be made available to them both through organizational policy and in fact. Only then can the safety and quality of patient care be assured.

There is a critical need to provide educational opportunities for nurses to assist them to develop the necessary assessment and intervention skills to prevent the need for restraint and seclusion. ANA is concerned that lack of personnel to provide adequate monitoring of patients and less restrictive approaches to behavior management may place patients at greater risk of violation of their rights and of harm caused by being placed in seclusion and/or restraints.

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- Effective Date: October 17, 2001  
Status: Position Statement  
Originated By: Congress on Nursing Practice and Economics  
Adopted By: ANA Board of Directors
- Related Past Actions:
1. 2000 HOD Reduction of Patient Restraint and Seclusion in Health Care Settings (Action Report)

## American Psychiatric Nurses Association

### Position Statement on the Use of Seclusion and Restraint

#### Introduction

Psychiatric-mental health nursing has a 100-year history of caring for patients in psychiatric facilities. Currently, nurses serve as frontline workers as well as unit-based and executive level administrators in virtually every organization providing inpatient psychiatric treatment. Therefore, as the professional organization for psychiatric-mental health nurses, the American Psychiatric Nurses Association (APNA) recognizes that the ultimate responsibility for maintaining the safety of those in the treatment environment and for maintaining standards of care in the day-to-day treatment of these clients rests with nursing and the hospital or behavioral health care organization that supports the unit. Thus, APNA supports a sustained commitment to the reduction of seclusion and restraint and advocates for continued research to support evidence-based practice for the prevention and management of behavioral emergencies. Furthermore, we recognize the need for and are committed to working together with physicians, clients and families, advocacy groups, other health providers, and our nursing colleagues in order to achieve the vision of eliminating seclusion and restraint.

#### Background

In the mid-1800s proponents of “moral treatment” of psychiatric patients advocated the elimination of the practice of restraining patients. Despite the relative success of this movement in England and Europe, psychiatrists in the United States concluded that restraints could never be eliminated in the United States (Bockoven, 1963; Deutsch, 1949; Freedman, Kaplan, & Sadock, 1975; Strumpf & Tomes, 1993). To this day, belief in the necessity for continuing the practice of secluding and restraining patients persists. Fisher (1994) concludes from his review of the literature that not only is it “nearly impossible to operate a program for severely symptomatic individuals without some form of seclusion or physical or mechanical restraint” (p. 1584) but that these methods are *effective* in preventing injury and reducing agitation. However, the determination of the efficacy of the use of seclusion and restraint is not grounded in research that supports the therapeutic efficacy of this intervention, but upon the observation that the intervention interrupts and controls the patient’s behavior (Walsh & Randell, 1995).

Recent research has prompted psychiatric-mental health nurses to question the therapeutic benefit of secluding and restraining psychiatric patients. Some of these studies underscore the potential negative impact of this practice on patients. These studies bring to the fore the ethical dilemmas inherent in the use of seclusion and restraints (Binder & McCoy, 1983; Browne & Tooke, 1992; Johnson, 1998; Mohr, Mahon, & Noone, 1998; Norris & Kennedy, 1992). On the one hand, this practice has the potential for physically and/or psychologically

harming patients (Brown & Tooke, 1992; Fisher, 1994; Martinez, Grimm, & Adamson, 1999) and for violating the patient's right to autonomy and self-determination (Moss & La Puma, 1991; Stilling, 1992). On the other hand, studies of violence on inpatient units underscore the reality that violence cannot be predicted. Since the nursing staff are held responsible for maintaining the safety of *all* of the patients, they often see seclusion and restraint as a necessary last-resort intervention to maintain that safety (Alty, 1997; Steele, 1993). Furthermore, studies of the impact of assault on those who care for patients must be taken into consideration when developing standards for practice and when addressing organizational strategies to assure equal commitment to worker as well as patient safety (OSHA, 1998; Lanza, 1992; Poster & Ryan, 1989; Ryan & Poster, 1989).

Other studies have highlighted the influence of unit philosophy and culture, treatment philosophy, staff attitudes, staff availability, staff training, ratios of patients to staff, and location in the United States on either the disparity in the incidence of seclusion and restraint or the perpetuation of the practice of secluding and restraining psychiatric patients (Browne & Tooke, 1992; Holzworth & Wills, 1999; Kirkpatrick, 1989; Harris & Morrison, 1995; Johnson & Morrison, 1993; Morrison, 1990, 1992, 1993, 1994). From the research, it appears that the key to seclusion and restraint reduction is prevention of aggression by (1) assessing the patient and intervening early with less restrictive measures such as verbal and nonverbal communication, reduced stimulation, active listening, diversionary techniques, limit setting and prn medication (Canatsey & Roper, 1997; Lehane & Rees, 1996; Maier, 1996; Martin, 1995; Morales & Duphorne, 1995; Richmond et al., 1996; Stevenson, 1991) and (2) changing aspects of the unit to promote a culture of structure, calmness, negotiation, and collaboration rather than control (Cahill, Stuart, Laraia, & Arana, 1991; Delaney, 1994; Harris & Morrison, 1995; Johnson & Morrison, 1993; Whittington & Patterson, 1996). To date, there is some evidence that changes in a unit's treatment philosophy can lead to changes in patient behavior that will ultimately impact the incidence of the use of seclusion and/or restraints (Goren, Abraham, & Doyle, 1996).

Despite the best efforts at preventing the use of seclusion and restraint, there may be times that these interventions are necessary. Thus, it is important to be cognizant of the vulnerability of clients who are secluded or restrained and the risks involved in using these interventions (Weiss, 1998). Moreover, the dangers inherent in the use of seclusion and restraint include the possibility that the client's behavior is a manifestation of an organic or physiological problem that requires medical intervention and may therefore predispose the client to increased physiological risk during the time the individual is secluded or restrained. Therefore, skilled assessments of clients who are restrained or secluded will not only ensure the safety of clients in these vulnerable conditions but also ensure that the intervention is discontinued as soon as the client is able to be safely released.

## **Position Statement**

APNA believes that psychiatric-mental health nurses play a critical role in the provision of care to clients in psychiatric settings. Therefore,

- We take responsibility for providing ongoing opportunities for professional growth and learning for the psychiatric-mental health nurse whose treatment promotes client safety as well as autonomy and a sense of personal control.
- We promulgate professional standards that apply to all populations and in all settings where behavioral emergencies occur and that provide the framework for quality care for all individuals whose behaviors constitute a risk for safety to themselves or others.
- We advocate and support evidence-based practice through research directed toward examining the variables associated with the prevention of and safe management of behavioral emergencies.
- We articulate the following fundamental principles to guide action on the issue of seclusion and restraint:
  - Clients have the right to be treated with respect and dignity and in a safe, humane, culturally sensitive, and developmentally appropriate manner that respects client choice and maximizes self determination.
  - Seclusion or restraint must never be used for staff convenience or to punish or coerce patients.
  - Seclusion or restraint must be used for the minimal amount of time necessary and only to ensure the physical safety of the individual, other patients, or staff members and when less restrictive measures have proven ineffective.
  - Clients who are restrained must be afforded maximum freedom of movement while assuring the physical safety of the client and others. The least number of restraint points must be utilized and the client must be continuously observed.
  - Seclusion and restraint reduction requires preventative interventions at both the individual and milieu management levels using evidence-based practice.
  - Seclusion and restraint use is influenced by the organizational culture of a setting that develops norms for how patients are treated. Seclusion and restraint reduction efforts must include a focus on necessary culture change.
  - Hospital and behavioral healthcare organizations and their nursing leadership groups must make commitments of adequate professional staffing levels, staff time and resources to assure that staff are adequately trained and currently competent to perform treatment processes, milieu management, de-escalation techniques, and seclusion or restraint.
  - Oversight of seclusion and restraint must be an integral part of an organization's performance improvement effort and these data must be open for inspection by internal and external regulatory agencies. Reporting requirements must be based on a common definition of seclusion and restraint. Specific data requirements must be consistent across regulatory agencies.

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## Federation of Families For Children’s Mental Health

### **Position on the Use of Seclusion and Restraints**

The Federation is strongly opposed to the use of physical, chemical, or mechanical restraints and seclusion with any child but especially for children and youth who have mental, emotional, or behavioral disorders or children and youth who have been exposed to violence. We view restraint and seclusion as inhumane, cruel, and ineffective. These techniques, at best, may temporarily relieve stress for the adults in charge and always increase stress for the child or youth. There is no evidence that the use of restraints or seclusion has any therapeutic benefit whatsoever.

Restraint and seclusion are not appropriate forms of treatment. Children and youth who are “out of control” need services, supports, and highly specialized attention—not seclusion. When implementation of an IEP, service, or treatment plan fails to achieve the desired or appropriate behavior, there must be a review and revision of the plan. Subjecting a child or youth to restraints and seclusion in such situations is equivalent to punishing the victim. No service or treatment plan should EVER include provisions for the routine use of seclusion or restraints. Seclusion or “time out” or any form of restraint are punishments that should be eliminated from the behavioral contracting and discipline protocols of schools, day and residential treatment centers, group homes, hospitals, and juvenile detention and correctional facilities.

Holding children should be a loving act, not a violent one. Restraining children teaches them that it is acceptable to treat others with physical force when they do things you don’t like. This is a very bad message. Children and youth, whose behavior is (or appears to be) very difficult for them and those who care for them to control, need first and foremost a comprehensive assessment to learn what is causing this behavior and also figure out what function(s) it is serving. A specific and individualized service plan consisting of effective therapeutic, medical, social, educational, and rehabilitative supports and services can then be drawn up by the family and youth along with their team of service providers and advisors. Such a plan must build on the child’s and family’s strengths and address the behavioral issues of greatest concern to them first. The overarching goal of any service plan should be to support the child and family so the child can live safely at home (or as close to home as possible), go to school and be successful in the general curriculum, and fully participate in the cultural, spiritual, and recreational life of the community.

Time out must be distinguished from seclusion. We would define time out as giving the child or youth the opportunity to temporarily and **VOLUNTARILY** remove her or himself from a

situation to **PREVENT** further escalation of stress or anxiety. Time out must also be supervised and the child should be allowed to talk to a professional or supportive and trusted adult if she or he so wishes. Time out should end when the child feels ready to return to the group.

There may be rare instances where safety makes it necessary to use seclusion or restraints, such as in a life-threatening situation where there is absolutely no other way to safely protect a child whose behavior is violent or insure the safety of others who are in danger from that behavior. In such cases, only the responsible chief administrator or attending physician should authorize the procedure and

- the child should NEVER be left alone—professional staff (not child care attendants or peers) trained in de-escalation and conflict resolution should be working with the child throughout the episode;
- seclusion should be ended or restraints be removed as soon as the behavior begins to subside AND an effective therapeutic intervention should be initiated within no more than 15 minutes of the onset of the incident;
- the child’s parents or family should be notified as soon as the seclusion or restraint is initiated;
- the IEP, service, or treatment plan should be reviewed within 24 hours and revised if necessary.

There should be no instances of seclusion or restraints that last more than a few minutes (i.e., 15 minutes). If they do, the child should have ready (on demand) access to food, water, bathroom facilities, and be allowed to make a phone call to a predetermined, trusted, family member, professional, or support person. Any child who is secluded for more than 15 minutes should be provided with appropriate and safe learning materials and instruction.

Denial of contact with family members should never be used as tool to control or manipulate behavior. All uses of restraints, seclusion, or physical intervention should be immediately documented in the child’s file and a copy of the report should be provided to the child’s parent or guardian within 24 hours of the incident. The child’s family should be allowed to insist that restraints and seclusion not be used for their child under any circumstances and this should not jeopardize the child’s admission to or treatment at the facility.

## NAMI

### **Seclusion and Restraint Position Paper**

(Summarized from the NAMI Policy Platform)

The use of involuntary mechanical or human restraints or involuntary seclusion is only justified as an emergency safety measure in response to imminent danger to a patient or others. These extreme measures can be justified only so long as, and to the extent that, an individual cannot commit to the safety of him or herself and others.

Restraint and seclusion have no therapeutic value and should be used only for emergency safety by order of a physician with competency in psychiatry or a licensed independent mental health professional (LIP). A physician trained in psychiatry or a LIP should see the patient within one hour after restraints are initiated. Restraints should be continued only for periods of up to one hour at a time, and a face-to-face examination of the patient by the physician or LIP must occur prior to each time a restraint order is renewed.

Alternatives to the use of restraint and seclusion should be used. De-escalation techniques and debriefings should be used after each restraint and seclusion incident.

#### **A Clear Pattern of Abuse Exposed**

In October 1998, *The Hartford Courant* published a five-part investigative series that revealed an alarming number of deaths resulting from the inappropriate use of physical restraints in psychiatric treatment facilities across the United States. A 50-state survey conducted by the newspaper documented at least 142 deaths in the past decade connected to the use of physical restraints or to the practice of seclusion. The report also suggested that the actual number of deaths is many times higher because many incidents go unreported. According to a separate statistical estimate commissioned by *The Courant* and conducted by the Harvard Center for Risk Analysis, between 50 and 150 restraint- or seclusion-related deaths occur every year across the country.

As a result of *The Hartford Courant* series and NAMI's communications with its members, NAMI members have shared their horror stories of abuse and death. These are compiled in NAMI's report, *Cries of Anguish*. More than 60 personal stories of incidents from 24 States and the District of Columbia were reported as of August 2000.

## Understanding the Issue

Restraints are human or mechanical actions that restrict freedom of movement or normal access to one's body. Since the development of more effective psychotropic medications, emergency situations have become increasingly rare. In fact, some hospitals have moved to restraint-free policies.

In current practice, physical restraints are sometimes imposed on a patient involuntarily for **control of the environment** (curtailing individual behavior to avoid the necessity for adequate staffing or clinical interventions); **coercion** (forcing the patient to comply with the staff's wishes); or **punishment** (staff punishing or penalizing patients). NAMI rejects these as legitimate reasons to impose restraints.

## Federal Protections Enacted in 2000

In October 2000, President Clinton signed the Children's Health Act of 2000, P.L. 106-310. This significant new law established national standards that restrict the use of restraint and seclusion in all psychiatric facilities that receive Federal funds and in "non-medical community-based facilities for children and youth."

NAMI will be following the implementation of key provisions under the general requirements, which include:

Restraints and involuntary seclusion (R/S) may only be imposed to ensure the physical safety of a patient. They cannot be used as punishment or for staff convenience.

R/S may be imposed only under the written order of a physician or other licensed practitioner permitted to issue such orders under State law. Orders must specify the duration of and circumstances for the R/S.

Although no timeframe is specified for conducting face-to-face evaluations of patients who have been or will be restrained or placed in seclusion, the legislation declares that the lack of a specified timeframe should not be interpreted as offsetting or impeding any Federal or State regulations that provide greater protections for patients. This declaration then affirms hospital rules promulgated last year by the Health Care Financing Administration (HCFA), including the "one-hour rule" that requires face to-face evaluations by licensed professional practitioners within one hour of initiating R/S.

Facilities must report every death that occurs within 24 hours after a patient has been removed from R/S or where it is reasonable to assume that a death is the result of R/S. Reports must be made to agencies determined appropriate by the Department of Health and Human Services (HHS), which most likely will include State protection and advocacy agencies.

Within 12 months, HHS also must issue regulations specifying adequate numbers of staff for facilities and appropriate training for the use of R/S and its alternatives.

For children's non-medical community programs:

R/S may be used with children in community programs only in emergencies and to ensure immediate physical safety for the child or others. Mechanical restraints are prohibited. Seclusion is allowed only when a staff member continuously monitors a child face-to-face. Time outs, however, are not considered seclusion, and physical escorts are not considered physical restraints.

Only individuals trained and certified by a State-recognized body may impose R/S. Until a State certification process is in place, R/S can be used only when a supervisory or senior staff person with skills and competencies specifically listed in the legislation conducts a face-to-face assessment of the child within an hour after R/S is imposed. The use of R/S must then be monitored by the supervisory or senior staff person.

Required skills and competencies include an understanding of the needs and behaviors of the populations served, relationship-building, avoiding power struggles, de-escalation methods, alternatives to R/S, time limits, monitoring signs of physical distress, position asphyxia, obtaining medical assistance, and familiarity with relevant legal issues.

Within 6 months, States (which license such facilities) must develop licensing and monitoring rules and HHS will begin to develop national staffing standards and guidelines.

These R/S standards apply only to psychiatric treatment facilities that receive Federal funding. They do not affect use of restraint and seclusion in schools, wilderness camps, jails, or prisons. P.L. 106-310 also does not impede any Federal or State laws or regulations that provide greater protections than written in the Children's Health Act of 2000. Thus, rules issued by the Health Care Financing Administration in 1999 that included a requirement for face-to-face evaluations by mental health professionals within one hour of initiating restraint are affirmed.

### **NAMI's Advocacy Goals and Strategies**

NAMI strongly supports full implementation of the restraint and seclusion provisions included in P.L. 310-106.

NAMI will monitor the progress of the Department of Health and Human Services in issuing national guidelines and regulations specifying adequate number of staff in facilities and appropriate training in the use of R/S and their alternatives.

NAMI will also advocate for a national standard in schools, wilderness camps, jails, and prisons.

**What Should You Do If You Experience Restraint and Seclusion Abuse?**

If you or your family member has experienced abuse of R/S in a treatment facility, you should take the following action:

- Contact your State’s Protection and Advocacy program. For the phone number of your State’s program, call the National Association of Protection and Advocacy Systems (NAPAS) at 202-408-9514. If a P & A does not assist you, let NAMI know by contacting Kim Encarnation at 703-312-7895 or by E-mail at kim@nami.org.
- File a complaint with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) hotline at 1-800-994-6610 and/or complaint@jcaho.org
- File a complaint with your State’s health and hospital-licensing agency.
- File a complaint with your U.S. Health Care Financing Administration (HCFA) regional office. There are 10 regional offices in the United States. To find yours, call the HCFA Medicare Hotline at 1-800-638-6833. You can also call the HCFA Office of Medicare Customer Assistance, 410-786-7413.
- Share your story in writing and submit it to be included in NAMI’s *Cries of Anguish* report. Contact Kim Encarnation at 703-312-7895 or kim@nami.org
- Consider sharing your story with your local media.
- Consider retaining an attorney if you believe your legal rights have been violated.

## National Association of State Mental Health Program Directors (NASMHPD)

### **Position Statement on Seclusion and Restraint**

The members of the National Association of State Mental Health Program Directors (NASMHPD) believe that seclusion and restraint, including “chemical restraints,” are safety interventions of last resort and are not treatment interventions. Seclusion and restraint should never be used for the purposes of discipline, coercion, or staff convenience, or as a replacement for adequate levels of staff or active treatment.

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

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

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

- The dignity, privacy, and safety of individuals who are restrained or secluded should be preserved to the greatest extent possible at all times during the use of these interventions.
- Seclusion and restraint should be initiated only in those individual situations in which an emergency safety need is identified, and these interventions should be implemented only by competent, trained staff.

As part of the intake and ongoing assessment process, staff should assess whether or not an individual has a history of being sexually, physically, or emotionally abused or has experienced other trauma, including trauma related to seclusion and restraint or other prior psychiatric treatment. Staff should discuss with each individual strategies to reduce agitation which might lead to the use of seclusion and restraint. Discussion could include what kind of treatment or intervention would be most helpful and least traumatic for the individual.

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

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

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

**Approved by the NASMHPD membership on July 13, 1999.**

## The National Mental Health Association Position Paper

### **The Rights of Persons with Mental Illness**

#### **Purpose and Summary**

This statement expresses the convictions of the National Mental Health Association (NMHA) with regard to the rights of persons involved with the mental health system and/or who are recovering from mental illness (including children, adolescents, and their families). The NMHA is committed to promoting adherence by all treatment systems to the policies and principles set forth herein and to assisting our State and local affiliates in working with their State and local governments to do likewise. This pledge also includes adherence to the ADA, IDEA, the Rehabilitation Services Act, the Fair Housing Act, and other legislation that protects the rights of citizens, especially those recovering from mental illness. This statement consolidates prior policies that addressed rights issues.

#### **Background**

Equal justice under the law is a fundamental concept in American jurisprudence. Yet persons with mental illness are often denied equal justice in virtually every part of our country. Too often discriminatory practices proceed from the misconception that people who are in the mental health treatment system are incapable of exercising the rights of citizenship. In fact, the decision to institutionalize people or treat them against their will may be based upon the assumption that to resist treatment recommendations is evidence that one is incapable of making such a judgment. This completely ignores the principle that a person is competent unless legally proven otherwise. While major strides have been made, people with mental illness continue to be denied rights as citizens, dignity as human beings, and a life free from stigma.

The NMHA recognizes that myths and misinformation prohibit the full participation of individuals recovering from mental illness in their communities. For example, despite common misperceptions, persons with mental illness are not more violent than people without mental illness. NMHA has worked to educate the public, as well as legal and medical advisors, providers, educators, and the media about laws protecting rights and to provide information that counteracts stigmatizing attitudes, language, and behavior.

#### **Specific Rights**

The NMHA reaffirms its commitment to equal justice and protection of legal rights for all persons with mental illness, including children, adolescents, and their families. To carry out this principle, NMHA pledges itself to protecting the civil rights of persons who are recovering from mental illness. The following rights are specifically identified because they are most likely to be abridged:

## **Rights Regarding Benefits and Service Delivery**

- The right to receive timely, culturally appropriate, and complete information about rights upon enrollment in a health plan, upon entering the treatment system, and at any time upon request. This information must include benefits and services, as well as information about how to access available services, appeal a decision, lodge a complaint, and/or get help to navigate a service delivery system.
- The right to be fully informed of all beneficial treatment options covered and not covered, including related costs.
- The right to have advance directives about treatment preferences—and the right to have them honored.
- The right to insurance parity, including freedom from limits based on annual and lifetime expenditures, days or visits, co-payments, or diagnosis.
- The right to the least restrictive and least intrusive response to a need for mental health services.
- The right to sue the health plan for authorization denials that result in harm to the consumer.
- The right to expedited reviews and appeals from one's health plan when the situation is emergent or urgent.
- The right to access services in one's own community, including but not limited to crisis intervention, emergency, diversion, rehabilitation, outreach, housing, employment, and mobile services, including the right to seek care from a provider who does not participate in the health plan if the provider network is insufficient.
- The right to be fully involved in treatment, referral, and discharge plans as they are developed, implemented, and revised. Parents and guardians have the right to meaningful involvement in developing and implementing the treatment plan for their children who are still minors, as well as for their adult children if consent is given by the adult consumer.
- The right to be fully informed of treatment side effects and treatment alternatives in order to make informed decisions without coercion or the threat of discontinued services.
- The right to selectively refuse undesired treatment services without the loss of desired services.
- The right to receive services from providers who have appropriate language skills and linguistic support services.
- The right to be directed to treatment modalities that are culturally competent according to ethnicity, sexual orientation, religious beliefs, and disability.
- The right to access medically necessary and effective medications without being subjected to "fail first" policies, discriminatory or excessive co-payments, or time-consuming prior authorization paperwork.
- The right to receive appropriate, specialized, and individually tailored education as a component of treatment for youths.

- The right to receive treatment services in one's own community, with reasonable efforts to serve children and adolescents while they remain in their homes.
- The right to be transported to treatment facilities by medical personnel, rather than law enforcement agents.

### **Rights Related to Preservation of Liberty and Personal Autonomy**

- The right to receive treatment services in a setting and under conditions that are the most supportive of personal liberty, with restrictions of that liberty only as needed to preserve safety.
- The right to easy access to any available rights protection service and other qualified advocates, including federally funded protection and advocacy systems.
- The right to assert grievances and to have them addressed in a timely manner, as well as with an external reviewer upon request, with no negative repercussions.
- The right to the use of voluntary admission procedures wherever possible.
- The right to receive treatment and services only with informed consent, except as overridden by a court.
- The right to establish advance directives and living wills and to appoint surrogate decisionmakers (with durable power of attorney), specifying how one wishes to be treated in an emergency or if s/he is incapacitated, as permitted by law.
- The right to be free from any form of corporal punishment.
- The right to a humane treatment environment affording appropriate privacy and personal dignity and protection from harm.
- The right to converse with others privately, to have convenient access to the telephone and mail, and to see visitors during regularly scheduled hours in inpatient or residential facilities.

### **Rights Related to Competency**

- The right to be deemed competent to exercise all constitutional, statutory, and common law rights and privileges and to manage one's own affairs unless restricted or limited through appropriate due process procedures.
- The right to inexpensive, stigma-free guardianship procedures that are the least intrusive necessary to accomplish the provision of appropriate services and which include a delineation of the duties of the guardian.
- The right to have all restrictions explicitly enumerated in the court order and to have copies provided to the interested parties.
- The right to legal counsel for every threat of loss of a privilege or right.
- The right to easy access to a person's attorney or legal representative while under a commitment order.

- Where involuntary commitment to an inpatient facility is deemed necessary, the following rights should apply (at a minimum):
  - due process hearing, provision of counsel,
  - minimum burden of proof of “clear and convincing” evidence,
  - a jury trial (at their election),
  - presentation of witnesses and opportunity for cross examination,
  - clear standards for commitment based upon constitutional principles, and
  - commitment based on proof that:
    1. the person requires the confinement being sought by the petitioner,
    2. the place of confinement can provide the treatment being sought by the petitioner,
    3. there are no less restrictive but suitable alternatives to the placement being sought, and
    4. A specific overt act of dangerousness (including a stated threat).

### **Rights Related to Seclusion and Restraint**

- Seclusion and restraint should be used only after other less restrictive techniques have been tried and failed, and only in response to violent behavior that creates extreme threats to life and safety.
- Seclusion and restraint procedures should not be used on individuals with medical conditions that would render this dangerous.
- Facilities should have written procedures governing the use of seclusion, restraints, and restraining procedures. These procedures should require the documentation of alternative, less intrusive intervention approaches that were tried and the rationale why these failed or were not appropriate.
- Facilities should never use seclusion or restraint as punishment or for the convenience of staff.
- Use of restraints and seclusion should always be implemented by experienced and trained staff, overseen by senior medical staff, approved by a physician, and be well-documented and justified in a consumer's file.
- Seclusion and restraining procedures should be used only for the amount of time needed to restore safety and security of the consumer and others.
- People in seclusion and restraints should be monitored on a continuous basis.
- Facilities should be sufficiently staffed to reduce the need for physical and chemical restraints and the use of seclusion.
- All staff should be trained and demonstrate competence in non-physical intervention techniques and in safe use of restraining procedures.
- Facilities must be held accountable for all uses of seclusion and restraints, collect data, and report it to the appropriate State agency or regulatory bodies. Failure to produce appropriate data or adhere to clinical guidelines should result in sanctions.
  - Facilities should apply the use of advance directives, where they exist, that address the use of seclusion and restraint.

- Consumers should be informed that specific behaviors may result in the use of restraining procedures or seclusion. Cooperation of the consumer with the procedure should be sought.
- An individual's age, developmental needs, gender issues, ethnicity, and history of sexual or physical abuse should be taken into account when implementing seclusion and restraining procedures.

### **Rights Related to Privacy and Information Management**

- The right to access and supplement one's own mental health record.
- The right of parents or guardians to access their minor children's mental health records, except where such information is protected by law.
- The right to receive information about confidentiality protocols when consumers join a new health plan or begin treatment with a new clinician, as well as on request on an ongoing basis.
- The right to withdraw, narrow, or otherwise modify terms of consent for information to be released.
- Consumers have the right to be informed of:
  - the type(s) of information that will be disclosed (nature and extent);
  - who has the authority to disclose information;
  - to whom the information will be disclosed; and
  - for what purpose(s) the information is needed.

**Approved by the NMHA Board of Directors June 11th, 2000**

**Expires on December 31st, 2005**

Pennsylvania: Use of Restraints, Seclusion, and Exclusion  
in State Mental Hospitals and Restoration Center

**Mental Health and Substance  
Abuse Services Bulletin**

*Commonwealth of Pennsylvania \* Department of Public Welfare*

**DATE OF ISSUE**

June 1, 2001

**EFFECTIVE DATE**

July 1, 2001 NUMBER: SMH-01-02

**SUBJECT**

Use of Restraints, Seclusion and Exclusion in State Mental Hospitals and Restoration Center

**BY:**

Deputy Secretary for Mental Health and Substance Abuse Services

**SCOPE:**

State Mental Hospitals and Restoration Center

**PURPOSE:**

To update and synthesize statewide policies and procedures for the use and monitoring of Restraint, Seclusion and Exclusion in OMHSAS operated facilities.

**POLICY:**

State mental hospitals and South Mountain Restoration Center shall adopt and implement the attached procedures and practices relating to the use and monitoring of Seclusion/Restraint and Exclusion, and shall revise local policies and procedures, staff training requirements and monitoring practices accordingly.

**BACKGROUND:**

It is the Office of Mental Health Substance and Abuse Services' belief that Seclusion and Restraint are not treatment but reflect treatment failure. Since 1999, OMHSAS has become a recognized national leader in an emerging national movement to substantially reduce and ultimately eliminate these dangerous, emergency practices. The attached policies reflect the substantial reduction in OMHSAS's use of these modalities since the first standardized policy was released in 1999, and take further steps toward the goal of ultimate elimination of their use.

This Bulletin synthesizes OMHSAS policies relating to seclusion and restraint developed since 1999, establishes additional controls on the use of restraint as a so-called protective device, integrates recent changes in HFCA and JCAHO requirements and adds evidence based best practices regarding seclusion and restraint safety and reduction.

**OBSOLETE BULLETINS:**

OMHSAS 99-01 Use of Restraints, Seclusion and Exclusion in State Mental Hospitals;  
SMH-00-01 Use of Physical Restraint in State Mental Hospitals

**COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:**

The Medical Director's Office at 717-772-2351 or Bureau of Hospital Operations 705-8159

## **USE OF RESTRAINTS, SECLUSION, AND EXCLUSION IN STATE MENTAL HOSPITALS**

### **I. Philosophy of Care**

The use of restraints, seclusion, and exclusion in a treatment setting must be directed by the values of the organization providing treatment. In order to affirm why and how restraint/seclusion/exclusion procedures are used, it is necessary to establish organizational values that guide and direct all administrative oversight and team involvement in providing treatment, while maintaining the safety of each individual patient.

Each facility/treatment setting under the scope of this document establishes and adheres to the following value statements:

- \_\_\_ Restraint/seclusion/exclusion procedures may only be used as an intervention of last resort following a series of efforts by staff to promote less restrictive problem-solving by the patient and used only in emergency situations to prevent patients/residents from seriously harming themselves or others;
- \_\_\_ Use of a restraint/seclusion/exclusion procedure is viewed as an exceptional or extreme practice for any patient;
- \_\_\_ Once a restraint/seclusion/exclusion procedure is initiated, it shall be as limited in time as possible. Staff and the patients need to work together to lessen the incidence and duration of these procedures;
- \_\_\_ All clinical staff with a role in implementation of restraint/seclusion/exclusion procedures must be trained and demonstrate competency in their prevention and proper and safe usage;
- \_\_\_ Leaders of the hospital, leaders of clinical departments, and leaders of wards/units are held accountable at all times for the initiation, usage, and termination of restraint/seclusion/exclusion procedures. This accountability is demonstrated as a component of the hospital's Performance Improvement efforts and staff competency evaluations;
- \_\_\_ The patient and family, as appropriate, are recognized members of the treatment team; as appropriate, family members shall be notified of each seclusion and restraint incident and of the department's policy regarding seclusion/restraint use.

- \_\_\_ The Client Representative or Patient Advocate is recognized as a spokesperson for the patient and shall be involved in care and treatment, if the patient so desires (within the parameters of current law/regulation);
  - \_\_\_ The treatment plan shall address specific interventions to be used to avoid restraint/seclusion/exclusion procedures and shall address patient strengths and cultural issues;
  - \_\_\_ All decisions to initiate restraint/seclusion/exclusion procedures shall be based on assessment of the patient; assessments shall address history of sexual or physical abuse, violence history, and medical/psychiatric issues that may be pertinent to seclusion or restraint practices.
  - \_\_\_ Patient/staff involvement in a post-procedure debriefing and discussion is essential to determine how future situations may be prevented or de-escalated by employing alternative problem-solving measures;
  - \_\_\_ Patient dignity shall be maintained to the extent possible during these procedures;
  - \_\_\_ Restraint/seclusion/exclusion procedures shall not be initiated or maintained as a substitute for treatment, as punishment, or for the convenience of staff;
  - \_\_\_ Restraint and seclusion are emergency safety interventions, not therapeutic techniques, but shall be implemented in a manner designed to protect the patient's safety, dignity, and emotional well being.
  - \_\_\_ In administering restraints and seclusion, as well as in attempting to prevent its use and the necessity for subsequent/recurrent use, staff shall recognize and use the strengths of the patient, and remain sensitive to issues of cultural competence; and
  - \_\_\_ The commitment status of the patient requiring seclusion/restraint/exclusion shall be reviewed prior to initiating any of these procedures.
1. Patients who are involuntarily committed may be placed in seclusion, restraint, or exclusion if indicated, but only when less restrictive measures and techniques have proven ineffective.
  2. If a patient in voluntary treatment (Legal Section 201) requires seclusion, restraint, or exclusion, it is possible to utilize such measures if this has been agreed upon in the initial evaluation signed by the patient as part of the voluntary commitment procedure or via an advance directive. However, if the patient retracts or denies this agreement concerning

possible restrictions and restraints, and refuses their use, an involuntary commitment must be obtained as soon as possible under the criteria, standards, and procedures of Legal Section 302 or 304C if seclusion, restraint, or exclusion is ordered.

3. Residents of the State Restoration Center are not subject to the provision of seclusion, restraints, or exclusion. Should a resident require the use of one of these modalities for psychiatric reasons, commitment to a psychiatric treatment facility shall be initiated.

\_\_\_ The specific methods of implementing and monitoring these values are detailed in the following sections.

## **II. Family Notification**

On admission of the patient, the patient's family shall be informed of the hospital's policies/procedures regarding the use of seclusion, restraint, and exclusion. With the patient's informed consent, as documented in the medical record, designated family members shall be informed of their opportunity to be notified of each incident of seclusion/restraint within a time frame agreed to by the family and to participate in the patient debriefing, as appropriate.

## **III. Staff Training**

It is the Office of Mental Health and Substance Abuse's philosophy and policy that restrictive interventions may only be used as a last resort to protect patients and other persons from physical injury. Consequently, staff training shall focus upon the development of skills and abilities needed to assess risk, identify escalating behaviors, and effectively assist patients to maintain control and learn safer ways of dealing with stress, anger, fear, and frustration.

Training of staff shall focus upon identifying the earliest precipitant of aggression for patients with a known, suspected, or present history of aggressiveness, and on developing treatment strategies to prevent exacerbation or escalation of these behaviors. Patient involvement in the identification of precipitants is paramount.

Training shall encompass the primary importance of patient safety, at all times, during the seclusion or restraint process. This shall include the time preceding the placement of a patient into seclusion or restraint as well as the time spent in seclusion or restraint. Training shall be provided to all direct-care staff during employment orientation and on an annual basis.

Staff training in seclusion and restraint techniques and policies shall result in initial certification/demonstration of competency for each staff person who will be authorized to employ them. Retraining, re-certification, and demonstration of competency in the use of physical restraint shall occur annually.

Training in safe physical intervention techniques shall be provided only by approval/certified instructors using methodologies approved by OMHSAS.

Specific training components shall include:

1. hospital and OMHSAS policies and procedures relating to the use of, Documentation, and monitoring of seclusion and restraint;
2. assessment skills needed to identify those persons who are at risk of violence to self or others;
3. treatment interventions that will reduce the risk of violence and increase the patient's capacity to benefit from psychosocial rehabilitation and educational programs;
4. skills in developing patient education programs that will assist patients in learning more adaptive ways of handling the stress, frustration, or anger that precipitates aggressive behavior;
5. treatment planning skills that will enable staff to better plan and coordinate treatment activities that will reduce the incidence of assaultive behaviors;
6. conflict resolution, mediation, therapeutic communication, de-escalation, and verbal violence prevention skills that will assist staff to diffuse and safely resolve emerging crisis situations;
7. the nature and identification of the possible negative psychological effects these measures may have upon some individuals, and positive therapeutic strategies to combat such effects;
8. medical precipitants to aggressive behavior;
9. understanding of how age, gender, cultural background, history of abuse or Trauma, and other personal experiences may affect a patient's response to physical contact, holds, mechanical restraints, seclusion, or exclusion.
10. use of verbal de-escalation and crisis management techniques;
11. identification and use of less restrictive alternatives;
12. first aid and CPR;
13. use of safe physical intervention techniques and restraint techniques and devices;
14. use of alternative adaptive support or assistive devices and care strategies in lieu of protective restraints for body positioning and falls prevention;

15. recognition and management of signs of patient physical and psychological distress during seclusion and restraint, and appropriate follow-up;
16. recognition of the behavioral and psychological indicators that restraint/seclusion may be safely terminated;
17. participation in debriefings; and,
18. expectations for documentation in the patient's medical record, the SI-815, and other PI data collection systems.

#### **IV. Patient and Staff Debriefing**

After each incident of seclusion, restraint or exclusion, a mental health professional and members of the treatment team shall meet with the patient for the purpose of:

1. assisting the patient to develop an understanding of the precipitants which may have evoked the behaviors necessitating the use of the restrictive technique;
2. assisting the patient to develop appropriate coping mechanisms or alternate behaviors that could be effectively utilized should similar situations/emotions/thoughts present themselves again;
3. developing and documenting a specific plan of interventions for inclusion in the Comprehensive Individualized Treatment Plan, with the intent to avert future need for restrictive techniques; and,
4. evaluating whether alternate staff responses and interventions could be more effectively used in the future.

The team member shall document the debriefing process in the patient's medical record. Findings from the staff debriefing and proposed administrative changes or strategies to prevent recurrence shall also be documented on the SI-815 incident report to facilitate hospital internal review.

The debriefing processes shall be initiated within 24 hours of the end of each incident of seclusion, restraint, or exclusion, unless further delay is clinically indicated.

#### **V. CONTINUOUS PERFORMANCE IMPROVEMENT MONITORING**

The leadership staff of each State mental hospital shall maintain a performance improvement program designed to continuously review, monitor, and analyze the use of seclusion, restraint, and exclusion and issues related to these processes. Ongoing efforts to reduce utilization of these measures shall be employed.

The facility Chief Executive Officer and Assistant Superintendent for Clinical Services of each State mental hospital are responsible for assuring that ongoing documentation and monitoring of patients placed in seclusion, restraint, or exclusion are maintained.

Monitoring shall consist of reviewing the necessity for use or continuation of these measures based upon documentation of unsuccessful, less restrictive alternatives, and appropriate rationale and justification. Patient “debriefing,” health teaching, clinical response to seclusion, treatment plan revisions, and incidents where the physician involved does not see the patient within thirty (30) minutes of the initiation of seclusion shall also be monitored.

Seclusion or restraint incidents in excess of 12 continuous hours, or more than one seclusion/restraint incident within 12 hours, shall be reported to the ASCS or his/her designee. Thereafter, the leadership is notified every 24 hours if either of the above circumstances continues.

Events triggering notification of the ASCS noted in “c” above shall prompt ASCS review of the patient record, and consultation with the patient’s psychiatrist and other treatment team members regarding alternatives to seclusion and restraint. All incidents of seclusion, exclusion, and restraint, regardless of type, shall be documented on the State’s Risk Management Incident Reporting form (SI-815).

## **VI. Seclusion**

### **A. Definition**

A brief, time-limited placement of a patient into a safe, well ventilated, furniture free, visually observable locked room for the purpose of assisting the individual to regain emotional and physical control over his/her dangerous, destructive behaviors.

**NOTE:** Seclusion is not a modality utilized in the State Restoration Center.

### **B. Indications**

Prior to the use of seclusion, the following criteria must be met:

1. All less restrictive options/interventions, including changes in pharmacological interventions, have been considered and attempted and have failed to diminish the patient’s immediate danger to self and/or others. Documentation of all such efforts shall be entered into the patient’s medical record, in addition to rationale and justification of the need for seclusion;
2. Unless clinically contraindicated, prior to the use of seclusion the patient shall be given a choice of treatment options that may assist with limiting the environmental stimuli and their consequent effects on the patient’s emotional status. The reason/justification for seclusion shall be communicated clearly to the patient. Treatment expectations and the outcomes which should occur within brief, time-limited intervals shall be carefully explained.

### **C. Contraindications**

Seclusion shall not be used for patients who exhibit suicidal or self-injurious behaviors or who have any known medical condition which precludes the safe application of this modality (such situations shall be determined by the attending/on-call physician on a case-by-case basis).

### **D. Procedures**

1. Each patient shall be made aware of the specific behaviors that necessitated the use of seclusion and those behaviors and mental status components which will terminate seclusion;
2. Individual treatment plans shall have goals and interventions established to change the behaviors precipitating the need for seclusion;
3. Seclusion shall be used only with a physician's order. In emergency situations, a registered nurse may initiate the use of seclusion for the protection of the patient and/or others. The physician on duty/on-call shall be contacted immediately, and a verbal order may be obtained. The physician's order shall not exceed one (1) hour. Orders shall specify "up to" one (1) hour, rather than a predetermined amount of time. The physician involved shall see the patient within thirty (30) minutes of the initiation of seclusion (barring extenuating circumstances), and then shall write/countersign the order for the seclusion and document his/her assessment of the patient in the medical record. Specific behavioral criteria written by the physician shall specify when the seclusion may be discontinued, to insure minimum usage. When a physician's order has expired, the patient must be seen by a physician and his/her assessment of the patient documented before seclusion can be reordered;
4. Patients in seclusion shall be continuously monitored, face to face, through the seclusion room window or in the room itself.
5. Patients are to be removed immediately from the seclusion room once the danger to self or others is no longer imminent;
6. During the seclusion process, each patient's dignity and need for physical care shall be carefully monitored and addressed. Each patient's safety is of paramount concern and, as such, potentially dangerous clothing and objects shall be removed from the patient and the seclusion area. This, however, does not prohibit the use of appropriate non-dangerous attire or such things as may be therapeutically indicated (i.e., soft inanimate objects, magazines, etc.);

7. Patient physical needs shall be met promptly. Opportunity for personal care, including fluids, bathroom use, exercise, meals, and hygiene, shall be provided, and the patient's physical condition assessed and documented at no less than 15-minute intervals during the seclusion incident.

## **VII. Restraint**

### **A. Restraint for Emergency Behavior Control**

#### *1. DEFINITION*

The use of manual holds or mechanical devices used to restrict movement of all or part of a patient's body in emergency situations in which the patient's violent behavior presents an immediate risk of physical harm to self or others, and less restrictive interventions have failed.

#### *2. EXPECTATIONS*

- a. All members of the treatment planning team shall be involved in preventing and reducing the need for restraints by resolving the underlying problem which necessitates restraint.
- b. Prior to the use of physical or mechanical restraint for aggressive behavior which presents an immediate danger to self and/or others, the patient (unless clinically contraindicated) will be given a choice of treatment options to enable him/her to regain self-control over the injurious behavior. The reason for restraint shall be communicated clearly to the patient. Behavioral expectations shall be clearly explained as conditions for release from restraint. Restraint shall never be used as substitute for treatment, as punishment, or for convenience of staff.
- c. Only restraint devices and techniques approved by OMHSAS may be used according to manufacturer's instructions and for the purpose intended. See Attachment #A.
- d. Staff shall demonstrate competence in recognizing signs of escalating behavior that could potentially lead to physically aggressive behavior, by intervening in a therapeutic manner to prevent escalation, and to assisting persons to learn alternative ways of dealing with stress and/or anger.
- e. The patient's Comprehensive Individualized Treatment Plan shall describe the therapeutic interventions to be used by staff when a patient's behavior is starting to escalate.
- f. Behaviors necessitating the use of restraints must be addressed on the patient's treatment plan. The overall goal is to eliminate the use of restrictive interventions. In doing so, it is essential that the patient's treatment plan clearly describe the dangerous behaviors necessitating treatment, identify the antecedents or causes of such behavior and prescribe

coordinated and integrated treatment approaches that reduce or eliminate the dangerous behaviors. The treatment plan should also include treatment goals for the patient that will provide positive alternatives to behavior that is physically harmful to self or others.

- g. Individual treatment plans shall have goals and interventions written to eliminate the need for restraints. Plans shall also include behavioral indicators of impending violent behavior and positive, constructive crisis interventions.

### *3. PROCEDURES FOR THE USE OF MECHANICAL RESTRAINT DEVICES*

- a. Restraints are prescription devices and shall be used only with a physician's order. In emergency situations, a registered nurse may initiate the use of restraints for the protection of the patient and/or others. The physician on duty/on-call shall be contacted immediately and a verbal order may be obtained. The physician's order shall not exceed one (1) hour.

Orders shall specify "up to" one (1) hour, rather than a predetermined amount of time. The physician involved shall see the patient within thirty (30) minutes of the initiation of the restraints (barring extenuating circumstances), and then shall write/countersign the order for the restraints and document his/her assessment of the patient in the medical record.

Specific behavioral criteria written by the physician shall specify under what conditions the restraints may be discontinued, to insure minimum usage. When a physician's order has expired, the patient must be seen by a physician and his/her assessment of the patient documented before restraints can be reordered;

- b. Patients in mechanical restraint devices shall be placed on constant 1:1 observation (at arm's length), and this action is to be documented by attending staff;
- c. Physical needs shall be met promptly. The patient's physical condition shall be assessed, and the opportunity for personal care, including fluids, bathroom use, exercise, meals and hygiene, shall be provided and documented throughout each restraint incident at no less than 15-minute intervals.

### *4. PROCEDURES GOVERNING THE USE OF PHYSICAL RESTRAINT/HUMAN HOLDS*

- a. Physical Restraint(PR) will only be used in situations where the person's behavior presents a clear threat of harm to self or others and it is necessary to use approved physical restraint techniques to prevent injury to self or others; this includes restraint necessary to apprehend an involuntary patient attempting to go AWOL. Staff shall always attempt to assist the person to regain control without the use of physical restraint or any other restrictive intervention.

- b. PR may only be used as long as absolutely necessary to protect the patient from injuring self or others. However, use of PR shall not exceed 10 minutes. If the patient has not gained control within this time period, the patient shall be transitioned to seclusion or mechanical restraint.
- c. The deliberate use of floor restraint techniques shall be avoided whenever possible. However, if floor techniques are used either inadvertently or by necessity, a minimum of two staff shall be involved in the restraint application, with a third staff person observing the patient for duress throughout the use of floor restraint. If insufficient staff are available to meet this condition, staff shall attempt to disengage from the floor hold, and wait for the patient to rise before reapplying restraint, if physical restraint continues to be needed.
- d. Use of physical restraint requires a physician's order. Physician's orders for physical restraint shall not exceed 10 minutes. The physician shall conduct a face to face evaluation of the patient within 30 minutes of initiation.
- e. Whenever physical restraint is used on a living area, or any area under the supervision of nursing staff, the Registered Nurse in charge of the patient's living area shall ensure that a Registered Nurse assesses the patient's mental and physical status within 10 minutes of PR initiation, the physician is notified, and a physician's order obtained.
- f. If the incident necessitating PR occurs on grounds, in an area not under the direct supervision of nursing staff, the following procedures are to be followed:

It is the responsibility of the supervisor of the staff who utilized PR to ensure that: the nursing supervisor responsible for the patient's ward is immediately notified and provided with the following information:

- a description of what happened and why it was necessary to employ PR;
- any injuries to the patient or staff involved;
- the current physical and behavioral status of the patient;
- the immediate need for additional staff assistance, if indicated.
- The incident is properly documented and the SI-815 is initiated by the person applying or observing the application of the restraint;
- The patient is safely returned to the ward, as soon as possible after the incident;
- Debriefing is provided to all staff involved in the incident.

It is the Nursing Supervisor's responsibility to ensure that:

- a Registered Nurse notifies the physician and obtains a verbal order,
- a Registered Nurse is promptly dispatched to the site of the restraint to assess and monitor the patient and determine next steps, and,

- additional staff are sent to the site to ensure staff and patient safety and to assist in the patient's safe return to the ward, if necessary.
  - Physical restraint use may continue only so long as is needed to return the patient to his living area.
- g. If an incident requiring the use of physical restraint occurs off grounds, and a Registered Nurse is unavailable, the person applying or observing application of the restraint shall:
- attempt to ensure the safety of the patient, staff, and the public in a manner affording the patient the most privacy and dignity possible;
  - contact the hospital nursing department for assistance and direction, following local policy and procedure, as soon as it is safe to do so;
  - provide the hospital contact person with the following information:
    - a description of what happened and why it was necessary to employ PR;
    - any injuries to the patient or staff involved;
    - the current physical and behavioral status of the patient;
    - the immediate need for additional staff assistance, if indicated.
- The Nursing Supervisor shall:
- designate a nurse assigned to the patient's ward to assess the emotional and physical status of the patient immediately upon return to the hospital, and
  - ensure that the attending psychiatrist or on-site physician is notified and a physician's verbal order for use of the restraint is obtained.
- h. A physician's order for any use of physical restraint must be obtained and the physician shall examine the patient within 30 minutes. If the incident occurs off grounds, the Registered Nurse shall notify the physician promptly when the patient is returned to the hospital and the physician examination shall occur within 30 minutes of the patient's return.
- i. Physical restraint shall only be used by staff with demonstrated competency in its use.
- j. Physical restraint used in an off grounds emergency may be used only so long as necessary to return the patient to his hospital living area.
- k. It is recognized that there may be emergency situations that require an individual to act quickly to prevent harm to the patient or others. Individual staff members should refrain from attempting to use physical management techniques alone unless absolutely essential. The following guidelines should be followed in a psychiatric emergency that involves violent behavior or the potential for violent behavior:
- Attempt to establish rapport with the patient. Speak to the person in a calm manner.
  - Acknowledge the patient's emotions and offer to help.
  - At the first sign of escalating behavior, staff shall immediately summon help

- If other patients or visitors could be placed in danger due to the escalating behavior, remove them from the area as soon as possible.
- Keep other patients from entering to the area.
- Unless absolutely necessary to protect the patient, self or others, do not attempt to employ PR techniques alone. Wait for help to arrive.

If physical restraints are essential, only approved interventions in which the employee has demonstrated competency, may be employed.

Before and during use of any physical restraint technique, staff applying or observing the technique shall explain to the patient what is happening, why the restraint is being used, and what the patient must do to obtain release.

l. Documentation requirements:

At least one staff person directly involved in the administration or observation of the physical restraint episode must document the incident in the patient's medical record;

The RN who assessed the patient must also record the findings of the assessment, along with any follow-up actions recommended. The physician order and assessment shall all be documented in the medical record, as well as any ordered or recommended treatment changes.

m. Documentation shall provide at least the following information:

- when and where the incident occurred;
- a clear description of the behaviors that necessitated use of PR;
- a description of prior interventions tried and patient response;
- a description of the PR techniques used and their duration;
- a description of the patient's physical and emotional response during and subsequent to the restraint episode;
- a description of how the patient's physical and emotional response was monitored during the incident;
- a description of any injuries observed or suspected by staff, or reported by the patient;
- the time and location of the nursing assessment;
- the name of the physician notified , time of notification, name/title of employee notified, and any instructions or orders received from the physician upon notification;
- the time of physician examination and physician findings and orders.

## **B. Protective Restraint**

### *1. DEFINITION*

The use of restraint devices to restrict the movement of a person with a medical condition to prevent falls, achieve maximum body functioning, or promote normal body positioning, when the patient is unable to remove the restraining device without assistance.

### *2. INDICATIONS*

Protective restraint involving the use of Geri chairs, chairs with trays, bed rails, straps or cloth devices used to position the patient, restrict freedom of movement or access to one's body, prevent falls, maintain posture and for other medical purposes shall only be used as a last resort, when:

- a. adaptive or assistive devices or environmental changes have failed to prevent patient injury,
- b. assessment of the patient's history and condition indicates the strong probability that substantial harm to the patient will occur in absence of temporary restraint;
- c. the risks of potential injury exceeds the known risks of injury and death associated with use of protective restraint.

### *3. EXPECTATIONS*

- a. As with restraint used for behavioral control in emergency situations, it is the goal of the OMHSAS to ultimately eliminate the use of protective restraint.
- b. Use of alternative interventions shall be added to the treatment plan to reduce the need for protective restraint. Such alternatives include physical therapy, ambulatory assertive devices, recliner chairs, alarms, perimeter beds, non-slip cushions or shoes, beds with shortened legs and safety belts removable by the patient.
- c. Use of protective restraint requires the written time limited order of the physician.
- d. The patient in protective restraint must be continually monitored and reassessed and the restraint removed as soon as the alternative measures for safety are feasible.

### *4. PROCEDURES FOR THE USE OF PROTECTIVE RESTRAINT*

- a. Restraints are prescription devices and shall be used only with a physician's order. In emergency situations, a registered nurse may initiate the use of restraints for the protection of the patient and/or others. The physician on duty/on-call shall be contacted immediately and a verbal order may be obtained. The physician's order shall not exceed one (1) hour. Orders shall specify "up to" one (1) hour, rather than a predetermined amount of time. The

physician involved shall see the patient within thirty (30) minutes of the initiation of the restraints (barring extenuating circumstances), and then shall write/countersign the order for the restraints and document his/her assessment of the patient in the medical record. Specific behavioral criteria written by the physician shall specify under what conditions the restraints may be discontinued, to insure minimum usage. When a physician's order has expired, the patient must be seen by a physician and his/her assessment of the patient documented before restraints can be ordered;

- b. Patients in restraint devices shall be placed on constant 1:1 observation (at arm's length), and this action is to be documented by attending staff;
- c. Physical needs shall be met promptly. The patient's physical condition shall be assessed, and the opportunity for personal care, including fluids, bathroom use, exercise, meals and hygiene, shall be provided and documented throughout each restraint incident at no less than 15 minute intervals.

*5. PROTECTIVE RESTRAINT DOES NOT INCLUDE:*

- a. use of adaptive, assistive, or positioning devices that can be moved or removed by the patient;
- b. helmets used to prevent head injury;
- c. wheelchairs, Geri chairs or trays, safety belts, postural supports, orthopedic devices, or bed rails, if the patient can remove these devices, and,
- d. alarmed chairs, beds, or doorways.
- e. Family notification, patient/staff debriefing, continuous quality improvement and staff training requirements contained in sections II through V of this bulletin shall also be applicable to the use of protective restraint.

**C. Restraint for the Purpose of Administering Necessary Medication or Medical Treatment**

*1. INDICATIONS*

Physical or mechanical restraints may be applied briefly to enable clinical staff to administer necessary medication or medical treatment consistent with established protocol in the following situations:

- a. To facilitate necessary medical treatment of a resisting or uncooperative patient who is adjudicated to be incompetent to make informed decisions about medical care, when a substitute decision-maker has given permission for the necessary treatment, under the provisions of Mental Health Bulletin 99-83-26;

- b. To permit administration of prescribed psychoactive medication or facilitate veni-puncture for laboratory studies required by the use of psychoactive medication to a physically resisting patient, in accord with Mental Health Bulletin 99-85-10.

## 2. EXPECTATIONS

- a. Every effort to gain patient cooperation for essential medical procedures has occurred but failed.
- b. The restraint will be used only so long as is necessary to successfully complete the procedure.
- c. A time-limited physician's order for the restraint procedure is obtained reflecting the anticipated length of the procedure. PRN's and standing orders may not be used.
- d. The treatment plan shall be modified to address the patient's need for restraint.
- e. Provisions for patient debriefing, staff training, and continuous quality improvement contained in this bulletin are met.
- f. Procedures for mechanical or physical restraint use described in this bulletin are followed, depending on the type of restraint used. (Section VII, A3 or Section VII 4d).

### **D. Contraindications and Conditions for Use of Physical Holds and Mechanical Restraints**

- 1. Physical restraint may not be used on persons who have known medical or physical conditions where there is reason to believe that such use would endanger their lives or exacerbate a medical condition, e.g. fractures, back injury, pregnancy, etc. See Attachment B.
- 2. Choice of mechanical restraint devices and positioning of the body within shall be designated by a physician based on assessment of the patient's physical and psychiatric condition. See Attachment B.

### **E. Human Holds or Mechanical Devices Used to Restrict Movement of All or Part of The Patient's Body Do Not Constitute Restraint Under the Following Circumstances:**

- 1. Physical prompting, escorting or guiding of a person to assist in development or use of ADL's;
- 2. Physically holding a cooperative person in a manner that is necessary to administer needed medical, dental or nursing care;

3. Physically redirecting a nonresistant person to avoid a physical confrontation with another person;
4. Locked areas or wards for security or safety purposes;
5. Use of mechanical restraints for security purposes on forensic patients subject to criminal detention, outside of the forensic center's secure perimeter or in security emergencies, as required by law and Bulletin SMH 97-04.

## **F. Chemical Restraint**

### *1. DEFINITION*

Chemical restraint shall mean the use of drugs or chemicals for the specific and exclusive purpose of controlling aggressive patient behavior, which restricts the patient's freedom of movement by rendering the patient semi-stuporous or unable to attend to personal needs. Drugs administered on a regular basis, as part of the individualized treatment plan, and for the purpose of treating the symptoms of mental, emotional, or behavioral disorders, and for assisting the patient in gaining progressive self-control over his/her impulses, are not considered chemical restraints.

### *2. POLICY*

It shall be the policy of the Department of Public Welfare and the Office of Mental Health and Substance Abuse Services that chemical restraints are not utilized at any State mental hospital or the Restoration Center.

### *3. CONTINUOUS PERFORMANCE IMPROVEMENT MONITORING*

The Chief Executive Officer of each State mental hospital and the Restoration Center, in conjunction with the Medical Staff, is responsible for assuring that ongoing drug utilization monitoring of patients/residents is maintained to ensure that chemical restraints are not prescribed. Leadership staff (including Nursing, Pharmacy, and Quality Improvement) and the facility Pharmacy and Therapeutics Committee shall maintain compliance with the provisions of this policy through the institution of performance improvement programs designed to continuously review, monitor, and analyze drug utilization.

## **VIII. Exclusion**

### **A. Definition**

The therapeutic removal of a patient from his/her immediate environment and the restriction of this individual to an unlocked (quiet) room for a brief, time-limited period not to exceed 30 minutes, for the purpose of assisting the individual to regain emotional control. Exclusion involves the patient's cooperation in leaving the immediate environment and in remaining in

another, specified area (e.g., unlocked seclusion room) with the door open and unlocked for a specified period of time. Each facility shall designate rooms/areas to be utilized for exclusion.

**B. The Following Events Are Not Considered Exclusion:**

1. A patient's request to spend time in a private, unlocked room is not considered exclusion and should be granted where feasible and not clinically or therapeutically contraindicated;
2. Quarantine or other preventive health measures are not considered exclusion; and Exclusion is not a modality utilized in the State Restoration Center.

**C. Indications**

Prior to the use of exclusion, the following criteria must be met:

1. All lesser restrictive treatment options/interventions, including the use of alternative pharmaceutical interventions have been considered and attempted and have failed to diminish the patient's escalating behavior. Documentation of all such efforts shall be entered into the patient's medical record as well as the necessary rationale and justification of the exclusion need;
2. Unless clinically contraindicated, prior to the use of exclusion the patient shall be given a choice of treatment options that may assist with limiting the environmental stimuli and their consequent effects on the patient's emotional status. The reason/justification for exclusion shall be communicated clearly to the patient. Treatment expectations shall be carefully explained, including the outcomes which should occur within brief, time-limited intervals; and
3. Exclusion is an adjunct to treatment with defined clinical parameters of expected care and, therefore, shall never be used in a punitive or otherwise non-therapeutic manner.

**D. Contraindications**

Exclusion shall not be utilized for patients who exhibit suicidal or self-injurious behaviors for who have a known seizure disorder or any other medical condition, which precludes the safe application of this modality (such situations shall be determined by the attending/on-call physician on a case-by-case basis).

**E. Procedures**

1. Each patient shall be made aware of the specific behaviors that necessitated the use of exclusion and those behaviors and mental status components which will terminate the exclusion;
2. Individual treatment plans shall have goals and interventions established to eliminate the need for exclusion;

3. Exclusion shall be used only with a physician's order. In emergency situations, a registered nurse may initiate the use of exclusion. Immediately the physician on duty/on-call shall be contacted and a verbal order may be obtained. The physician's order shall not exceed 30 minutes. Orders shall specify "up to" thirty (30) minutes, rather than a predetermined amount of time. The physician involved shall see the patient within thirty (30) minutes of the initiation of exclusion (barring extenuating circumstances) and then shall write/countersign the order for the exclusion, and document his/her assessment of the patient in the medical record. Specific behavioral criteria written by the physician shall specify when the exclusion may be discontinued, to insure minimum usage. When a physician's order has expired, the patient must be seen by a physician and his/her assessment of the patient documented before exclusion can be reordered;
4. Patients in exclusion shall be monitored/checked at routine intervals not to exceed fifteen (15) minutes;
5. Exclusion shall not affect the rights of an individual to basic sustenance, clothing, or communication with appropriate or responsible persons (i.e., family, attorneys, physicians, patient advocates, or clergy); however, any person wishing to visit the patient in exclusion must gain authorization from the attending/on-call physician;
6. Patient physical needs shall be met promptly. Opportunity for personal care, including fluids, bathroom use.

**Commonwealth of Pennsylvania**  
**Department of Public Welfare**  
**Office of Mental Health and Substance Abuse Services**

February 3, 1999

**SUBJECT:** Guidelines for the use of physical management and mechanical restraint techniques

**TO:** CEOs, State Mental Health Facilities and Assistant Superintendents for Clinical Services  
**FROM:** Steven Karp, D.O., Medical Director

In recent months national attention has been directed toward the techniques used to restrain and physically contain persons hospitalized for psychiatric treatment, living in residential treatment settings, residing in nursing homes and even those who are incarcerated, during crisis in which their behavior poses a danger of harm to self or others. Following press reports of the death of persons subject to physical or mechanical

restraint, the National Alliance for the Mentally Ill called upon the federal government to investigate and provide oversight into patient deaths in restraint. Pennsylvania Protection and Advocacy has requested we officially ban restraint practices which may have adverse medical consequences, and JCAHO had published a summary and analysis of sentinel event restraint death root causes, with recommendations for safer practice.

We have subsequently affirmed that each hospital's use of physical and mechanical restraint application techniques is based on a variety of private sector training and certification programs. These programs usually include verbal and nonverbal crisis de-escalation techniques, self-defense and physical containment strategies to promote safe physical management of the patient. Training in these certified programs is required at the time of employment, usually for all staff in patient contact assignments, and annually for all direct care staff engaged in actual physical management of patients (i.e. nursing).

Internal hospital policies were subsequently developed to require use of the techniques taught in these programs.

Safe physical management technique training was originally mandated for all direct care staff in State mental hospitals over 15 years ago, using a copyrighted training program provided by OMH through a private vendor. During subsequent years, some hospitals have updated the curricula, or contracted with new vendors for this service. Consequently, the systems in place across the State are no longer consistent. Although none of these systems

appears to teach techniques that are now known to increase risk of harm during the physical management or restraint of patients, they may not explicitly prohibit the methods and techniques that are more likely to incur a risk to patient safety nor describe the reasons for such risk.

The purpose of this memorandum is to apprise all Superintendents and Assistance Superintendents for Clinical Services of the following risk factors and guidelines for the prevention of restraint deaths. They shall ensure that hospital policy and direct care staff training reflect these guidelines.

#### **A. Factors Contributing to Risk of Asphyxia During Physical Management and Restraint**

\_\_\_ Cocaine induced excited delirium (impaired thinking, disorientation, visual hallucinations, etc.) may increase the heart rate to a critical level when the patient is being restrained or is confined to restraints.

\_\_\_ Drug or alcohol intoxication reduce respiratory drive, diminishing the individual's realization that suffocation is occurring.

\_\_\_ The patient who engages in extreme violent activity and struggles may be more vulnerable to subsequent respiratory failure during physical intervention and restraint.

\_\_\_ Sudden unresponsiveness or limpness during or immediately after a struggle may indicate cardiopulmonary events that warrant immediate medical attention.

\_\_\_ Preexisting risk factors combined with body position can compound the risk of sudden death, particularly following a struggle. These risk factors include:

\_\_\_ Obesity

\_\_\_ Alcohol and drug use

\_\_\_ An enlarged heart (stress and low blood oxygen enhance the susceptibility to cardiac arrest)

\_\_\_ Smoking

\_\_\_ Deformities that preclude proper restraint positioning

\_\_\_ Emphysema, bronchitis, asthma, colds, and other respiratory conditions enhance risk, especially if the patient is placed face down.

### **B. Procedural Factors That Increase Risk During the Restraint Process**

- \_\_\_ All of the above preexisting risk factors are exacerbated when the patient is placed in a face down position and/or when “hands are held behind the back” holds or restraints are employed.
  
- \_\_\_ When the patient is held or restrained in a face down (prone) position, lungs are compressed and breathing may become labored. The more pressure that is applied to the person’s torso, the more compression is increased.
  
- \_\_\_ Restraint in a supine (face up) position may predispose the patient to aspiration.
  
- \_\_\_ Inadequate numbers of staff to safely manage mechanical restraint application may increase the likelihood that staff will place their body weight across the patient’s back, or use other unsafe practices which enhance the danger of patient injury.
  
- \_\_\_ Failure to search the patient for contraband when placed in mechanical restraints can result in fire from attempted use smoking materials, or other self-harm.
  
- \_\_\_ Placing a pillow, blanket, or other item under or over the patient’s face as part of a restraint or holding process, especially when the patient is in a prone position, may result in suffocation.
  
- \_\_\_ Use of high neck vests are blamed for strangulation deaths in geriatric patients, as are use of unprotected split side bed rails.
  
- \_\_\_ Incorrect application of a mechanical restraint device enhances strangulation potential.
  
- \_\_\_ Techniques which pull the patient’s or employee’s arms across the neck contribute to risk of asphyxiation.
  
- \_\_\_ Leaving a patient in mechanical restraints without continuous staff observation precluded timely corrective action in response to physical distress.

### **C. Guidelines for Safe Physical Management and Restraint**

Effective immediately, the following practices shall be adopted and incorporated into staff training curricula:

1. No fewer than 3 staff persons shall be present to apply mechanical restraints. If insufficient staff are available to safely control and restrain a patient in a psychiatric crisis, staff should remove others from harm’s way and get help before attempting physical management or restraint.

2. At no time is pressure to be placed upon the patient's back while the patient is in the prone position in a floor control situation. Patient arms, shoulders, and legs are to be immobilized. Staff body weight is not to be applied to the torso or above the upper thighs.
3. Patients in restraints must be placed under a physician's order for constant staff observation for the duration of the restraint.
4. Patients placed in seclusion or restraint must always be promptly searched for contraband.
5. High neck vests or waist restraints are not to be used for body positioning in geriatric or long term care settings, nor is any patient to be restrained to a bed with unprotected split side rails.
6. Never place a towel, bag, blanket, or other cover over a patient's face during the physical management process.
7. If a patient is placed under floor control in a prone position for the purpose of administering an injection or application of mechanical restraint, the patient shall be rolled/turned to the supine (face up) position as soon as the procedure is completed, unless the risk or act of vomiting is present.
8. When restraining patients in a supine position, ensure that the head is free to rotate. The head of the bed should be elevated to minimize the risk of aspiration, unless clinically contraindicated.
9. Physicians writing initial and renewed orders for restraint shall assess, consider, and document the patient's preexisting physical condition when ordering the body position, number and manner of mechanical restraints.

Deviation from the above guidelines for clinical reasons in individual cases must be documented and approved by the Assistant Superintendent for Clinical Services.

In the coming months, I will be reviewing available physical management technologies and training programs with the Assistant Superintendent for Clinical Services and the Statewide Risk Management Committee to select a statewide training curriculum. Until then, please be sure that your staff are made aware of the aforementioned risk factors and policy guidelines.

cc: Mr. Curie  
Mr. Kopchick  
Ms. Hardenstine

**Commonwealth of Pennsylvania**  
**Department of Public Welfare**  
**Office of Mental Health and Substance Abuse Services**

May 15, 2000

**SUBJECT:** Mechanical Restraint Devices

**TO:** CEOs, State Mental Health Facilities

**FROM:** Steven Karp, D.O, Medical Director, OMHSAS, and George A. Kopchick, Jr.,  
Director, Bureau of Hospital Operations

The purpose of this memorandum is to revise OMHSAS 99-01, specifically the section entitled Restraints: Treatment Expectations, Section B, located on p.8 of that Bulletin, which describes the mechanical restraint devices which are acceptable for use for psychiatric purposes in the State mental hospital system.

This memorandum is also intended to delete obsolete devices currently listed in the ERPS Manual, Appendix B.

Effective immediately, restraint devices which can be legitimately used for psychiatric purposes are limited to those found in the following list. The two-letter code adjacent to the device is the ERPS code for the device, which will be incorporated into the SI-815 in the very near future.

**Permitted Devices:**

**Soft Velcro Leather Restraint**

- a a one point b c two point
- a b two point b i three point
- a c three point b i four point
- a d four point
- a f soft mitts

All body restraints listed in the OMHS 99-01 and/or the ERPS Bulletin, Appendix B are henceforth prohibited for psychiatric purposes. The category of "Psychological Restraint" coded on Appendix B, code sheet 3, of the E/R/P/S Manual is also abolished.

Items (c b) helmets and (d b) geri chair may continue to be used as “protective or adaptive devices” under the conditions listed on p. 7 of OMHSAS 99-01, under the section entitled “Excluded from the Definition of Restraint,” but are not to be used as restraint devices to control acute or episodic aggressive behavior.

Metal restraints may be used only in forensic units, for security purposes, and only during the transport of such patients outside of the forensic unit’s secure perimeter as described in Bulletin SMH-95-02. Metal restraints may not be used to control acute or episodic aggressive behavior or as a substitute for other restraint devices for any purpose described in Bulletin OMHSAS-99-01.

Any mechanical restraint not included in the list of approved devices listed above is prohibited. Requests to introduce new or additional devices to the above list must be approved in writing by the OMHSAS Chief of Clinical Services and the Director, Bureau of Hospital Operations.

cc: Mr. Curie  
Assistant Superintendents for Clinical Services  
Performance Improvement Directors  
Assistant Superintendents for Nursing Services