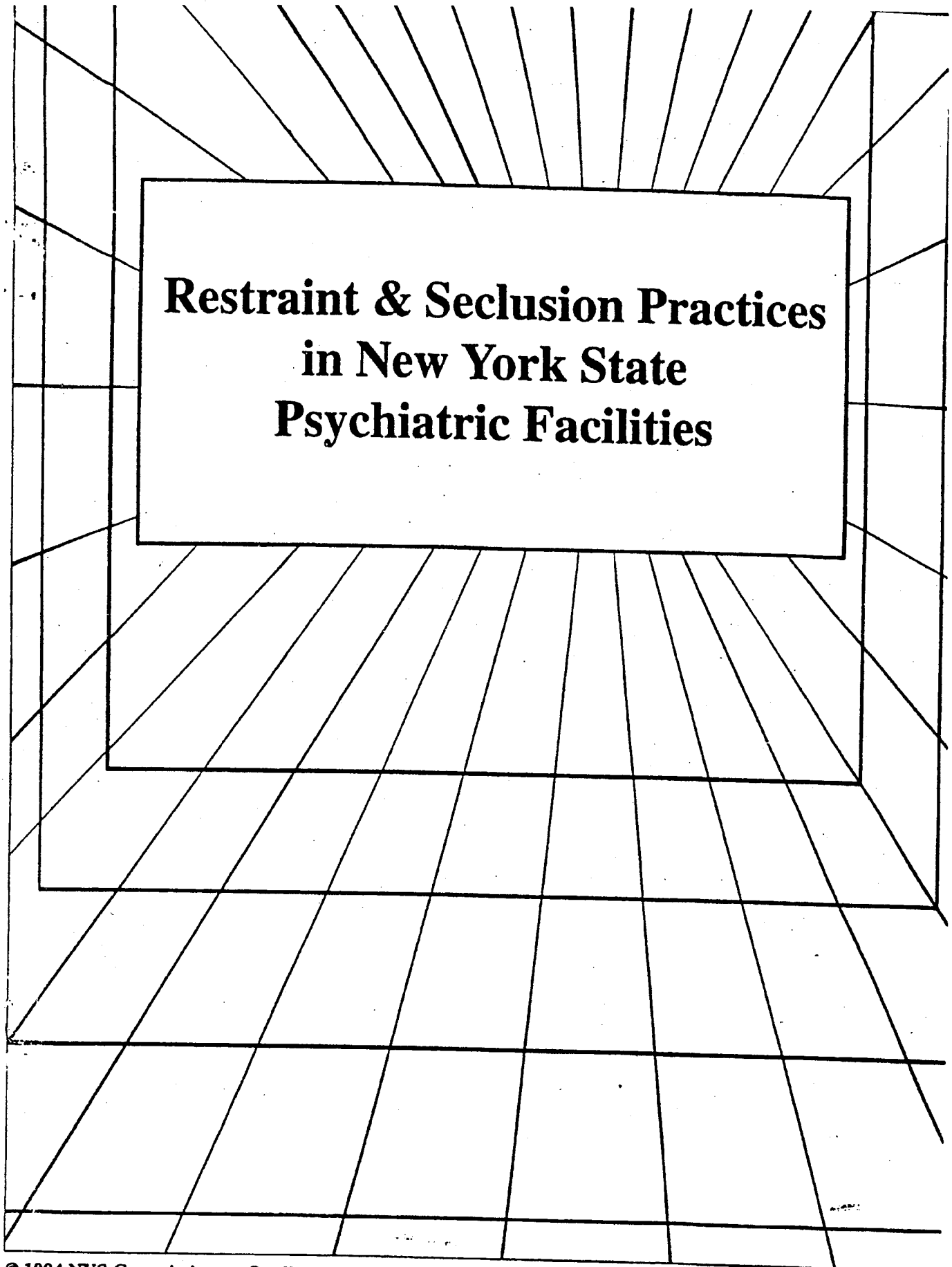

Restraint and Seclusion Practices in New York State Psychiatric Facilities

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Preface

In Chapter 50 of the Laws of 1992, the State Legislature requested that the Commission examine restraint and seclusion practices in NYS psychiatric facilities. The Legislature was troubled by a newspaper account, drawing on reports of Commission investigations, which had detailed more than 100 patient deaths attributed to restraint and seclusion use in New York psychiatric facilities over the previous decade. Concern was also expressed that New York's psychiatric facilities relied more heavily on these interventions, and especially the camisole (or the straightjacket) than other states.

In undertaking this review, the Commission examined restraint and seclusion practices from a number of different perspectives. This report details the Commission's examination of restraint and seclusion usage patterns across adult psychiatric facilities in New York State and explores the factors which may be associated with psychiatric facilities' varying usage rates of these interventions. A second report, *Voices From the Front Lines: the Patients' Perspective of Restraint and Seclusion Use*, relates the data from a large mail survey to individuals (N = 1,040) who had received inpatient psychiatric services.

Some psychiatric facilities (16%) in New York State make no use of restraint or seclusion

As related in this report, the Commission found that some psychiatric facilities (16%) in New York State make no use of restraint or seclusion and that the majority (51%) had *combined* monthly usage rates of fewer than 20 orders of restraint *and* seclusion per 100 patients in their average daily census [See Report pp. 11 - 20]. Simultaneously, a minority of New York's psychiatric facilities use these interventions relatively often. These facilities included 39 of the 125 facilities studied (31%) which had combined monthly order rates for restraint and seclusion of 40 or more orders per 100 patients in their average daily census [See Report p.19]. Even among the three forensic state psychiatric centers, which tended to have the highest rates of restraint and seclusion use, there was 500% variation in usage rates for these interventions [See Report p. 17].

Facilities located downstate, designated as teaching hospitals, and having lower average patient acuity levels, were more likely than other facilities to have higher restraint and seclusion usage rates.

Study of the psychiatric facilities, the characteristics of their patient populations, and their restraint and seclusion usage rates generally found that variations in the use of these interventions could not be significantly linked to differences in their patient populations or to most facility characteristics. Facilities located downstate, designated as teaching hospitals, and having lower average patient acuity

levels, were more likely than other facilities to have higher usage rates of these interventions [See Report p. 23]. Other variables that the Commission studied, including the percentage of patients with concomitant drug/alcohol abuse disorders; the percentage of patients classified as seriously mentally ill; urban/rural location of the facility; age, sex, race, or socio-economic status of the patient population; or size of the facility were generally found to be not significantly associated with the variations in restraint and seclusion usage measures [See Report p. 22].

Treatment practices at psychiatric facilities making low use of restraint and seclusion shared several characteristics, associated with a strong patient–centered treatment orientation.

In contrast with these findings, however, the Commission's more indepth study of 12 psychiatric facilities (seven state psychiatric centers and five psychiatric services of general hospitals) indicated that *treatment philosophy and practices*, as opposed to patient characteristics, may be more determinant of low restraint and seclusion use. These reviews indicated that treatment practices at psychiatric facilities making low use of restraint and seclusion shared several characteristics, associated with a strong patient–centered treatment orientation.

- These low-use facilities were more likely to have administrators who believed strongly that restraint and seclusion use should be minimized and who had instituted a number of specific practices—ranging from increased clinical scrutiny of restraint and seclusion use to more crisis intervention training for their staff to more emphasis on patient–staff interactions — in a direct effort to keep restraint and seclusion use low [See Report p. 28].
- These facilities were more attentive to various practices which afforded patients more personal liberties while they were in the facility — including greater provisions for escorted and unescorted off–unit privileges, privacy when making telephone calls, privacy in visiting, access to a telephone in times of crisis, ability to attend weekly church services, freedom to take showers at unscheduled times [See Report p. 32].
- These facilities were more likely to have ensured at least 50% of their patients at least 20 hours of active therapeutic programming weekly [See Report p. 34].

The low restraint and seclusion use facilities demonstrate a culture oriented towards patient-centered values communicated from the top down, not a random assortment of "reformed" facility practices.

- These facilities were more likely to ensure better patient living conditions — especially in dayrooms and patient bedrooms [See Report p. 33].

Together, these findings indicate that low use of restraint and seclusion appears to be less associated with differences in the needs of the patients served than with differences in

the overall treatment philosophies and practices promoted by the managers and senior clinical staff of psychiatric facilities. The findings further suggest that adoption of key features of the management philosophy, leadership, and daily treatment practices of low use facilities may assist high use psychiatric facilities in lowering their usage of these potentially dangerous interventions.

It is also clear, however, that making these changes is not a simple matter. The low restraint and seclusion use facilities demonstrate a culture oriented towards patient-centered values communicated from the top down, not a random assortment of "reformed" facility practices. These changes cannot be accomplished overnight; nor are they likely to be instituted easily by fiat. They require a reorientation of all facility staff, diligent attention by senior management and clinical staff, and ongoing assistance, training, and support to frontline staff.

Letting psychiatric facilities know where they stand regarding the use of these interventions intended to protect patients from harm, but which can also be potentially and lethally dangerous, is critical to any sound quality assurance program,

This report also reinforces the importance of efforts by the NYS Office of Mental Health in collecting and disseminating restraint and seclusion usage data from its state–operated and – licensed inpatient psychiatric facilities. Letting psychiatric facilities know where they stand regarding the use of these interventions intended to protect patients from harm, but which can also be potentially and lethally dangerous, is critical to any sound quality assurance program. In the past year, the Commission has published these facility usage rates in its newsletter, and it is apparent that facilities have generally been attentive to these reports. Notably, three of the highest user facilities have recently attempted reforms to reduce their restraint and seclusion use.

But if patients' clinical characteristics don't explain the wide variations in practice, it seems reasonable to conclude that, despite the legal prohibitions, factors unrelated to patients' needs are driving the use of restraint and seclusion in many cases.

The wide variations in practice in using these highly restrictive forms of intervention, which expose both patients and staff to the risk of injury, also call into question the broad latitude of judgment entrusted to psychiatric facilities. The Mental Hygiene Law and OMH regulation and policies state that these interventions should not be used as punishment, for the convenience of staff, or as a substitute for programs. But if patients' clinical characteristics don't explain the wide variations in practice, it seems reasonable to conclude that, despite the legal prohibitions, factors unrelated to patients' needs are driving the use of restraint and seclusion in many cases.

Thus, while there is ample room for self-improvement in psychiatric facilities in reducing the unnecessary use of restraint and seclusion, there is also a need to reexamine the framework of laws, regulations and poli-

cies that have permitted such broad discretion. The Commission plans to assist in that process of reexamination in a third report, *Governance of Restraint and Seclusion Practices*, to be issued in the fall of 1994, which will examine the adequacy of New York State law, regulation, and policy in governing the use of these interventions in psychiatric facilities.

The Office of Mental Health reviewed a draft of this report, and it responded that the agency would be taking steps to reduce the use of restraints and seclusion at state psychiatric centers with high usage rates (Appendix B). The Office noted, however, that its monitoring of state-licensed psychiatric facilities' restraint and seclusion use would be limited due to resource constraints. In its response the Office of Mental Health also shared with the Commission its own recommendations related to restraint and seclusion use.

The Commission responded to the Office of Mental Health (August 10, 1994) restating its recommendation for systemic, on-going monitoring of restraint and seclusion use at state-licensed psychiatric facilities', emphasizing the significant role of these facilities in providing approximately 75% of all inpatient psychiatric care in the state. While supporting many of the recommendations in the Office of Mental Health's Task Force report, the Commission also raised objections to three recommendations, including the reversal of New York's long-standing prohibition of the use of seclusion with individuals who are mentally retarded and the introduction of two new restraining devices (the blanket restraint and PADS, arm to wrist restraints). The Commission's letter to the Office of Mental Health is included in Appendix C.

Clarence J. Sundram, Chairman

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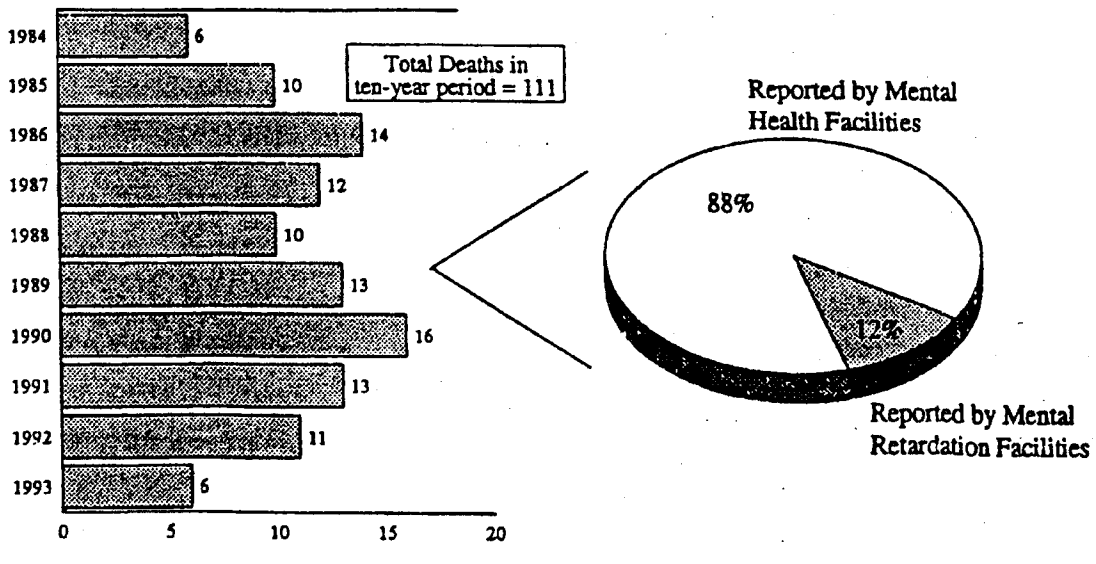
Chapter I
Introduction

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 psychiatric facilities.

Investigation of restraint- and seclusion-related deaths has been an ongoing priority of the Commission's Mental Hygiene Medical Review Board, and in total, over the ten-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 investigations conducted by the Commission into complaints from patients and allegations of abuse, have reinforced the need for all treatment facilities using restraint and seclusion to do so with extreme caution and diligent quality assurance review.

Although patient deaths directly related to restraint and seclusion have been relatively infrequent, each year the Commission has investigated cases involving preventable injuries and deaths, and has identified problems and defi-

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



ciencies which have contributed to their occurrence.[1] These problems and deficiencies have included:

- the unnecessary use and misuse of restraint and seclusion without adequate efforts to calm the patient or resolve the problem using less restrictive interventions;
- use of restraint and seclusion by staff who had not been adequately trained, and who thereby misused techniques and sometimes used excessive force, 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 requirements governing the use of restraint and seclusion, which often left patients' comfort and safety seriously 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 that are 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 cardiopulmonary resuscitation.

Figure 2
Review Methods

- ✓ Review of the restraint and seclusion literature.
- ✓ Analysis of NYS law, regulations, and policies governing restraint and seclusion.
- ✓ Restraint and seclusion usage rates of NYS psychiatric facilities were calculated and analyzed.
- ✓ Review of NYS psychiatric facilities' internal restraint and seclusion policies.
- ✓ On-site visits to 12 NYS psychiatric facilities.
- ✓ Survey of individuals restrained or secluded in NYS psychiatric facilities.

Methods of the Review

Based on its experience reviewing the use of restraint and seclusion in psychiatric treatment 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 (Figure 2).

Five research activities were designed:

(1) The professional literature on restraint and seclusion use was reviewed.

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1 NYS Commission on Quality of Care, *Christopher Dugan - A Patient at South Beach Psychiatric Center*, January 1985; *Mia Martine - A Patient at Mid-Hudson Psychiatric Center*, December 1982; *Pedro Montez - A Patient at Manhattan Psychiatric Center*, December 1982; *Alex Zolla - A Patient at South Beach Psychiatric Center*, May 1982; *Janice Sherman - A Patient at South Beach Psychiatric Center*, February 1982; *Fred Zimmer - A Patient at Kingsboro Psychiatric Center*, June 1981; *Alphonse Rio - A Patient at South Beach Psychiatric Center*, March 1981; *Peter Breen - A Patient at St. Lawrence Psychiatric Center*, February 1981; *Allen S. - A Patient at Manhattan Psychiatric Center*, November 1979.

(2) State law and regulations governing restraint and seclusion use, as well as the formal written policies related to restraint and seclusion of state-operated adult psychiatric centers and all general hospitals with certified inpatient psychiatric units were reviewed.

(3) Via a mail survey, restraint and seclusion usage data from state-operated adult psychiatric centers and general hospitals with certified inpatient psychiatric units in New York State were collected and analyzed.

(4) Formal site visits were conducted at 12 inpatient psychiatric facilities, including 5 facilities classified as low users of restraint and seclusion and 7 facilities classified as moderate/high users of restraint and seclusion.

(5) A mail survey of individuals who had formerly received inpatient psychiatric treatment in New York was conducted to obtain a patient perspective on the use of restraint and seclusion, as well as their overall inpatient psychiatric treatment.

Major Policy Questions

Through the above research activities, the Commission sought answers to several basic questions regarding the use of restraint and seclusion in inpatient psychiatric settings:

(1) *What advice does the literature and research on the use of restraint and seclusion offer regarding the appropriate and therapeutic use of these interventions among adults in inpatient psychiatric treatment facilities?*

(2) *What is current practice among New York's state-operated and -licensed inpatient psychiatric settings related to the frequency of restraint and seclusion use?*

(3) *Are there readily identifiable factors pertaining to facility characteristics, formal policies, the patient populations served, or other treatment practices, which are associated with variations in psychiatric treatment settings' use of restraint and seclusion?*

(4) *Do current laws, regulations, and policies adequately protect patients in psychiatric facilities by ensuring the safe and appropriate use of restraint and seclusion? And, if not, what specific changes should be made?*

(5) *What do individuals who have been treated in inpatient psychiatric treatment settings in New York have to say regarding the use of restraints and seclusion? How do patients' perspectives appear similar to or different from the perspectives of clinicians on the use of restraint and seclusion?*

Organization of the Report

This initial report, *Restraint and Seclusion Practices in NYS Psychiatric Facilities* (September 1994), summarizes the Commission's findings related to the first three of the above research activities. This report describes the restraint and seclusion usage rates of New York's 25 state-operated psychiatric centers and its state-licensed psychiatric services in 103 general hospitals. Casting these findings against the backdrop of prior published research and also against the Commission's own analyses, this report also seeks explanations for the widely variant usage rates which were found.

Two other reports complete the Commission's reporting on its examination of restraint and seclusion practices in New York's psychiatric facilities. *Voices From the Front Line: Patients' Perspectives 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.

A third report, *Governance of Restraint and Seclusion Practices by NYS Law, Regulations, and Policy,* which will examine the governance of restraint and seclusion practices in New York's psychiatric facilities, will be issued later this year. The dedication of an entire report to this issue reflects the Commission's belief that existing statutory, regulatory, and state policy mandates governing restraint and seclusion use are inconsistent and inadequate and that 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.

Chapter II
Review of the Literature

Published works on the use of restraint and seclusion in psychiatric treatment settings are plentiful. This research, summarized in a recent report by the NYS Office of Mental Health (*Report on the Task Force on Restraint and Seclusion*, NYS Office of Mental Health, Appendixes III, IV, V, March 1993), has examined the use of these interventions from multiple perspectives.

Therapeutic Benefits

Much research has focused on the therapeutic benefits of the use of restraint and seclusion, with authors asserting various points of view ranging from strongly advocating the benefits of the interventions in preventing injury, reducing sensory stimulation, maintaining the ward milieu, and conserving staff resources (Gutheil, 1978; Fitzgerald and Long, 1973; Cotton, 1989) to advising cautious use of the interventions, noting that they have few therapeutic benefits and that they may, in fact, contribute to psychiatric problems of the patients (Pilette, 1978; Guirguis, 1978; Chamberlin, 1985; Hammill, et al., 1989; Monroe, et al. 1988; Outlaw and Lowery, 1992) (Figure 3).

At least three divergent points of view emerge on the therapeutic benefits/disadvantages of restraint and seclusion. One school of thought, represented in the works of Telintelo and his colleagues (1983), advocates for the use of restraint and seclusion as an "early intervention," suggesting that these interventions have a calming effect upon some patients, help to teach "internal controls," and generally provide a positive adjunct to a therapeutic treatment regime. Consistent with this permissive perspective on the use of restraint and seclusion, others have suggested that protection of the ward atmosphere and/or patient request are legitimate reasons for employing restraint and seclusion (Fassler and Cotton, 1992; Rosen, 1978; Tardiff and Mattson, 1984; Whaley and Ramirez, 1980, Liberman and Wong, 1984).

Figure 3
Three Schools of Thought on Restraint and Seclusion

- As early intervention strategies to:
  - reduce sensory stimulation
  - teach internal controls
  - protect property & treatment milieu
  - conserve staff resources
  - respond to patient requests
- As a "last resort" intervention to:
  - prevent patients from harming themselves or others
  - prevent patients from destroying property
- As intrinsically harmful to patients and nontherapeutic interventions:
  - advisable only in the most dangerous situations
  - signal "treatment failure"
  - require diligent clinical review

The second more popularly expressed point of view is that restraint and seclusion are necessary, last resort interventions in an inpatient psychiatric treatment setting to prevent patients from harming themselves or others or from destroying property. Advocates of this point of view (Outlaw and Lowery, 1992), while not suggesting that restraint and seclusion have intrinsic positive benefits, acknowledge that their use is sometimes imperative to prevent negative consequences of the patients' behavior that cannot be treated with other means. This is also the perspective which has been adopted by New York State and which has been codified in New York law and regulations governing the use of restraint and seclusion by state-operated and -licensed psychiatric facilities (NYS Mental Hygiene Law §33.04 and 14 NYCRR 27.1, 27.2, 27.7).

A third perspective is that the use of restraint and seclusion may be intrinsically *harmful* to patients, that these interventions should be considered *nontherapeutic*, and that their use should be avoided in all but the most threatening and dangerous situations. Proponents of this school of thought (Irwin, 1987; Pilette, 1978; Guirguis, 1978) usually advocate that psychiatric treatment units not be constructed with the availability of seclusion rooms and that every incident of restraint use be carefully reviewed, with specific attention to the patient's treatment plan, as the use of restraint is viewed as *indicative of treatment failure.*

An emerging body of literature has also focused on the therapeutic contraindications of restraint and seclusion use for certain vulnerable populations, including persons with compromised physical health (American Psychiatric Association, 1985; Tardiff, 1992), children (Kalogjera, 1989; Antoinette, et al., 1990; Susselman, 1973), and the elderly (Burger, 1993; Covert, et al., 1977; Blakeslee, et al., 1990; Evans, et al., 1991). These authors make various arguments that use of restraint and seclusion can be especially dangerous to the physical and/or emotional well-being of these patient groups. They advocate that the use of these interventions with these vulnerable populations be very restricted, diligently monitored and reviewed, and governed by strict practice guidelines.

Usage Rates for Restraint and Seclusion

Several researchers have also targeted their examinations to measuring the frequency of use of restraint and seclusion across different treatment settings (Angold, 1989; Okin, 1985; Phillips and Nasr, 1983; Soloff, et al., 1985; Way, 1986; Way and Banks, 1990). Without exception, these researchers have found that usage rates have varied widely and unpredictably across treatment facilities and often among treatment units within the same facility (Figure 4). The NYS Office of Mental Health's (1994) recently prepared summary of the literature identifies rates of restraint and seclusion use from .4% to 66% of the patients served across the various studies reviewed.

The Way and Banks study (1990) is particularly relevant to this report as the authors reported on February 1984 restraint and seclusion usage among 24 New York State psychiatric centers, including 22 nonforensic centers and 2 forensic centers.[2] The study found widely variant monthly rates among the nonforensic centers studied (3 to 213 "occurrences" per 100 patients), and an average usage rate of 9.5 occurrences per 100 patients. Subsequent follow-up data collected by the NYS Office of Mental Health in June 1992 revealed that although the census at the centers had decreased by approximately 43% in the interim eight years, the number of orders for restraint and seclusion had

[2] At the time the Way and Banks study was conducted (1984), New York had only 24 state psychiatric centers, as the state's third forensic center (Kirby Psychiatric Center) had not yet opened.

Figure 4
General Observations of Studies of Restraint and Seclusion Use

- Restraint and seclusion use varies dramatically among psychiatric facilities.
- ***Variations in restraint and seclusion use among psychiatric facilities cannot be readily explained.***
- Patients' characteristics are not reliable predictors of restraint and seclusion use.
- Facility characteristics are not reliable predictors of restraint and seclusion use.
- Time of day and day of week are not reliable predictors of restraint and seclusion use.
- No or low seclusion use is not a reliable predictor of restraint use (or vice versa).
- Low restraint or seclusion use is not consistently associated with greater use of medications.

remained virtually unchanged, resulting in an 80% increase in usage rates of the interventions. (*Report of the Task Force for Restraint and Seclusion*, NYS Office of Mental Health, 1994).

In general, however, comparative review of research studies on usage rates of restraint and seclusion is compromised by methodological issues, including the small samples of hospitals/units that are being studied and the different approaches in calculating usage rates (Gutheil, 1984; NYS Office of Mental Health, 1993).[3] Whereas the small sample sizes in all but a handful of studies (Carpenter, et al., 1988(b); Guirguis and Durost, 1978; Okin, 1985; Tardiff, 1981; Thompson, 1986; Way, 1986; Way and Banks, 1990) limit the validity of comparing usage rates within studies, the different methods employed by researchers in calculating restraint and seclusion rates yield very different usage rates, and comparing rates across studies based on different calculations is much like comparing apples and oranges.

It is significant, however, that most published studies which have examined usage rates of restraint and seclusion across more than five treatment settings or facilities have generally concluded that usage cannot be clearly associated with specific patient characteristics or needs (Okin, 1985; Way and Banks, 1990). The mixed findings of other studies, limited to a smaller number of treatment settings, also suggest that usage of restraint and seclusion may be largely independent of the treatment needs and characteristics of the patients.

[3] Researchers in the field have calculated rates using various numerators (e.g., patients involved, episodes of the intervention, physician orders) and denominators (e.g., average census, patients served, patient days, etc.). The choice of numerator is particularly significant as alternate choices measure fundamentally different aspects of usage. Use of "patients involved," for example, relates the prevalence of use among the patient population served, while use of episodes and orders measures the frequency and duration of use of the interventions in the particular treatment setting. Similarly, various denominators can alter rates significantly, especially in studies over a relatively long period of time, which include treatment settings with varying average lengths of stay. Conversely, when study intervals are kept short (less than 30 days), choice of denominator makes less of a difference.

Who is Restrained and Secluded?

Many researchers have also studied patients who have been restrained or secluded attempting to discern demographic and clinical characteristics which distinguish these patients from the majority of patients who are not restrained or secluded. Despite their number, however, these studies have yielded few consistent findings suggesting that any particular demographic or clinical patient characteristic is significantly associated with either restraint or seclusion use.

In studies, race, age, sex, socioeconomic class, diagnoses, length of stay, and different aspects of a patient's psychiatric or behavioral history have been shown to be both significantly and nonsignificantly associated with restraint and seclusion use (Binder, 1979; Bond, et al., 1988; Carpenter, et al., 1988(a); Flaherty and Meagher, 1980; Lawson, et al., 1984; Oldham, et al., 1983; Okin, 1985; Plutchik and Karasu, 1978; Philips and Nasr, 1983; Ramachandani, et al., 1988; Shuger and Rehaluk, 1990; Soloff and Turner, 1981; Tardiff, 1981; Thompson, 1986; Way and Banks, 1990). Similarly, the relatively fewer published studies which have examined the impact of certain characteristics of inpatient unit or the time of the incident, including average length of stay, size of the unit, high or low census, shift, and day of the week, have not demonstrated consistent findings (Binder, 1979; Gerlock and Solomons, 1983; Tardiff, 1981; Thompson, 1986; Way, 1986; Way and Banks, 1990).

Influence of Statutory, Regulatory, and Policy Mandates

Another smaller body of literature has sought to examine what happens to hospital practices when restraint or seclusion use is prohibited and, specifically, whether the prohibition of one intervention encourages increased use of the other intervention or of chemical restraints (Antoinette, et al., 1990; Miller, et al., 1989; Sloane, et al., 1991; Tsemberis and Sullivan, 1988). Again, the research findings are inconclusive, and it appears that the impact of such prohibitions are largely idiosyncratic to the hospital affected and other policy and value orientations that have transpired in the same interval.

At the same time, however, 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; Kalogjera, et al., 1989; Davidson, et al., 1984; Erickson and Realmuto, 1983). 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., 1988).

Clinical Practice Guidelines

There is also an emerging body of literature, especially in the past two decades, which focuses on guidelines for the appropriate use of restraint and seclusion (American Psychiatric Association, 1985; Bursten, 1975; Daar and Nelson, 1992; Halleck, 1974; Chu and Ryan, 1987; Mitchell and Varley, 1990; Roper, et al., 1985; Tardiff and Mattson, 1984). These various sets of guidelines tend to share some central principles, including 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 (Figure 5).

Most published guidelines also assert that restraint and seclusion are very restrictive inter-

Figure 5
Clinical Standards for Restraint and Seclusion Use

Commonly Accepted	*Debated*
✓ May be used only when there is a risk of harm to the patient or others.	? Length of restraint/seclusion orders.
✓ May **not** be used as punishment or for staff convenience.	? Types of mechanical restraints to be used.
✓ May be used only after less restrictive interventions have been tried and failed.	? Timeliness of physician exams.
✓ Orders must be signed by a physician.	? Safety features of seclusion rooms.
	? Frequency of patient breaks for bathroom use or exercise.
	? Required staff training.

ventions that should be used only when there is a risk of harm to the patient or others and only after other less restrictive interventions have been attempted. Notably, principles for the limited use of restraint and seclusion, only after less restrictive interventions have been attempted, have also been articulated and reaffirmed by federal and state courts in various court orders and consent decrees in class actions on behalf of institutionalized persons. (Wyatt v. Stickney, 344 F. Supp. 387 [(M. D. Ala. 1972)]; New York State Association for Retarded Children, Inc. v. Carey, 393 F. Supp. 715 [(E. D. N.Y. 1975)]; Youngberg v. Romeo, 457 U. S. 307 [(1982)]. Most states now also have state laws governing at a minimum the limited justifications for the use of restraint and/or seclusion (Brakel, et al., 1985).

Despite the consistency of federal and state guidelines on these basic principles guiding the use of restraint and seclusion, various states' regulations and policies, as well as clinical experts' suggestions for policy mandates, differ in many other respects (Naumann, et al., 1983). 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 (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

In short, despite its volume, the published literature on the use of restraint and seclusion leaves many unanswered questions and even more equivocally answered questions. Even on the most fundamental issues, including the "indications" for restraint and seclusion use, the patient populations which are most likely to benefit from the interventions, and the appropriate safeguards which facilities should ensure to protect patients from the inappropriate, punitive use of the interventions, there remains considerable debate among clinical experts.

Additionally, largely absent from the published research are reports which have posited reliable explanations for the dramatic variations in reported restraint and seclusion usage rates across hospitals or reports which have examined how more or less frequent restraint and/or seclusion use affects patient outcomes (Moss and LaPuma, 1991; Crespi, 1990). Simultaneously, the implication of much of the research that has been done is that: (1) hospital usage rates tend to be unrelated to their patient population characteristics; and (2) these rates can be easily influenced by specific administrative and programmatic changes affecting a hospital.

Reflective of the inconclusive clinical research, civil rights and mental health advocates have looked chiefly to federal and state courts, state legislatures, and executive state agencies to take the lead in developing guidelines for the use of restraint and seclusion in psychiatric treatment facilities. Yet, these government agents have generally been cautious in treading in this arena, and have continued to allow broad discretion to hospital staff regarding the use of these interventions. As a result, there continues to be wide and unexplained variations in the use of restraint and seclusion.