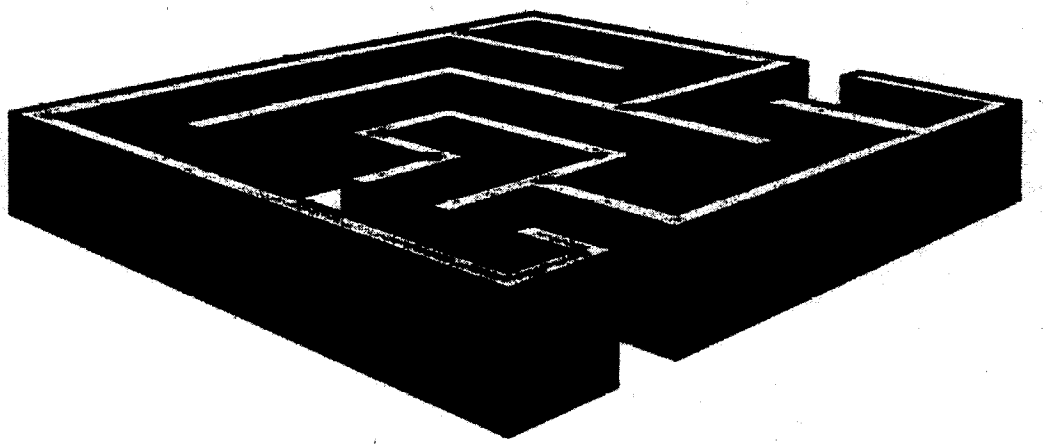
GOVERNANCE OF RESTRAINT & SECLUSION PRACTICES BY NYS LAW, REGULATION, AND POLICY



A REPORT BY THE
NYS COMMISSION ON QUALITY OF CARE FOR THE MENTALLY DISABLED
SEPTEMBER 1995

Governance of Restraint & Seclusion Practices by NYS Law, Regulation, and Policy

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ON QUALITY OF CARE
FOR THE MENTALLY DISABLED

Preface

In Chapter 50 of the Laws of 1992, the State Legislature asked the Commission to conduct a study of restraint and seclusion use in psychiatric facilities. In response to that request, the Commission issued two reports, *Restraint and Seclusion Use in NYS Psychiatric Facilities* and *Voices From the Front Lines: Patients' Perspectives on Restraint and Seclusion Use* (September 1994).

The findings of these reports offered some sobering observations about restraint and seclusion use among New York psychiatric facilities.

- Over the past decade there have been 111 deaths of patients in New York State associated with restraint and seclusion use.
- Rates of use of restraint and seclusion in NYS psychiatric facilities in September 1992 varied from none at all at approximately 18% of the facilities to much higher use of more than 40 orders per month per 100 patients at nearly one-third (30%) of the facilities.
- The variability in restraint and seclusion usage cannot be explained by differences in the hospitals' patient populations. Indeed, the Commission's research verified that hospitals sharing very similar patient populations often had dramatically different restraint and seclusion usage rates.
- Former patients overwhelmingly report that restraint and seclusion are not used in accordance with current state law and regulation, and that undue force, physical injuries and abuse are often associated with restraint and seclusion episodes.
- Commission reviews of 12 psychiatric facilities suggested that low restraint and seclusion use was associated with facilities which offered more rehabilitative programming, more comfortable custodial conditions, including reasonable provisions for telephone calls, visits, and showers.
- Commission research and investigations have consistently indicated both higher rates of restraint and seclusion use and more frequent problems among vulnerable populations, including the elderly, children, and persons with mental retardation.

This third Commission report on restraint and seclusion examines the governance structure provided in current state law, regulation, and NYS Office of Mental Health policy for the use of restraint and seclusion in New York psychiatric facilities. As reflected in this report, although New York once led the nation in its progressive state statute governing restraint use, nearly two decades later, New York's legal protections for patients from unnecessary, abusive and/or neglectful restraint and seclusion practices require substantial revision.

- NYS law does not address the use of seclusion in psychiatric facilities.
- Current NYS law governing restraint and New York's Code of Rules and Regulations governing both restraint and seclusion have not been updated in nearly twenty years, and certain provisions in state regulations conflict with those in state law and vice versa.
- State Office of Mental Health policy governing restraint and seclusion, the most comprehensive governance structure available, extends only to state psychiat-

ric centers and does not apply to state-licensed psychiatric facilities, which today serve three of every four individuals hospitalized for psychiatric care in New York.

- Although there are well-recognized problems in the overuse of restraint and seclusion among the elderly, children, and persons with mental retardation in New York, special protections or safeguards are not offered to these vulnerable populations in either New York State law or regulations.
- In the absence of more comprehensive state law and regulation governing restraint and seclusion, individual psychiatric facilities have developed their own restraint and seclusion policies, but these policies do not uniformly incorporate the limited safeguards which are now present in state law and regulations.

The gaps and contradictory standards in New York's current governance structure for restraint and seclusion, together with the findings of other Commission investigations of inappropriate restraint and seclusion usage, provide strong support for the State Legislature to amend and enhance current statute governing the use of restraint and to extend these safeguards to seclusion use as well. They also indicate a need for added safeguards for the elderly, children and persons with mental retardation in psychiatric facilities who appear to be especially vulnerable to inappropriate and excessive restraint and seclusion.

Therefore, it is recommended that the Legislature consider codifying a single comprehensive statute governing the use of restraint and seclusion in psychiatric facilities to replace four sets of inconsistent, contradictory and duplicative directives contained in state law, regulations, OMH policies and JCAHO standards. In the Appendix of this report, the Commission offers principles which should guide the Legislature in universally ensuring, through statutory reform, that the use of restraint and seclusion in psychiatric facilities* is an option of last resort, carefully carried out and vigorously monitored.

The Commission also recommends that psychiatric facilities in New York consider the principles presented — which reflect best practices at some New York facilities — and, where indicated, revise their existing policies and practices to ensure vital protections for the people they serve.

Clarence J. Sundram, Chairman

Elizabeth W. Stack, Commissioner

William P. Benjamin, Commissioner

* The Commission's recommendation pertains to the use of restraint and seclusion in psychiatric facilities. Current state law covers both mental health and mental retardation facilities. The use of restraint in mental retardation facilities is governed by regulations of the OMRDD. Some of the OMRDD mandates appear inconsistent with state law and warrant closer review and revision. This matter was beyond the scope of the Commission's review.

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Chapter I
Introduction

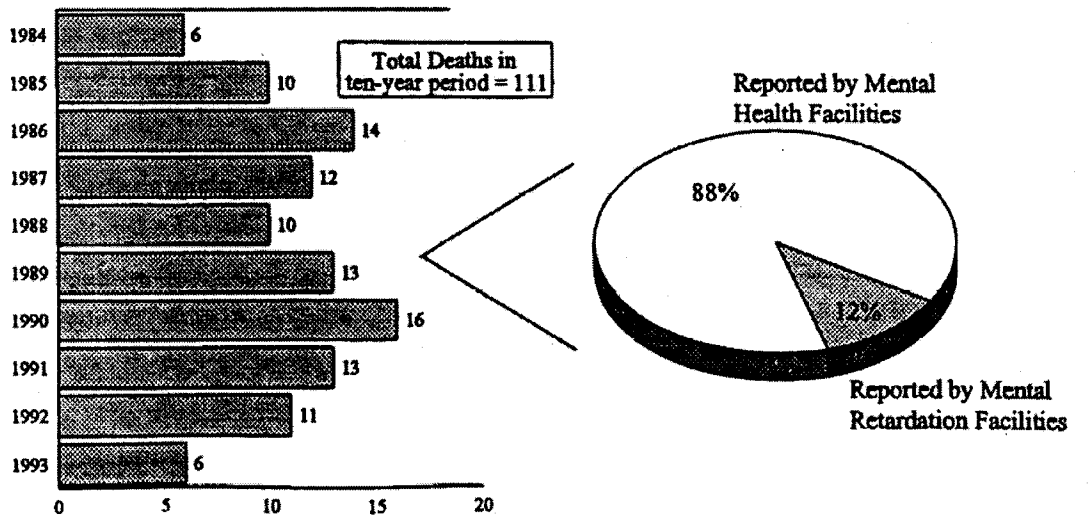
In Chapter 50 of the Laws of 1992, the State Legislature requested that the New York State Commission on Quality of Care conduct a review of the use of restraint and seclusion in the treatment of persons who are mentally disabled.

Investigations of restraint- and seclusion-related deaths have been an ongoing priority of the Commission's Mental Hygiene Medical Review Board, and in total, over the 10–year period 1984–1993, 111 deaths associated with restraint and seclusion use have been reported, investigated, and reviewed by the Board (Figure 1). These individual death reviews, as well as other advocacy complaints and abuse investigations conducted by the Commission, have reinforced the need for all treatment facilities using restraint and seclusion to do so with extreme caution and diligent quality assurance review.

Although serious adverse patient outcomes directly related to restraint and seclusion have been relatively infrequent, there has been a constancy to the number of these recurring preventable injuries and deaths, as well as the problems and deficiencies which have contributed to their occurrence. These problems and deficiencies have included:

- use of restraint and seclusion without adequate efforts to calm the patient or resolve the problem using less restrictive interventions;

Figure 1
Restraint and Seclusion Related Deaths
Reported by Mental Hygiene Facilities
(1984-1993)



- misuse of restraint and seclusion by staff who had not been adequately trained, and who thereby used excessive force or techniques which compromised the safety and well-being of the patient, leading to serious injury or death;
- failure of professional staff to comply substantively with the state's statutory and regulatory monitoring requirements associated with the use of restraint and seclusion, which often left patients' comfort and safety compromised for long periods of time, contributing to the serious harm and sometimes the death of patients;
- use of restraint and seclusion without adequate attention to other environmental hazards, including excessive heat, poorly ventilated rooms, and suicide hazards, which contributed to serious harm to patients and sometimes death; and,
- failure of facilities to recognize medical emergencies sometimes associated with restraint and seclusion use and to ensure that emergency medical equipment was promptly accessible and that staff were well-trained in emergency medical procedures, including cardio-pulmonary resuscitation.

The Review

Based on its experience reviewing the use of restraint and seclusion in psychiatric facilities, the Commission recognized that its response to the Legislature's requested study would require a number of different research activities which incorporated data collection from many sources and perspectives. In accordance with this recognition, the Commission has responded to the Legislature's request with the preparation of three reports.

(1) The first report, *Restraint and Seclusion Practices in NYS Psychiatric Facilities* (September 1994), details the highly variable rates of restraint and seclusion use among NYS psychiatric facilities and provides analyses which indicate that these variations appear to be independent of differences in the patient populations served and of most facility characteristics. The report provides other information, however, which suggests that low restraint and seclusion use by a psychiatric facility tends to be associated with other specific treatment and custodial practices, including greater assurances of patients' personal liberties, including off-ward privileges, better environmental conditions, and more patient participation in programming.

(2) The second report, *Voices From the Front Line: The Psychiatric Patient's Perspective of Restraint and Seclusion Use* (September 1994), reports the findings of the Commission's mail survey to individuals who had been inpatients of New York psychiatric facilities. Summarizing the responses of over 1,000 former service recipients to the mail survey, the report provides both a clear statement of patient concerns regarding restraint and seclusion use and a better understanding of specific restraint and seclusion practices which most substantially influence patients' negative versus positive opinions about their inpatient stays.

(3) This third report, *Governance of Restraint and Seclusion Practices by NYS Law, Regulation, and Policy,* examines the governance of restraint and seclusion practices in New York's psychiatric facilities. The dedication of an entire report

to this issue reflects the Commission's conclusion that existing statutory, regulatory, and state policy mandates governing restraint and seclusion use are inconsistent and inadequate. These limitations in the state's governance of restraint and seclusion have contributed both to the different professional clinical interpretations of existing legal standards regarding restraint and seclusion use and to the widely variable use of these restrictive interventions among the state's psychiatric facilities.

Methods

In conducting its review of the governance of restraint and seclusion practices, the Commission undertook four distinct research steps.

(1) The published literature pertaining to states' laws and regulations and psychiatric facilities' policies and guidelines governing the use of restraint and seclusion with psychiatric patients was reviewed.

(2) Existing New York State law and regulations (which carry the force of law), as well as Office of Mental Health policies, governing restraint and seclusion use in psychiatric facilities were assessed in terms of their comprehensiveness, consistency, and currency with contemporary clinical standards for restraint and seclusion use.

(3) Accreditation standards pertaining to the appropriate use of restraint and seclusion issued by the Joint Commission on Accreditation of Healthcare Organizations, the largest accrediting body of psychiatric hospitals and psychiatric services of general hospitals, were reviewed.

(4) Internal restraint and seclusion policies of state-operated psychiatric centers (N = 24) and psychiatric services of general hospitals (N = 101[1]) were reviewed to assess their compliance with state law and regulations, as well as Office of Mental Health policy governing restraint and seclusion use, and the extent to which these policies provide added patient safeguards.

Through the above research activities, the Commission sought answers to two basic questions.

(1) *Do current New York State laws and regulations, together with the NYS Office of Mental Health's and psychiatric facilities' policies provide adequate direction to ensure the safe and appropriate use of restraint and seclusion in the state's psychiatric treatment facilities?*

(2) And, if not, what specific changes should be made in state law and regulations and/or Office of Mental Health and internal facility policies?

[1] Policies were not reviewed for 4 of the 105 psychiatric services of general hospitals, as these hospitals either reported that they did not have policies or these hospitals did not respond to the Commission's request. In addition, policies were not reviewed at one of the 25 state-operated adult psychiatric centers, as this center reported that it did not use either restraint or seclusion.

Chapter II
Review of the Literature

As more comprehensively summarized in the Commission's report, *Restraint and Seclusion Practices in NYS Psychiatric Facilities* (September 1994), there is an enormous body of published literature on restraint and seclusion use in psychiatric facilities. Much of this literature debates the clinical efficacy and necessity of restraint and seclusion use, while another large segment of this literature attempts with little success to identify the key clinical and/or demographic patient characteristics which tend to predict the minority of psychiatric patients who are subjected to these interventions (Binder, 1979; Carpenter, et al., 1988a; Lawson, et al., 1984; Oldham, et al., 1983; Okin, 1985; Plutchik, et al., 1978; Ramachandani, et al., 1981, Shugar and Rehaluk, 1990; Soloff and Turner, 1981; Tardiff, 1981; Thompson, 1986; Way and Banks, 1990).

There are also many studies which have examined the rates of restraint and seclusion use across several inpatient psychiatric facilities. These studies, like the Commission's own research findings, confirm that restraint and seclusion usage rates vary dramatically among psychiatric facilities, and that these variations cannot be consistently linked to differences in the patient populations served by the facilities or to the characteristics of the facilities themselves.

Simultaneously, several researchers have noted dramatic short–term reductions in restraint and seclusion use following the enactment of specific laws or regulations governing the use of these interventions or when strict protocols were instituted to guide the use, monitoring, and documentation related to their use (Swett, et al., 1989 and Kalogjera, et al., 1989). Several researchers have also noted that use of restraint and seclusion, as well as violent patient episodes and injuries, is generally reduced when strict staff adherence to other less restrictive behavioral management plans is assured (Carmel and Hunter, 1990; Colenda and Hamer, 1991; Wong, et al., 1988; VanRybroek, et al., 1987).

Federal Courts Influence Restraint and Seclusion Practices

While there remains considerable debate in clinical circles regarding professional practice guidelines for restraint and seclusion use, over the past two decades federal district courts have increasingly articulated requirements governing the use of these interventions. *Wyatt v. Stickney* (344 F Supp. 373 [M.D. Ala. 1973]) set forth initial requirements regarding the use of these interventions, and these requirements have become the basis of many other decisions (Figure 2).

In *Wyatt*, the court held that patients had the right to be free from restraints and seclusion and that these interventions, except in emergency situations, could only be used consistent with a written order and rationale by a qualified mental health professional. The court order further clarified that restraint and seclusion could only be used in situations where the patient could harm himself or others, that a qualified mental health professional must personally evaluate the patient, that emergency orders may not extend longer than one hour, that written orders may extend for only 24 hours, and that while in restraint or seclusion the patient must be regularly monitored and have bathroom privileges every hour.

Figure 2
Major Provisions of Wyatt v. Stickney Re: Restraint and Seclusion Use

- ☐ States affirmatively patients' right to be free from restraint and physical isolation.
- ☐ Patients may be restrained or secluded only when they may harm themselves or others.
- ☐ Patients may be restrained or secluded only when less restrictive methods are not feasible.
- ☐ Patients may be placed in restraint or seclusion only on a written order of a qualified mental health professional which states a rationale for such action.
- ☐ Qualified mental health professionals may write such orders only after personally seeing and evaluating the patient.
- ☐ Written orders for restraint and seclusion shall be valid for only 24 hours.
- ☐ Emergency imposition of restraints or seclusion without an order by a qualified mental health professional must be limited to one hour.
- ☐ While in restraint and seclusion the patient must be monitored and have bathroom privileges hourly and must have the opportunity to bathe at least every 12 hours.

Subsequently, other federal district court decisions, also emanating from class actions alleging constitutional abuses in public institutions' restraint and seclusion practices, have reaffirmed the *Wyatt* principles governing restraint and seclusion use, and in some instances they have added more stringent requirements. These added requirements have included required 15–minute monitoring checks, review of all restraint and seclusion orders by the administrator or other senior staff persons, required release of patients every two hours, and restrictions against the use of these interventions with persons who are mentally retarded *(New York State Association for Retarded Children, Inc. v. Carey, 393 F. Supp. 715 [E. D. New York 1975]; Youngberg v. Romeo, 457 U.S. 307 [1982]; Eckerhart v. Hensley, 475 F Supp. 908 [W.D. Mo. 1979]; Rogers v. Okin, 478 F. Supp. 1342 [D. Mass. 1979]).*

States' Laws

Often arising from the abuses made public in class action cases over the past two decades, most state legislatures have also passed specific statutes governing the use of restraints and seclusion in the facilities caring for persons who are mentally disabled. As summarized by Brakel et al. (1985), the various state statutes share similar provisions articulating that restraint and seclusion may only be used in situations which may be harmful to the patient or others. In most other respects, however, state statutes governing restraint and seclusion evidence much variability — both in their specific provisions (e.g., length of orders, who can write orders, specific proscriptions against restraint and seclusion use as a punishment or for the convenience of staff) and in their general comprehensiveness. Additionally, specific descriptive language defining dangerousness, risk of harm, imminent harm, etc. is usually not present in states' statutes.

Professional Practice Standards

In the wake of the initiatives of federal courts and state legislatures, some professional organizations and individual clinicians have also published guidelines for the appropriate use of restraint and seclusion (Joint Commission on Accreditation of Healthcare Organizations,

1992; American Psychiatric Association, 1985; Bursten, 1975; Daar and Nelson, 1992; Mitchell and Varley, 1990; Roper, et al, 1985; Tardiff and Mattson, 1984). These various sets of guidelines tend to share some central principles articulated by federal court decisions and state legislatures, including that restraint and seclusion may only be used after other less restrictive interventions have been attempted, that restraint and seclusion must not be used as punishment or for the convenience of staff, and that these interventions must be ordered by a physician, although most concur that they may be initially authorized by nursing staff, with a subsequent physician order.

Most (although not all) professional guidelines also assert that restraint and seclusion are very restrictive interventions which should be used only when there is a "risk of harm" to the patient or others. "Risk of harm," however, is variably defined, with indications varying from imminently dangerous behaviors to property damage to situations where reducing sensory stimulation is judged as an appropriate means of preventing dangerous behavior (Telintelo, et al. 1983; Fassler and Cotton, 1992; Tardiff and Mattson, 1984; Outlaw and Lowery, 1992).

Professional guidelines, like federal court decrees and state statutes, also differ in many other specific areas. Guidelines for the duration of physician orders vary from 1 to 24 hours, and there is considerable disagreement as to the types of mechanical restraints that should be authorized (Joint Commission on Accreditation of Healthcare Organizations, 1992; American Psychiatric Association, 1985; Lion and Soloff, 1984). Published guidelines also offer different advice relative to specific mandates for hands–on physician exams of the patient, the frequency of bathroom and exercise breaks for patients restrained or secluded, the safety design features of seclusion rooms, and required staff training in the use of restraints and seclusion (Tardiff and Mattson, 1984).

Summary

As reflected in this chapter, despite the volume of published clinical research and dialogue on the use of restraint and seclusion in psychiatric facilities, there remains much clinical debate over the efficacy and appropriate use of these interventions. Most research studies confirm markedly variant rates of restraint and seclusion usage across psychiatric facilities which cannot be linked to differences in patients' needs and characteristics. There is also little clinical data which explain the patient behaviors, symptoms, and characteristics which reliably distinguish the minority of psychiatric patients who are restrained and secluded from the majority of psychiatric patients who are not.

Perhaps reflective of these limitations of the clinical research, federal courts and state legislatures, *not clinicians*, have led the way in articulating practice standards governing restraint and seclusion use in psychiatric facilities. Literally dozens of federal class actions — centering on public institutions located across the United States — have closed with specific standards for restraint and seclusion use. And, in the past two decades, almost all state legislatures, often following federal court actions, have passed laws governing restraint and seclusion practices.

Notwithstanding these initiatives, however, the federal courts and state laws have generally treaded lightly in this "clinical arena." At the same time, although some professional organizations, including the Joint Commission on Accreditation of Healthcare Organizations and the American Psychiatric Association have issued practice guidelines related to restraint and seclusion use, as a general rule, these organizations have not gone beyond, and sometimes not as far as, those requirements stated by the courts and state legislatures. Additionally, while published professional guidelines share some common principles, they differ in other key requirements.

As a result, there is limited professional consensus on practice guidelines governing many aspects of restraint and seclusion use.

In this vacuum, there is much room for clinical discretion and variable decision-making. As reported in the Commission's report, *Restraint and Seclusion Practices in NYS Psychiatric Facilities,* this discretion has contributed to dramatic variations among psychiatric facilities in New York in their reliance on restraints and seclusion. Responses from former patients of New York psychiatric facilities, cited in the Commission's report *Voices From the Front Line: The Psychiatric Patient's Perspective of Restraint and Seclusion Use,* further suggest that the actual practices of hospitals in defining situations which warrant restraint and seclusion use, in ensuring attempts to use less restrictive interventions, and in monitoring patients subjected to these interventions are also variable across treatment facilities. Thus, the probability that a patient will be restrained or secluded during the course of a psychiatric hospitalization depends less on the patient's behavior than on the practices of the hospital to which the patient is admitted or committed.