

Creating Violence Free and Coercion Free
Mental Health Treatment Environments for the
Reduction of Seclusion and Restraint

Current Assumptions Regarding Seclusion and Restraint Use



Module created by Nihart, Huckshorn, LeBel 2003



**Conceptually excerpted in part from Mohr & Anderson, 2001.*

Although the concepts are restraint and seclusion, this initiative is really about being open to new ideas and re-thinking old practices. This initiative is also about learning from each other. In every state, with staff from every hospital and residential program that we have worked with, we – the faculty - have learned new ideas. So, during this training, all of us will learn from each other. We want you to ask questions when you have them – during or at the end of each session or when you see us during breaks. We learn from your questions. So, the operative words for all of us are: “Let’s have open minds!”

We always begin our NTAC training with this section on “Current Assumptions about the Use of Restraint and Seclusion”. This provides all of us with an opportunity to review our old assumptions. For many of you, listening to this section will be like preaching to the choir. You are already ‘there’: you already believe that we need to do things differently. But, I believe that there are still some of us here today and that each of you have staff in your facilities that carry some of the assumptions that we’re going to be talking about in this section.

Over the next several days you will learn is what has been effective in other hospital and residential programs in reducing restraints, seclusions and all coercive interventions. We are building, I believe, on the wonderful consumer empowerment and recovery movements and basically what these movements have asked of each of us is to challenge and rethink our practices and to be open to new concepts and ideas.

Any work used from this document should be referenced as follows:

“National Executive Training Institute (NETI). (2005). *Training curriculum for reduction of seclusion and restraint. Draft curriculum manual*. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD), National Technical Assistance Center for State Mental Health Planning (NTAC)”

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Definition

Assumption: A belief that is supposed to be factual; Something taken for granted. A supposition.

(Webster, 1994)

*(Some assumptions are based on facts,
some are based on myths...)*

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Basically an assumption is a belief that is supposed to be factual; something that is taken for granted. I am again going to make the assumption that some of you and many of the staff you work with may believe that some of the following assumptions are true.

Assumption

*Restraints keep the
people we serve safe*

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So, the first assumption that is prevalent in hospitals and residential programs is that restraints keep the people we serve safe. Is this true?

Reality

- 142 deaths found from 1988 to 1998, reported by the Hartford Courant
- 50 to 150 deaths occur nationally each year due to seclusion and restraints estimated by the Harvard Center for Risk Analysis

(NAMI, 2003)

- At least 14 people died and at least one has become permanently comatose while being subjected to S/R from July 1999 to March 2002 in one state alone

(Mildred, 2002)

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Reality tells us differently. The *Hartford Courant* reports identified 142 deaths due to restraints and seclusion from 1988 to 1998. The Harvard Center for Risk Analysis estimates that between 50 to 150 deaths occur nationally, every year, due to seclusion and restraint. In one state alone, they found 14 people died and one person was left permanently comatose after being restrained or secluded in an 18 month period.

Reality

- **Rick Griffin, 36**, of Stockton died of cardio-respiratory failure and extreme agitation in the county psychiatric health facility. He had been wrestled to the floor by eight staff members and bound in leather restraints.

(NAMI, 2003)

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The following are two painful examples of how restraints did not keep some of our patients safe. Rick died of cardio respiratory failure when he was wrestled to the floor by 8 staff and then put in leather restraints. Deaths can occur from cardio-respiratory failure and extreme agitation when struggling with staff members.

Reality

- **Kristal Mayon-Deniceros**, 16, died at a psychiatric hospital on February 5, 1999 after being restrained for 30 minutes, face-down (prone) on the floor with her legs and arms held. Kristal suffered respiratory and cardiac arrest.

(www.freedominla.org/issue03/page10.htm)

Reality

- **Gloria Huntley**, 31 years old, died in a state institution, after having been kept in restraints for 558 hours during the last two months of her life. Although she had been diagnosed with asthma and epilepsy, she was nevertheless restrained over and over again because of angry outbursts at hospital staff.

(Weiss et al., 1998)

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Gloria Huntley had significant medical risk factors associated with the use of restraint. She had both asthma and epilepsy, and her treating psychiatrist in the community explicitly stated in a letter to her other treaters that she should not be put into restraints. Nevertheless, she was repeatedly restrained in a psychiatric hospital and spent the equivalent of 23 days of the last of the last 2 months of her life in restraints – and she died while in restraints. Restraint use did not keep her safe.

Reality



- On **Tanner Wilson's, 9**, first day at a program his leg was broken when staff physically restrained him. After surgery, he returned to the program with a walker. His leg was later broken a 2nd time.

Eighteen months after being admitted, Tanner died while being restrained in a "routine physical hold." He died of asphyxiation – he suffocated to death. He was 11 years old.

(www.inclusiondaily.com/news/institutions/ia/iowa.htm)

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And restraint did not keep little Tanner Wilson safe.

Reported Injuries and Deaths

- Injuries including:
 - Coma
 - Broken bones
 - Bruises
 - Cuts requiring stitches
 - Facial damage
- Deaths due to:
 - Asphyxiation
 - Strangulation
 - Cardiac arrest
 - Blunt trauma
 - Drug overdoses or interactions
 - Choking

(Mildred, 2002)

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There are numerous documented injuries and deaths that have happened and continue to happen all over the country due to the use of restraint and seclusion. I do not think that any of us who have worked in a hospital or residential program have not seen rug burns on somebody. There has been untold number of bruises, broken bones and cuts due to restraints and seclusion. Later, will hear more about the specific risks for some of the people we serve for serious injury and death. So, I believe that it is a false assumption that restraints keep the people we serve safe.

Assumption

Restraints keep staff safe

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A second common assumption is that restraints keep our staff safe. Is this true?

Reality

- For every 100 mental health aides, 26 injuries were reported in a three-state survey done in 1996
- The injury rate was higher than what was found among workers in:
 - Lumber
 - Construction
 - Mining industries

(Weiss et al., 1998)

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In one study involving three states, it was determined for every 100 mental health aides, there were 26 injuries reported. This is a higher rate of injury for staff than people who work in the “high risk industries” of lumber, construction and mining.

Reality

- Implementation of staff training to reduce the use of restraints resulted in:
 - 13.8% reduction in annual restraint rates
 - 54.6% decrease in average duration of restraint per admission
 - 18.8% reduction in staff injuries

(Forster, Cavness, & Phelps, 1999)

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The reality is, this study found when you implement staff training to reduce the use of restraints, that the number of restraints are reduced and there is a corresponding near 20% reduction in staff injuries. This reduction of staff injuries is just from a focus on staff training, and you will be learning about other interventions that have been found to reduce the use of restraint and seclusion. This finding has been found again and again in hospitals and residential programs – once you begin to reduce restraint and seclusion, the number and seriousness of staff injuries decreases.

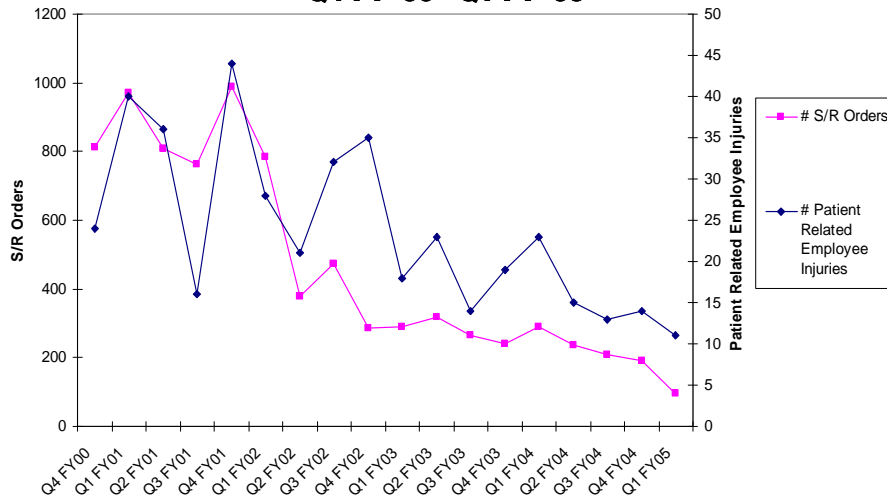
Worcester State Hospital

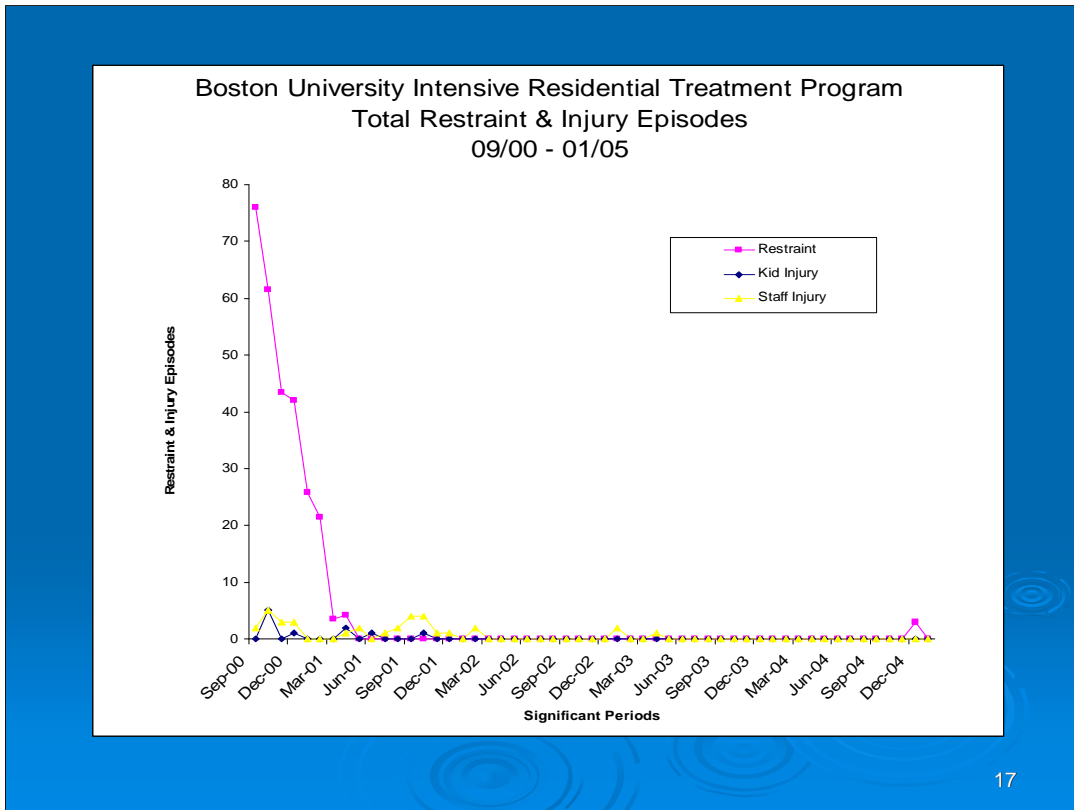
- Continuing care inpatient psych facility
- 156 Adult beds
 - 141 Continuing Care
 - 15 Court Evaluations (forensic)
- Public Sector, state funded/managed
- SMI diagnosis
- Age range: 19 and up

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Example of a facility that reduced injuries to staff as it reduced coercive practices.

**Seclusion and Restraint Orders and
Patient Related Employee Injuries
Worcester State Hospital
Q4 FY '00 - Q1 FY '05**





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This finding has been found again and again in hospitals and residential programs – once you begin to reduce restraint and seclusion, the number and seriousness of staff injuries decreases. For example, the Boston University Intensive Treatment Program and the Cambridge Hospital Assessment unit both reported a 100% reduction in staff injuries when they learned how to prevent the use of seclusion and restraint. So really, it is not true that restraints keep staff safe; it is actually true that *not* using restraints helps to keep staff safe.

Assumption

*Restraints are only used when
absolutely necessary and for
safety reasons*

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There's a third assumption, that restraints are used only when absolutely necessary and only for safety reasons. Is this true?

Reality



- **Andrew McClain** was 11 years old and weighed 96 pounds when two aides at Elmcrest Psychiatric Hospital sat on his back and crushed him to death.
- *Andrew's offense?*
- Refusing to move to another breakfast table.

(Lieberman, Dodd, & De Lauro, 1999)

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The next slides are really very sad realities. Andrew weighed 96 pounds. He was eating breakfast; he was having fun with his friends; they were talking and a staff member wanted him to move from his breakfast table, probably because he was being too loud. Andrew refused. It ended up in a power struggle. Because he didn't want to move from his friends, he ended up in a restraint, with staff sitting on his back, and it killed him. This was first reported first in the Hartford Courant and then in the reports during testimony at the Senate Committee on Finance, Andrew McClain died because he would not move to another breakfast table.

Reality



- **Edith Campos**, 15, suffocated while being held face-down after resisting an aide at the Desert Hills Center for Youth and Families.
- *Edith's offense?*
- Refusing to hand over an "unauthorized" personal item. The item was a family photograph.

(Lieberman, Dodd, & De Lauro, 1999)

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Another painful reality is Edith. Apparently there was a rule that you couldn't have something in your hands when you went between activities at this program. Well, a staff member saw that Edith had something in her hand and told her to "Give it to me". Edith said "No" and the staff said "Yes", and it ended up in a power struggle. They ended up restraining Edith, face down, she suffocated, and died. After she died, they discovered the object that was in Edith's hand was a family photograph that she liked to have with her. So the reality is that restraints often can again lead to death and serious injuries. They do not keep staff or the people we serve safe and restraint and seclusion are not only used when absolutely necessary.

Reality

- Ray, Myers, and Rappaport (1996) reviewed 1,040 surveys received from individuals following their New York State hospitalization
- Of the 560 who had been restrained or secluded:
 - 73% stated that at the time they were not dangerous to themselves or others
 - $\frac{3}{4}$ of these individuals were told their behavior was inappropriate (not dangerous)

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In a 1996 survey of over 1,000 individuals who had been hospitalized in New York State and had experienced restraint or seclusion, 73% stated that they were not dangerous to themselves or others at the time that they were restrained or secluded and three-fourths of the individuals were told that their behavior was simply inappropriate but not dangerous.

Assumption

Unit staff know how to recognize a potentially violent situation

(Mohr & Anderson, 2001)

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The fourth assumption is that staff know how to recognize a potentially violent situation. Is this true?

Reality

- Holzworth & Wills (1999) conducted research on nurses' decisions based on clinical cues of patient agitation, self-harm, inclinations to assault others, and destruction of property
- Nurses agreed only 22% of the time

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Many insist that nurses can easily determine if restraints should be applied, but the limited research in this area suggests otherwise. The study by Holzworth and Wills, published in 1999 found little agreement among nurses.

Reality

- When data was analyzed for agreement due to chance alone, agreement was reduced to 8%
- Nurses with the least clinical experience (less than 3 years) made the most restrictive recommendations

(Holzworth & Wills, 1999)

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What is really hard to believe, is that when they analyzed this data for chance alone, the percentage of nursing agreement fell to just 8%. What is interesting, and what we should look at when we are trying to improve our practices in our hospitals, is that the nurses with the least clinical experience, less than three years experience, made the most restrictive recommendations. Similar research has been conducted with other disciplines – it's not just nursing – but across disciplines as well. Our most inexperienced staff tend to make the most conservative, restrictive decisions. So, it is not true that we actually know how to recognize violent situations.

Assumption

*Staff know how to
de-escalate potentially
violent situations*

(Mohr & Anderson, 2001)

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The fifth assumption is that we know how to deescalate potentially violent situations. Is this true?

Reality

- In a study conducted by Petti et al. (2001) of content from 81 debriefings following the use of seclusion or restraint, staff responses to what could have prevented the use of S/R included:
 - 36% blamed the patient
 - Example: *“He could have listened and followed instructions”*
 - 15% took responsibility
 - Example: *“I wish I could have identified his early escalation”*

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The findings in one study found that almost half of the mental health technicians interviewed believed that there were no good alternatives to restraints, or they were not sure what the alternatives were.

In another study by Petti and colleagues, they looked at debriefings following the use of restraint and seclusion, and staff responses to what could have prevented the use of restraint or seclusion. Some staff blamed the patient, (almost a third!). In just 15% of the debriefings, staff took responsibility and wished they could have de-escalated the situation – but 85% did not see the role of de-escalation or feel they had the skills to try to handle the situation differently. We need to build on those 15% who see a need, a role for themselves, and want to intervene differently. These are the staff that we need to make change agents in our facilities because they understand that they have some responsibility in managing the crisis.

Reality

➤ Other responses included:

- 15% provided no response
- 12% were at a loss
 - Example: *“I don’t see anything else...all alternatives used.”*
- 11% blamed the system
 - Example: *“Need to make a plan for shift change”*
- 9% blamed the level of medication

(Petti et al., 2001)

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Other findings in the same study: some debriefings did not even address the issue of preventing; some staff claimed that they ‘didn’t see anything else that could have been done’, that ‘there were no other alternatives’. I think we’ve all heard these types of statements before. Some blamed the system; perhaps these are the smartest people because it really is our whole system that will support staff having more strategies for preventing the restraints in the first place. It is not the poor staff member left alone that often can prevent the situation if the hospital or residential system has not given him or her tools; it is how we set our hospitals and programs up and what tools we give our staff that will determine how he/she approaches each potentially volatile situation.

Reality

- Luiselli, Bastien, and Putnam (1998) conducted a behavioral analysis to explore contextual variables related to the use of mechanical restraints
 - Setting: Children/adolescent inpatient
- Results: The most frequent antecedent to the use of mechanical restraints was a staff-initiated encounter with the person

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In a 1998 study, the most frequent antecedent to the use of mechanical restraint was a staff initiated encounter with the person. Staff were not de-escalating ... they were escalating!

Reality

- Duxbury (2002) analyzed 221 reported incidents of aggression and violence over a 6 month period in 3 acute psychiatric units
- She found that de-escalation was used as an intervention less than 25% of the time
- Semistructured interviews identified lack of training

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In a 2002 study of aggression and violence in psychiatric units, de-escalation was used as an intervention less than 25% of the time. Staff reported they didn't have the skills to manage the situation differently.

Reality

- McCall audit found that 31% of direct care staff sampled did not receive mandatory training in preventing and managing crisis situations over the last 3 years.

(NYAPRS, 2002)

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In New York State, they found that 31% of the direct care staff did not receive the mandatory training in managing crisis situations. You're going to be exposed to many possible de-escalation and prevention tools in this training and the reality is that many of our staff just do not have enough knowledge and tools.

Assumption

*Restraints are not used as,
or meant to be, punishment*

(Mohr & Anderson, 2001)

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Restraints are not used as or meant to be punishment. Is this true?

Reality

- Strictly defined “physical punishment consists of infliction of pain on the human body, as well as painful confinement of a person as a penalty for an offense”

(Hyman, 1995, 1996)

- The involuntary overpowering, isolation, application and maintenance of a person in restraints is an aversive event from both the standpoint of logic and from that of the victim

(Miller, 1986; Mohr & Anderson, 2001)

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Punishment is defined as: 1) the infliction of pain, as well as 2) the confinement of a person, and 3) that it occurs as a penalty for an offense.

The involuntary overpowering, isolation, application and maintenance of a person in restraints is adverse from both the standpoint of logic and from that of the victim.

Reality

- 41 patients who had been secluded during their hospitalization were interviewed
 - One year after discharge, they were asked to draw pictures related to their hospitalization
 - 20 of 41 spontaneously drew pictures of their seclusion room experience – none were specifically asked to do this
 - Revealed themes associated with fearfulness, terror, and resentment

(Wadeson & Carpenter, 1976)

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In another study, 41 patients who were secluded during their hospitalization were interviewed one year after discharge. They were asked to draw pictures of their hospitalization. The researchers did not say anything about seclusion; they just asked the former patients to draw pictures of their experience of being in the hospital. Nearly half of people spontaneously drew pictures of their experience in seclusion. Their pictures revealed themes associated with anger, terror, and resentment.

Reality

- Feelings of bitterness and resentment toward seclusion prevailed at one year follow-up sessions
- Material interpreted from drawings of hallucinations while in seclusion contrasted sharply, reflecting:
 - excitement
 - pleasure
 - spirituality
 - distraction and
 - withdrawal into a reassuring inner world

(Wadeson & Carpenter, 1976)

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In addition to feelings of bitterness and resentment that lingered much later, up to one year after they were in seclusion, hallucinations while in seclusion may have provided the only reassurance available.

Reality

- Research study found that people who were secluded experienced: vulnerability, neglect and a sense of punishment

(Martinez et al., 1999)

- People who were secluded also stated that “anger and agitation were the result of being placed in seclusion”

(Martinez et al., 1999)

- Secluded persons expressed feelings of fear, rejection, boredom and claustrophobia

(Mann, Wise, & Shay, 1993)

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Another study found that people who experienced seclusion felt vulnerable, neglected, and punished. They felt angry and they expressed feelings of rejection, boredom and claustrophobia. We are recommending that you share this information with your own staff – share these assumptions and the actual realities.

Reality

- Analysis of six studies reported 58 – 75% conceptualized seclusion as punishment by staff
- Many persons-served believed:
 - Seclusion was used because they refused to take medication or participate in treatment program
 - Frequently, they did not know the reason for seclusion

(Kaltiala-Heino et al., 2003)

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In an analysis of six studies, it was reported that up to 75% of the people who were secluded viewed their seclusion as punishment by staff. Many persons served believed that seclusion was used primarily because they either refused to take their medication or participate in activities, and frequently they actually did not even know the reason for their seclusion.

Reality

- New York State survey found that 94% of those secluded or restrained had at least one complaint about their experience
 - 62% did not feel protected from harm
 - 50% alleged unnecessary force
 - 40% felt they had been psychologically abused, ridiculed or threatened

(Ray, Myers, & Rappaport, 1996)

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A New York State survey found that 94% of those secluded had at least one complaint about their experience. 62% felt they were not protected from harm; half alleged there was unnecessary force used by staff, and many felt they had been psychologically abused, ridiculed and/or threatened during the seclusion episode.

Reality

“The number and seriousness of former patients’ complaints about the use of these interventions [S/R] could be largely predicted by whether or not they believe that staff—prior to placing them in restraints or seclusion—had first tried to calm them down and solve their problems in another manner”

(Ray, Myers & Rappaport, 1996)

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In addition to these realities, those who reported that staff had attempted less restrictive interventions were less likely to have complaints about their experience and they were significantly less likely to be negative about their overall hospital experience.

The number and seriousness of the former patient’s complaints about the abuse of these interventions could be predicted by whether or not they believed that staff, (that means you and your staff) prior to placing them in restraint and seclusion, had first tried to calm them down and solve their problems in another manner.

Assumption

Seclusion and restraint are used without bias and only in response to objective behavior

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Another assumption is that seclusion and restraint are used without bias and only in response to objective behavior. Is this true?

Reality

- Research indicates that cultural and social bias may exist
- Those more likely to be restrained:
 - Younger and on more medications
 - Younger in age, male in gender, and African-American or Hispanic in ethnicity

(LeGris, Walters, & Browne, 1999)

(Donovan et al., 2003; Brooks et al., 1994)

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As noted earlier little agreement exists among nurses making decisions to restrain, therefore other factors must contribute to these decisions. Unfortunately, it appears that bias toward restraint of the young, the chronically ill, and the ethnically different may contribute to these decisions as well.

Research actually indicates that cultural and social bias exists. There have been a number of studies. A few are mentioned on this PowerPoint. Those more likely to be restrained were younger and on more medication. Those more likely to be restrained were younger in age; male in gender, and African American or Hispanic in ethnicity.

Reality



David “Rocky” Bennett, 38

Died in restraint in a UK hospital in 1998. He was racially-abused by a white consumer in the hospital and lashed out at a nurse. He was held in a prone restraint by 5 staff for 25 minutes and died. An inquest into his death found significant “*institutional racism*” in the NHS.

(www.blink.org.uk)

Reality

- Rocky's death and Inquiry lead to national 5-year plan, *Delivering Race Equality in Mental Health Care*, to be fully implemented by 2010. Two of the Inquiry's key recommendations include:
 - limiting restraint time (<3 minutes)
 - addressing **institutional racism**

Reality

- Data from a Pennsylvania study show that females are restrained at a higher rate than males

(Karp, 2002)

Reality

- Fisher (1994) concluded that factors that had a greater influence on the use of seclusion than demographic and clinical factors were:
 - Clinical biases
 - Staff role perceptions, and
 - Administrator attitudes
- Supported by more recent Harvard Review
- Cultural disparities appear to exist

(Fisher, 1994; Busch & Shore, 2000)

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Leading reviewers such as Fisher in 1994 and Busch & Shore in 2000 to conclude that cultural bias, staff role perceptions and administrator attitudes may have more to do with the use of restraints than clinical factors related to the patient.

Assumption

*Seclusion and restraint
are “therapeutic interventions”
and based on clinical knowledge*

(Mohr & Anderson, 2001)

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And the last assumption, one that is common in many hospitals and residential programs, is that seclusion and restraint are considered therapeutic interventions. Is this true?

Reality

- Semi-structured interviews with 24 previously secluded patients indicated:
 - 21% described it as dehumanizing and humiliating
 - 16% commented on loneliness and isolation
 - 54% reported nothing beneficial

(Binder & McCoy, 1983)

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No. In interviews with 24 previously secluded patients - they indicated differently. Again, the persons-served felt the seclusion was dehumanizing, they were lonely; half reported nothing beneficial.

Reality

- When asked what was bad about seclusion, 42% commented on the physical starkness, lack of toilet and running water, sleeping on a mat on the floor
- The majority reported that seclusion bothered them more than any other experience in the hospital

(Binder & McCoy, 1983)

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Dehumanizing, humiliating, loneliness, fearfulness, and isolation are all feelings repeatedly reported in studies of patients' responses to seclusion and restraint. These are powerful feelings to instill in an environment that is supposed to help.

Reality

- Punitive and isolating behaviors tend to be associated with a significant increase in negative behaviors and significant decrease in positive behaviors *(Natta et al., 1990)*

- Individuals who lack the capacity to understand contingency-based interventions may actually have counterproductive outcomes *(Papolos & Papolos, 1999)*

(Papolos & Papolos, 1999)

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What they found is that physiological reactions in a person that result from impending threat or takedown can result in excessive cortisol levels that actually alter their brain function. We're going to discuss more on the neurobiological and physiological response to traumatizing events later today.

Also, punitive and isolating behaviors tend to be associated with a significant increase in negative behaviors and a significant decrease in positive behaviors. What this reality is telling us is that when we use restraint and seclusion on our units, this use actually increases problem behaviors all around. When you reduce restraint and seclusion on your units, you actually decrease problem behaviors and increase positive, pro-social behaviors. What this reality is telling us is that many of the people who we serve actually lack the capacity to understand the contingency based interventions that are used in many programs. Elders, children, people with cognitive limitations may just not understand this kind of cause-effect approach.

Conclusion

- Numerous unfounded beliefs exist
- Harm in restraints and seclusion are well documented; positives are not substantiated
- Biases exist in the system
- Not evidence-based practice
- Significant culture change is required

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Looking at the history, the beliefs, the lack of research and the facts, no wonder regulators have taken a stronger stand. No wonder these interventions have come under scrutiny. While difficult to hear, it is more than time to revamp our institutional cultures, to move beyond our “comfort” zone and move toward new treatment approaches based in the principles of recovery and sanctuary, free from coercive methods, such as seclusion and restraint.

In conclusion, there are numerous, unfounded beliefs; there is harm caused by using restraint and seclusion. There are very few positive outcomes from the use of restraint and seclusion. If there are any, they are not substantiated or studied. Biases exist in our system. Restraint and seclusion are not evidence based practices. Significant culture changes are required if we are going to move to prevent, reduce or eliminate seclusion and restraint.

Conclusion

- The worst punishment deemed possible in prisons is seclusion/solitary confinement
- In psychiatric hospitals, people who behave inappropriately are placed in seclusion
- Perhaps the only difference is that in psychiatry we call it “therapeutic”

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The worst punishment deemed possible in prison is seclusion or solitary confinement. But when people behave inappropriately in our hospitals, we place them in seclusion. Perhaps the only difference between prisons and mental health settings is that we actually used to call these restrictive interventions therapeutic.

*“The breach between what we know and
what we do [can be] lethal.”*

Kay Redfield Jamison
Night Falls West