

Introduction to: Resource Document on the Use of Restraint and Seclusion in Correctional Mental Health Care

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It is well known that the number of persons incarcerated in prisons and jails in the United States has dramatically increased during the past two decades. On December 31, 2005, 1,446,269 inmates were in the custody of state and federal prison authorities, and 747,529 were in the custody of local jail authorities. When all forms of incarceration are included (e.g., facilities operated by or exclusively for the Bureau of Immigration and Customs Enforcement, juvenile facilities), there were nearly 2.2 million persons in prison or jail at year end 2005.¹

This increase has included a significant increase in the number of inmates with serious mental illness. Studies and clinical experience have consistently indicated that 8 to 19 percent of prison inmates have psychiatric disorders that result in significant functional disabilities and another 15 to 20 percent will require some form of psychiatric intervention during incarceration.²

The need for this document is summarized in the resource document. Additional reasons that this document is needed include the following:

It is all too common for the use of restraints in correctional settings for mental health purposes (i.e., an inmate requiring the use of restraints for behavior that is related to symptoms of his or her serious mental illness) to be treated as a security (i.e., custody) intervention. As a result, mental

health staff have little or no involvement in the assessment, monitoring, or subsequent treatment of the behavior that precipitated the need for such an intrusive and potentially dangerous (when improperly implemented) intervention.

Restraints used for custody purposes frequently result in transfer to, or occur in, locked down units, such as administrative or punitive segregation units. These units are rarely, if ever, clinically appropriate for inmates requiring the use of restraints for mental health purposes for reasons that include the absence of a therapeutic milieu, lack of reasonable access to health staff for monitoring and treatment, and an environment that often exacerbates the inmate's underlying condition that leads to the need for restraints.

Even when it is recognized by staff that restraints are being used for mental health purposes, the field of correctional mental health has lacked clear guidance concerning the standard of care to be applied for such an intervention. Without such guidance, it has been very difficult for many mental health staffs to advocate effectively for needed physical plant and staff resources to implement practices consistent with the standard of care. Not surprisingly, similar to the experience in free society, when the standard of care increases the required frequency and nature of the monitoring and emphasizes alternative interventions, the frequency and duration of the use of

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restraints for mental health purposes decreases significantly.

Implementation of the guidelines summarized in this resource document is likely, for many correctional facilities, to require additional staffing resources, physical plant renovations, and training of health care and correctional staffs regarding the process involved for using restraints and/or seclusion for mental health purposes. Such training should focus on clinical indications for use of these intrusive interventions, assessments, restraint and seclusion techniques, monitoring and documentation, and the rationale for these measures to occur in a health care setting.

This resource document was produced as part of an effort to revise the first edition of the American Psychiatric Association's Task Force Report No. 22, *Seclusion and Restraint: The Psychiatric Uses*,³ published in 1985.

References

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