Chapter 7:
Breaking the Bonds

Substance Abuse and Mental Health Services Administration
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Seclusion Restraint

Breaking the Bonds

The use of seclusion and restraint in treatment and rehabilitation facilities is controversial. Supporters acknowledge these practices as necessary safety measures of last resort in situations involving imminent risk of physical harm to service recipients and service providers. Detractors say seclusion and restraint are often used inappropriately as punishment or for staff convenience, and that these practices can cause physical injury, emotional trauma, and even death.

Definitions of seclusion and restraint vary widely. The U.S. General Accounting Office (GAO), in 1999 testimony to a U.S. Senate committee, defined restraint as "the partial or total immobilization of a person through the use of drugs, mechanical devices (such as er cuffs), or physical holding by another on. Seclusion refers to a person's involuntary confinement, usually solitary."

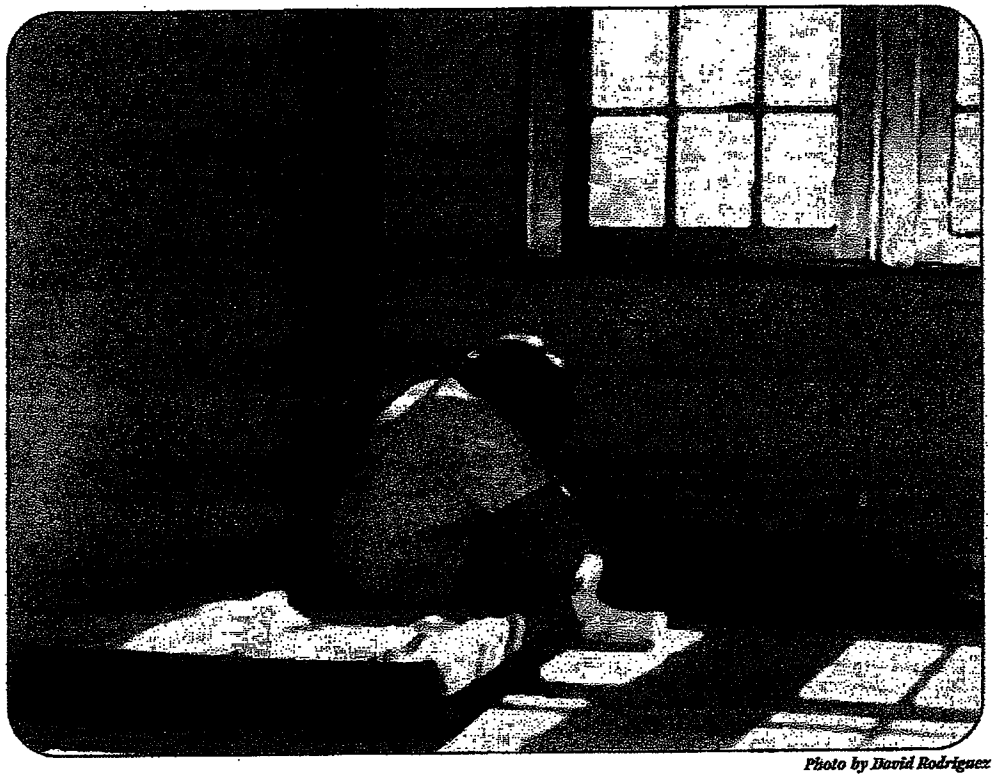

Photo by David Rodriguez

Although these practices have come under increasing scrutiny during the past decade, data documenting their use remain scarce. In 1998, the *Hartford Courant* ran a series of articles examining the use of these practices. The articles cited a statistical estimate by the Harvard Center for Risk Analysis that the annual number of deaths across the Nation due to seclusion and restraint ranged from 50 to 150—or 1 to 3 deaths per week.

In response to congressional concern following the *Hartford Courant* articles, the GAO prepared an evaluation of the issue. The GAO found that "at least 24 deaths that state protection and advocacy agencies investigated in Fiscal Year 1998 were associated with the use of restraint or seclusion." But, the GAO added, "The lack of comprehensive reporting es it impossible to determine all deaths ich restraint or seclusion was a factor." The GAO testimony emphasized that "Neither the Federal Government nor the states comprehensively track the use of restraint or seclusion, or injuries related to them across all types of facilities that serve individuals with mental illness or mental retardation."

Nevertheless, the seriousness of the consequences demands national attention. Injuries from restraint can include bruises, broken bones, and asphyxia. There are reports describing the use of seclusion and restraint to coerce or punish consumers of mental health services rather than to protect them from harm. Consumers tell of restraints being used, for instance, on a child throwing pencils. The GAO testimony also noted the lack of regulations governing the use of these practices.

Many in the mental health field agree with a statement by SAMHSA Administrator Charles G. Curie, M.A., A.C.S.W., that "Seclusion and restraint should no longer be recognized as a treatment option at all, but rather as treatment failure."

To address this issue, SAMHSA, under the leadership of Mr. Curie, has set forth a vision and a plan: to reduce and ultimately eliminate seclusion and restraint from treatment and rehabilitation settings for mental and addictive disorders.

Federal and State Policy

Legislation at the state and Federal level, self-examination within the treatment field, and efforts to formulate best practices have increased in recent years.

For example, in July 1999, the National Association of State Mental Health Program Directors (NASMHPD) issued a statement that "seclusion and restraint including 'chemical restraints,' are safety interventions of last resort and are not treatment interventions."

"Practices are changing rapidly," said Gail Hutchings, M.P.A., Acting Director of SAMHSA's Center for Mental Health Services. "There's renewed hope, based on the experiences of a number of states where there have been successful efforts."

For example, when Mr. Curie was Deputy Secretary for Pennsylvania's Office of Mental Health and Substance Abuse Services, facilities were able to reduce seclusion and restraint hours by more than 90 percent between 1997 and 2001.

The GAO testimony also cited Delaware, Massachusetts, and New York as states that have developed strategies to reduce the use of restraints in their public mental health or mental retardation service systems. Following the establishment of a new training program emphasizing crisis prevention and new management priorities, one Delaware facility reduced the number of emergency restrictive procedures by 81 percent between 1994 and 1997. Along with this reduction in restraint, residents' behavior improved, and the number of major injuries to residents fell by 78 percent.

The first Federal legislative change came the Children's Health Act in 2000. This legislation, co-sponsored by U.S. Senators Christopher Dodd and Joseph Lieberman, both of Connecticut, requires regulations for use of seclusion and restraint in all health care facilities—for children and adults—that receive Federal funds and in non-medical, community-based facilities for youth. The Centers for Medicare & Medicaid Services (CMS) and SAMHSA are working on this effort together.

In addition, the CMS Conditions of Participation, for all types of hospitals as well as for psychiatric residential treatment facilities for individuals under age 21, established standards for use of seclusion and restraint. Both sets of standards include the following requirements:

- Prohibiting their use as coercion or discipline
- Excluding their use for any reason but to ensure safety in emergency situations (and hasizing that only approved methods ld be used in those situations)

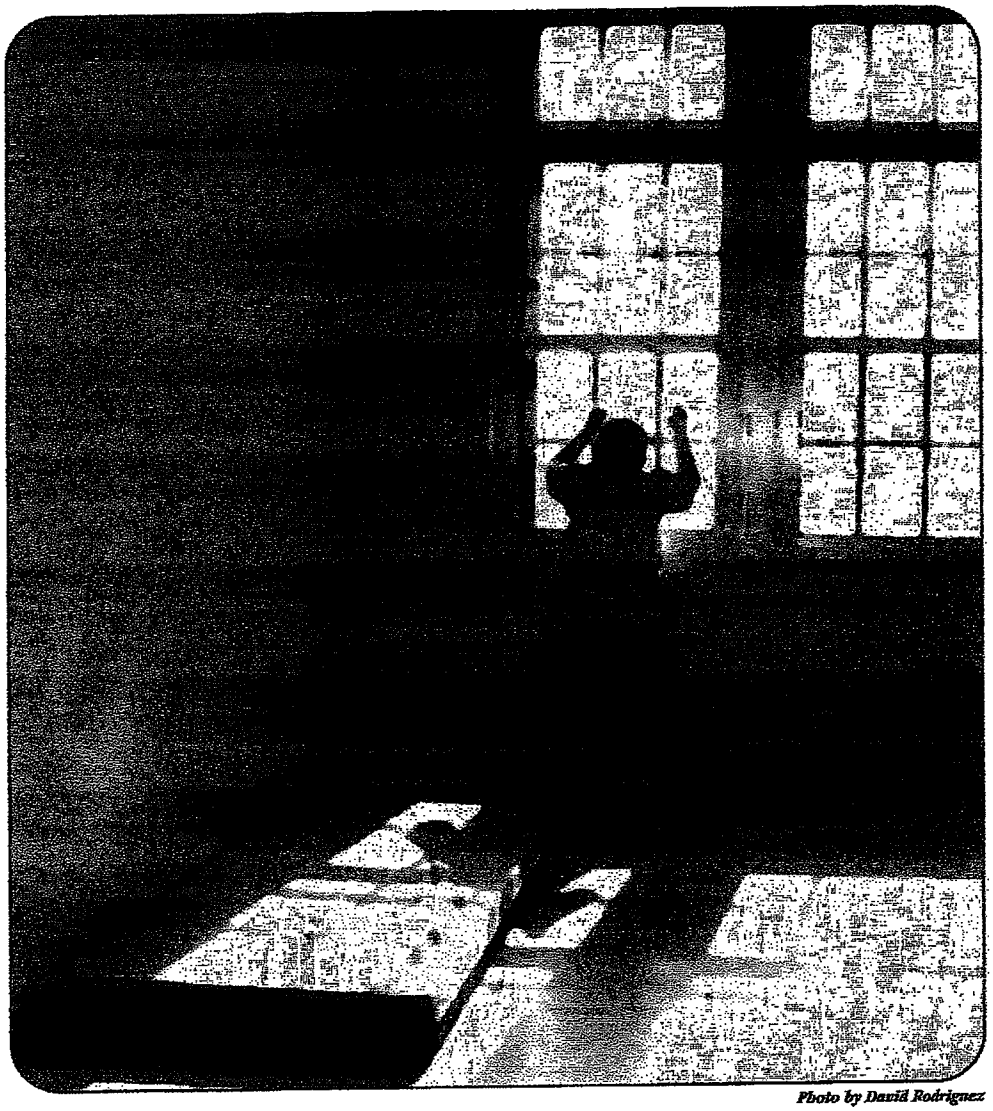

Photo by David Rodriguez

- Requiring staff and consumer debriefing and reporting of any deaths
- Requiring staff education and training.

SAMHSA's Vision and Plan

SAMHSA's National Action Plan to reduce and eliminate seclusion and restraint has targeted five domains under which to bring change into the field.

Data Collection to measure and track the use of seclusion and restraint: SAMHSA has been working with some states to define and measure usage. The Agency is also pursuing ongoing efforts in this area with state protection and advocacy programs and with NASMHPD.

Evidence-Based Practices and Guidelines to identify and promote approaches that have proven effective in reducing seclusion and restraint: SAMHSA is partnering with NASMHPD's National Technical Assistance Center for State Mental Health Planning (NTAC) and the National Registry for Effective Practice to identify, develop, and disseminate successful models of intervention.

Training and Technical Assistance to help staff learn effective, new approaches: SAMHSA is working on a consumer-based training manual on alternative methods including de-escalation and methods of preventing situations where seclusion and restraint might be used. SAMHSA is also

orting NTAC in conducting a series of regional training academies for state teams to develop and establish strategic plans to reduce seclusion and restraint at specified state-operated mental health facilities. For Fiscal Year 2004, SAMHSA has proposed a $2.5 million grant program in staff training for nine states. SAMHSA has also proposed a resource center to document and enhance evidence-based practices, provide technical assistance, and act as a clearinghouse on seclusion and restraint issues.

Further, the Child Welfare League of America and the Federation of Families for Children's Mental Health are in the middle of a 3-year, $6 million SAMHSA-funded grant program at multiple sites to determine best practices in staff training to reduce deaths and injuries.

Leadership and Partnership Development to help ensure widespread change: Elimination of seclusion and restraint equire buy-in from top leadership in all akeholder groups. To that end, SAMHSA and NASMHPD convened a national leadership conference in May 2003, at which a broad spectrum of partners contributed to the action agenda for the elimination of seclusion and restraint. (See "Seclusion & Restraint: Historic Conference," *SAMHSA News*, p. 12).

Rights Protection to uphold and enforce existing safeguards for consumers: SAMHSA advocates for consumer rights through its $32 million Protection and Advocacy for Individuals with Mental Illness (PAIMI) program, responding to allegations of rights violations related to seclusion and restraint, as well as providing technical assistance to state PAIMI programs.

The issue has received more attention in settings providing mental health services than in substance abuse treatment settings, but consumers with addictive or co-occurring disorders can also be at high risk for injury or death under seclusion and restraint, in part because of the possibility of increased agitation.

According to Claudia Richards, M.S.W., of SAMHSA's Center for Substance Abuse Treatment, "We're exploring ways to track the frequency and incidence of seclusion and restraint used on youth—particularly those with co-occurring serious emotional disturbances and substance abuse—who may be in settings like community-based residential treatment programs where there is currently no centralized reporting system to monitor the use of these practices."

Reflecting on all the recent activity in this area, Ronald S. Honberg, J.D., Director for Legal Affairs at the National Alliance for the Mentally Ill, observed, "There's a deep need for Federal leadership, and SAMHSA has stepped up to the plate."

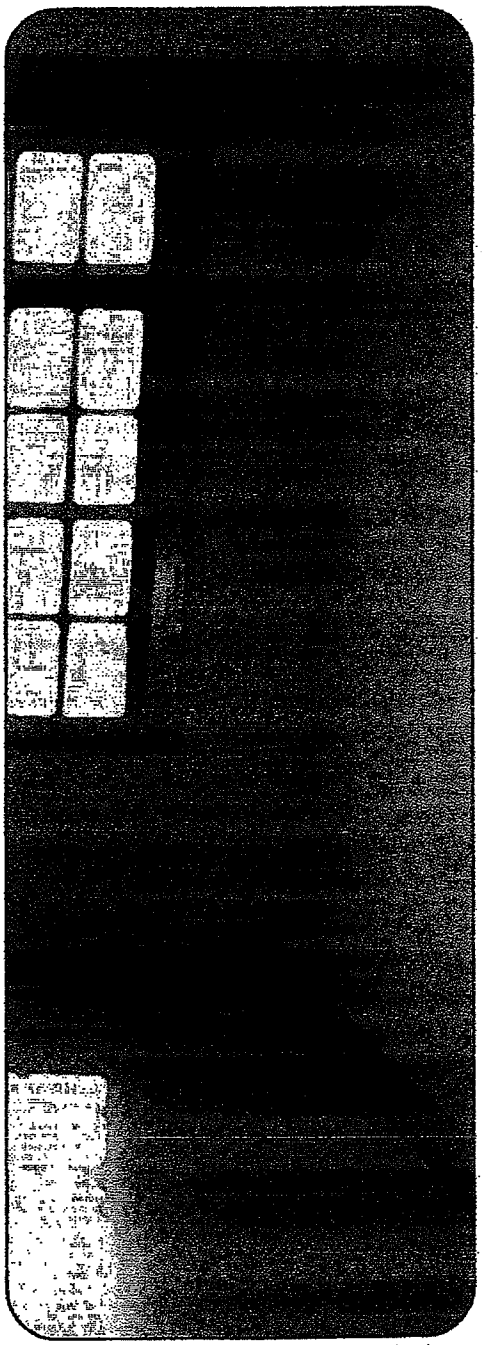

Photo by David Rodriguez

Seclusion Restraint Resources

The following resources provide more information about seclusion and restraint:

- SAMHSA's National Mental Health Information Center, P.O. Box 42490, Washington, DC 20015. Telephone: 1 (800) 789-2647 or 1 (866) 889-2647 (TTY). Or visit the Web site at **www.mentalhealth.samhsa.gov**.
- NASMHPD's National Technical Assistance Center for State Mental Health Planning at **www.nasmhpd.org/ntac**.
- The Child Welfare League of America and Federation of Families for Children's ntal Health staff-training project, funded SAMHSA, available at **www.cwla.org /programs/behavior**.
- *Learning from Each Other: Success Stories and Ideas for Reducing Restraint/ Seclusion in Behavioral Health*, available at **www.psych.org/clin_res /learningfromeachother.cfm**.

This 42-page publication was created by the American Psychiatric Association, American Psychiatric Nurses Association, and the National Association of Psychiatric Health Systems with support from the American Hospital Association Section for Psychiatric and Substance Abuse Services. A description and a copy of the resource guide are available.