

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

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This resource document discusses the use of seclusion or restraint for purposes of mental health intervention in correctional facilities. Correctional mental health standards essentially state that seclusion or restraint, when used for health care purposes, should be implemented in a manner consistent with current community practice. The community practice was significantly impacted and revised during July 1999, after the Health Care Financing Administration defined rules for the use of seclusion and restraint in facilities that participate in Medicare and Medicaid. Since few correctional facilities are Medicare or Medicaid participants, these rules had little impact on the use of seclusion or restraint for mental health care purposes in correctional systems. Consequently, many correctional health care systems have not developed policies, procedures, or practices that are consistent with current community practice. This document provides guidance in remedying such problems, with a focus on areas relevant to timeframes, settings, and monitoring.

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This resource document discusses the use of seclusion or restraint for purposes of mental health intervention in jails and prisons, in contrast to its use for correctional purposes (i.e., specifically, custody reasons). The use of seclusion or restraint for mental health reasons is an emergency measure to prevent imminent harm to the patient or other persons when other means of control are not effective or appropriate.

The use of seclusion or restraint for correctional purposes is generally driven by classification and disciplinary issues unique to the correctional setting. For example, an inmate's security classification may

require the use of handcuffs and leg irons (i.e., restraints) during movement outside of the inmate's cell or housing unit. Restraints may also be used by custody staff to control an inmate's assaultive behavior that is not related to mental illness. With few exceptions, cell extractions (both calculated use of force and on an emergency basis) by custody staff are governed by custody policies and procedures, even when they involve mentally ill inmates. However, there are generally special provisions in such policies and procedures when such a use of force involves the mentally ill inmate that usually includes attempted assessment/intervention by mental health staff prior to the use of force. Disciplinary segregation has many characteristics similar to seclusion, such as confinement to a cell and restricted access to personal belongings. Custody guidelines for using these security measures are generally very different from those relevant to the use of seclusion or restraint for mental health purposes and will not be addressed in this document.

This Resource Document was produced by a workgroup of the American Psychiatric Association's Council on Psychiatry and Law, and reviewed and approved by the Council in September 2006. It was approved by the Joint Reference Committee of the American Psychiatric Association in December 2006. The findings, opinions, and conclusions of this report do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association. Views expressed are those of the authors. Address correspondence to: Jeffrey L. Metzner, MD, 3300 East First Ave., Suite 590, Denver, CO 80206. E-mail: jeffrey.metzner@uchsc.edu

It is clear that there is a national movement to reduce the use of seclusion or restraint in mental health treatment, which is facilitated by treatment programs that focus on a plan of care that minimizes the need for it.¹ The importance of establishing a therapeutic culture to partner with the patient for safety rather than to control the patient for safety has been emphasized. Assessment and treatment planning measures should focus on patient-specific approaches to the prevention and management of behavioral emergencies. Patients should participate in the treatment planning process to ascertain successful crisis resolution measures that are based on the patient's psychiatric condition, prior experience with behavioral emergencies, and risk for future harm.

Several major mental health organizations joined together to produce a useful guide to reducing seclusion and restraint, "Learning from Each Other: Success Stories and Ideas for Reducing Seclusion and Restraint."² The appendix to that document includes a set of sample forms and checklists covering core skills and knowledge for direct care staff, patient-reported therapeutic interventions, de-escalation tips, and information relevant to the use of seclusion and restraint. The National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council³ and the National Technical Assistance Center for State Mental Health Planning⁴ have also produced very useful publications aimed at reducing the use of seclusion and restraint.

The efforts in recent years to minimize the use of seclusion and restraint of persons with mental illness have been a positive development. However, the nature of severe mental illness is such that seclusion and restraint cannot be eliminated as a necessary part of treatment and management. Therefore, it is crucial that there not be an expectation that seclusion and restraint be abolished in correctional mental health. Staff must feel that they are permitted to use seclusion and restraint when it is clinically necessary for the welfare and safety of the patient, other patients, and the staff. If staff are made to feel that these procedures should never be used and that using them, no matter what the circumstances, indicates that staff have done something very wrong and have failed in their jobs, they will be inclined to avoid seclusion and restraint, even when it was the best alternative for the situation. The unintended consequences may include unnecessary injuries to the patient, to other

patients, and to the staff. Once it becomes known that a treatment setting has become a dangerous place to work, retaining and recruiting good staff to work there becomes very difficult. Experience has shown that under such circumstances, the quality of the treatment environment deteriorates.

The Need for This Resource Document

The second edition of a Task Force Report of the American Psychiatric Association, entitled "Psychiatric Services in Jails and Prisons,"⁵ reiterates that principles and guidelines in the Task Force's publication are intended to supplement the standards published by the National Commission on Correctional Health Care.^{6,7} These standards essentially state that seclusion or restraint, when used for health care purposes, is implemented in a manner consistent with current community practice. However, little guidance is provided regarding current community practice, especially in terms of relevant timeframes or settings where inmates in seclusion or restraint should be housed.

Community practices pertinent to the use of seclusion or restraint for mental health purposes may vary across jurisdictions because of differing rules and regulations promulgated by the state Department of Mental Health or equivalent agency. Relevant rules and regulations were significantly impacted and revised during July 1999, after the Health Care Financing Administration (HCFA), now called the Center for Medicare and Medicaid Services (CMS), defined rules for the use of seclusion and restraint in facilities that participate in Medicare and Medicaid.⁸

Since few correctional facilities are participants in the Medicare or Medicaid systems, the rules established by CMS concerning the use of restraint and seclusion had little impact on use for mental health care purposes in correctional systems. As a result, many correctional health care systems have not developed policies, procedures, or practices that are consistent with the current community practice. In addition, the frequent lack of meaningful external review or oversight in many correctional facilities regarding their mental health care practices has contributed to correctional facilities' not keeping pace with prevailing community standards. When correctional health care systems use seclusion or restraint for health care purposes, they should be held to a similar standard of care as community health facili-

ties, just as correctional facilities are not permitted to perform intrusive medical interventions unless they are done in a manner consistent with the community standard in appropriate health care settings.

General Principles

General issues, indications, and contraindications for the mental health use of seclusion or restraint in noncorrectional mental health facilities and specific techniques are summarized in Appendix I. When seclusion or restraint is used as a mental health intervention, the principles described in Appendix I almost always apply, with a few exceptions that will be addressed below. The exceptions are related to certain differences between correctional and community health care settings.

Issues Unique to the Correctional Setting

Location

The first major issue specific to the correctional setting involves where the incarcerated person (hereinafter referred to as an “inmate”) is secluded or restrained for mental health purposes. This setting in jails and prisons nationwide may appropriately include hospitals, infirmaries, and/or special housing units (often referred to as residential treatment units, intermediate care units, special needs units, or extended outpatient units) within the correctional setting for inmates with serious mental illnesses.

When an inmate is secluded or restrained in a hospital setting, the rules promulgated by CMS should be followed, regardless of where the hospital is located or what agency administratively operates the hospital.

When an inmate is secluded or restrained in a nonhospital setting, the seclusion or restraint should nonetheless occur within a health care setting. The most common such setting is the prison or jail infirmary, which is generally characterized by 24-hour coverage by nurses whose mission is to provide health care assessments/treatment for inmates requiring a more structured medical setting than is available elsewhere in the correctional institution. The guidelines relevant to the design of the seclusion or restraint room in hospitals are applicable (see Appendix I), although the security requirements of a correctional facility will also impact the physical characteristics of the seclusion or restraint room.

The use of seclusion for clinical reasons is unusual in a correctional infirmary because it is common practice, due to security regulations, for an inmate to essentially be locked down (i.e., secluded for custody purposes) in his or her infirmary cell throughout the course of treatment, which is generally short-term in nature (i.e., less than two weeks). However, some states license correctional infirmaries and specifically prohibit such a routine practice, although exceptions are allowed. Under such circumstances, the guidelines described in this resource document relevant to seclusion would be applicable or the correctional facility would at least need to be compliant with the relevant licensure requirements.

Seclusion or restraint in special housing units for inmates with mental illness can be implemented in a clinically appropriate way, although it is often more logistically difficult to do so because of the physical plant of many of these housing units. In addition, many special housing units for inmates with mental illness are not staffed around the clock by nurses. The guidelines relevant to the use of seclusion or restraint in correctional infirmaries are applicable to these special housing units. In other words, if seclusion or restraint is used in these special housing units, staffing requirements such as 24-hour nursing will need to be available in order to implement the relevant policies and procedures.

It is not clinically appropriate to use locked-down units (housing unit where inmates are generally locked in their cells for 22 to 23 hours per day, for disciplinary or administrative reasons) such as administrative, disciplinary, or punitive segregation housing units for inmates with mental illnesses who require the use of seclusion or restraint for clinical reasons. These units do not provide a supportive or therapeutic environment, and the environmental conditions often exacerbate the clinical condition of the inmate requiring seclusion or restraint. In addition, these units are not adequately staffed by nursing or other health care staff for monitoring and treatment purposes.

Property

Unless clinically contraindicated, which should be infrequent, inmates secluded or restrained should have a mattress, blanket, and clothing. The nonflammable mattress should be constructed of durable foam and not fiber or other substance, which the patient could use for self-harm purposes. Clothing

may consist of paper gowns or so-called suicide smocks, which are essentially tear-resistant blankets that are designed to be worn as clothing.

Timeframes

As described in Appendix I, the Center for Medicare and Medicaid Services (CMS) has defined rules for the use of seclusion and restraint in facilities that participate in Medicare and Medicaid⁸ that have provided a framework for a national standard for the use of seclusion and restraint in psychiatric facilities. CMS guidelines specify that, absent immediate need to protect the patient or others from substantial harm, a physician or “licensed independent practitioner” (LIP) must be the one to order and monitor restraint and seclusion.

The major departure from the guidelines summarized in Appendix I involves the time parameters related to the initial face-to-face assessment by an appropriately credentialed mental health clinician. This resource document recommends that the initial face-to-face assessment by a licensed independent professional occur within four hours of the actual seclusion or restraint. All physicians and other licensed independent professionals (LIPs) should be appropriately trained in the use of seclusion and restraint. If the LIP is not a physician, consultation should be obtained by the LIP with a physician appropriately trained in the use of seclusion or restraints, within the same four-hour timeframe.

Face-to-face assessments should occur at least every 12 hours after the initial assessment and should be performed by an appropriately trained and credentialed physician, LIP, or registered nurse. If the assessment is not performed by a qualified physician, one should be consulted. A qualified physician should do a face-to-face assessment at least every 24 hours if the inmate remains in restraints or seclusion. Very brief periods of release do not reset the “clock” for assessments. Consultation by another psychiatrist, when feasible, should be obtained for inmates requiring prolonged periods (e.g., >24 hours) of seclusion or restraint.

A variety of restraint devices exist on the market. Steel restraints (e.g., handcuffs), although acceptable for use when the indications are custody issues, should rarely be used for mental health purposes. The use of a device commonly referred to as a “restraint chair” is much more frequent in correctional settings as compared to community hospital settings.

The main advantage of this device (i.e., mobility, which allows the restraint to occur in many different settings in contrast to just being limited to an appropriately constructed seclusion or restraint room) is also its major disadvantage. Specifically, the restraint chair is often used in a housing unit where the environment is not supportive and staff are not trained or experienced with the use of restraint. This is one of the reasons that the use of restraints for mental health purposes in a correctional setting should occur within a health care setting in contrast to a nonhealth care custody setting such as an administrative segregation housing unit. Proper procedures are less likely to be followed in such circumstances, which increases the likelihood of an adverse outcome.

Policies and procedures concerning the use of seclusion or restraint for inmates with mental illness need to be in written form as part of the health care policy and procedures manual. The initial order for the use of seclusion or restraint should be obtained within one hour of their use, from a licensed independent practitioner, preferably a physician, although seclusion or restraint can be initiated by nursing staff under emergency conditions prior to receiving the actual order from an LIP. Training and retraining of health care and correctional staff who will be involved in the seclusion or restraint procedure are required. This is particularly crucial in terms of the technique of actually restraining an inmate and the subsequent observations/interventions that are required, such as range of motion exercises and clinical assessments.

Logbooks should also be maintained of the use of seclusion or restraint for mental health purposes, which will facilitate quality improvement reviews. The logbooks should identify the inmate being secluded or restrained, reason for such intervention, duration of the intervention, and other pertinent data.

Appendix I

In 1999, the Health Care Financing Administration (HCFA), now called the Center for Medicare and Medicaid Services (CMS), defined rules for the use of seclusion and restraint in facilities that participate in Medicare and Medicaid.⁸ The final rule states that restraint use must be in accordance with safe and appropriate restraining techniques and selected only when other less restrictive measures have been found to be ineffective in protecting the patient or others from harm.

Other indications for seclusion and restraint include the following:

To prevent serious disruption of the treatment program/milieu or significant damage to the physical environment, and

For treatment as part of an appropriately approved, initiated, and monitored plan of behavior therapy.

CMS interpretive guidelines make it clear that for restraint used for behavioral/psychiatric purposes,

... it is important to note that these requirements are not specific to any treatment setting, but to the situation the restraint is being used to address. Further, the decision to use a restraint is driven not by diagnosis, but by comprehensive individual assessment that concludes that for this patient at this time, the use of less intrusive measures poses a greater risk than the risk of using a restraint or seclusion (Ref. 9, p 94).

Some reasons to consider seclusion or restraint include, but are not limited to the following:

Signs or symptoms associated with significant danger to others, including threats and intimidation of staff or other patients, which are not immediately manageable by less restrictive means;

Severe agitation for which medication is inadequate, unavailable (e.g., because of patient allergy or adverse effects), or has not yet taken effect;

Disruption of the clinical or residential milieu sufficient to interfere with the rights or well-being of patients or staff, for which less restrictive interventions are either inadequate or truly not feasible (that is, beyond mere staff or patient inconvenience);

Dangerous, agitated, or disruptive behavior of unclear origin, for which seclusion or restraint is likely to be safer than medication or other measures because of insufficient knowledge about the patient's medical condition;

Intractable behavior or impulse control problems for which a specific form of seclusion or restraint is part of an approved behavior modification program;

Repeated, or repeatedly threatened, significant damage to others' property for which less restrictive measures are inadequate or not feasible; and

Situations in which immediate control of the patient is necessary to protect the patient's or others' significant interests, but for which less restrictive measures are inadequate or not feasible (e.g., controlling severe agitation or manic behavior while waiting for calming medication to take effect.

Some reasons to consider not ordering seclusion or restraint include, but are not limited to the following:

A patient's marked panic at being restrained;

A patient's marked proneness to claustrophobia in a seclusion room;

Unavailability of sufficient qualified staff to monitor the secluded or restrained patient (including constant monitoring of a suicidal patient in seclusion or a patient whose general medical condition is unclear);

Unavailability of a seclusion room that is sufficiently free of ways in which the patient may injure himself;

In contemplating use for behavioral programs, insufficient consideration by appropriately trained and experienced professionals of the risks and benefits of seclusion or restraint and consideration of other available measures; and

Staff requests for seclusion or restraint that the ordering clinician believes may be related to neglect, abuse, insufficient consideration of alternative measures, or mere staff convenience.

Seclusion or restraint for intimidation of others or milieu disruption requires more discrimination than that for actual assault or agitation. Behaviors such as screaming, public masturbation, intrusiveness, or fecal smearing may constitute indications for restrictive measures, but the extent to which they actually affect others or interfere with their care requires careful consideration. Seclusion or restraint for protective reasons (as contrasted with approved behavioral programs) is not primary treatment in itself, and does not take the place of efforts to understand and address the causes of the aberrant behavior.

In most uses of seclusion or restraint, the staff should have considered or tried less restrictive means of control, such as verbal, environmental, or pharmacologic interventions. Staff should be trained, encouraged, and supervised to understand and engage with their patients. The treatment environment and individual treatment programs should "fit," and be able to tolerate, the symptoms and behaviors expected of patients with various disorders common to that unit.

The use of medication as an alternative to seclusion or restraint is different from its use in treating underlying symptoms or disorders. The latter should not be seen as, or compared to, a form of "restraint." Drugs are considered a restraint under CMS regulations only if the drug used is not a standard treatment for the patient's medical or psychiatric disorder. Standard treatments include use of the medication for its labeled indications, use of the medication that follows national practice standards, and use of the medication ordered by the prescriber for the patient's individualized needs. A medication that is not being used as a standard treatment for the patient's medical or psychiatric condition and that results in controlling the patient's behavior and/or in restricting his or her freedom of movement would be a drug used as a restraint under the regulations.⁹ Context and individual patient circumstances should be carefully considered in the weighing of risk and benefit when using a drug to treat the symptoms underlying episodes of patient aggression.

The use of seclusion and restraint as part of an approved and monitored behavior treatment program should be used infrequently. Such use differs from the other indications, in that it is planned beforehand and monitored so as to attempt long-term change in the patient's behavior or psychopathology rather than simply addressing immediate concerns.

Contraindications

Seclusion or restraint may be contraindicated in patients with certain clinical conditions (such as unstable medical status, known or suspected intolerance for immobility, conditions in which restraint positioning is contraindicated, some dementias and deliria, some paranoid conditions, and anxiety syndromes). In addition, some posttraumatic syndromes (including those following torture, kidnapping, or severe sexual abuse) can increase a patient's vulner-

ability to traumatic re-experiencing or sensory deprivation, making either seclusion or restraint (or both) very difficult to tolerate.

Seclusion as a purely punitive response is contraindicated in clinical settings. Similarly, patients should not be secluded solely for the comfort or convenience of the staff or for mere mild obnoxiousness, rudeness, or other unpleasantness to others that does not significantly interfere with their rights or treatment.

Seclusion Room Design

Clinicians and direct care staff should be aware of the real and potential hazards of seclusion rooms. Poorly designed ones can be relatively dangerous to patients, particularly those left unattended. Suicide and other harm is more likely in seclusion rooms than in many other locations on inpatient units, for reasons related partially to architecture and partially to the characteristics and higher acuity of patients confined there. Useful guidelines have been published by the National Association of Psychiatric Health Systems which address such things as fixtures, temperature control, lighting, and patient visibility in seclusion rooms and restraint settings.¹⁰

In general, the room should be empty, with a high ceiling (more than nine feet) and fixtures that are recessed sufficiently that they cannot be either damaged or used by the patient for self-harm. Temperature and lighting (with security fixtures) should be adequate, with sufficient privacy but good access to the nursing station. The room should be without sharp corners. Walls and ceilings should be made of material that cannot be gouged out or picked apart by patients who are intent on harming themselves. Sheet rock, plaster board, and ordinary tufted mats, for example, are not acceptable. Padded walls can be used, provided the integrity of the material used is high and the surfaces clean; there are insufficient data to warrant specific materials recommendations, except to say that the materials used must take into account foreseeable risks to the patients who will be confined.

The door should open outward, so that the patient cannot barricade himself inside. Protuberances, such as knobs, fixtures, or ledges, should not be present in the room. Each room must permit staff observation of the patient while still providing for patient privacy. Windows, which are recommended for lighting and to reduce isolation, must be constructed of Plexiglas®- or Lexan®-like material (or otherwise adequately shielded) and take safety and privacy into account. The mattress should be the only furnishing in the room; a bed, even when bolted to the floor, poses a number of dangers. The mattress should be constructed of durable foam, not fibers or other substances that the patient might use to hang or otherwise injure himself and should not be flammable or emit noxious fumes when heated. Any lock on a seclusion room must be controlled by staff at the door location and must unlock when released by the staff person.

Restraint room design is very similar to the seclusion room, with the exception of a bolted bed specifically designed for restraint purposes.

Timeframes

Initiation of a restraint procedure or placement of a patient in seclusion is usually an emergency procedure carried out by nursing and other professional staff in accordance with established hospital policy. CMS guidelines specify that, absent immediate need to protect the patient or others from substantial harm, a physician or licensed independent practitioner (LIP) must be the one to order

and monitor restraint and seclusion. CMS describes such clinicians as being trained in emergency care techniques and licensed by their state to write such orders. According to CMS, a patient should be seen face to face by the physician or licensed independent practitioner within one hour after initiation of restraint or seclusion. If a patient is released from seclusion before the initial assessment, the LIP must still render an evaluation within that first hour. The behavioral standard also requires that written orders for physical restraint or seclusion be limited to four hours for adults, two hours for children and adolescents aged 9 to 17, and one hour for patients less than 9 years old. After the first specified time period, new orders for further restraint or seclusion (of similar duration) are required, which may be given on the basis of information conveyed by telephone, without face-to-face evaluations, and repeated for up to 24 hours.¹¹

Some patients require face-to-face visits more frequently than others. Examples include those with significant concurrent medical problems, dementia or delirium, and significant intoxications, and restraint situations in which hyperthermia may occur. Some patients must be restrained or secluded for more than 24 hours. In such instances, a senior medical administrator, such as the chief physician of the institution or a qualified designee should review the treatment plan and concur that additional restraint or seclusion is necessary. In general medical facilities with psychiatric divisions, this person may be the chief psychiatrist.

It is recommended that orders be time and behavior specific, with a stated goal (e.g., "four-point restraints until patient is no longer agitated and combative, up to one hour"). Standing orders for restraint or seclusion should not be allowed. The clinician must document in the patient's record the failure of less restrictive alternatives or why they are inappropriate to attempt and the justification for continued seclusion or restraint. This decision should take into account the mental and physical status of the patient, his or her degree of agitation, the potential adverse effects of seclusion (both physical and emotional), and relevant other factors. Debriefing at the end of the episode, of staff at least and the patient when feasible, is important and should be well documented.

Restraint and Seclusion Techniques

Although there are no specific national protocols for restraint and seclusion technique, there are a number of common threads among acceptable procedures. First, the techniques practiced within a particular facility should be rehearsed and approved by the staff, including the relevant chief of service. If a particular technique and modality, such as four-point leather restraints, is viewed as usual practice, that should be specifically noted in the facility policy manual. Details of the technique should be disseminated to members of the clinical and direct care staff as part of service training. Written instructions, photographs, and videotapes are desirable.

Even patients at low risk of suicide should always be searched before being placed in seclusion. Agitated or violent patients may become self-destructive or self-mutilating when isolated.

Any need for seclusion or restraint should be part of the patient's treatment plan. With regard to the treatment plan, however, one should recognize that seclusion or restraint are usually emergency procedures that cannot be anticipated in many treatment plans unless there is a history of previous restrictive needs. That having been said, when clinically feasible, patients should be informed

about restrictive procedures and policies during the admission and orientation process.

Once the decision has been made to proceed with seclusion or restraint, a seclusion or restraint leader is chosen from available staff. When feasible or necessary for safety, the team should consist of at least one trained staff member per limb, including the head. Staff should convey an air of united confidence, calm, and measured control, reflecting a professional approach to a routine and familiar procedure. A seclusion monitor should be designated to clear other patients and physical obstructions. The monitor should remain clear of the physical activity to objectively observe the process and note any injuries or difficulties. This promotes accurate critique after the event.

Confrontation of the patient should begin with a clear communication of purpose and rationale for the seclusion or restraint. The patient should be given a few clear behavioral options without undue verbal threat or provocation. For example, the patient may be told that his or her behavior is out of control and that a period of seclusion is required to help him or her regain control; then, the patient is told to walk quietly to the seclusion room accompanied by staff.

This is not the time for negotiation or psychodynamic interpretation. Since the decision for seclusion or restraint has already been made, any further negotiation is superfluous and may lead to more disruptive behavior and/or aggravation of violence.

At this point, the team should position itself around the patient in such a manner as to allow rapid access to the patient's extremities if necessary. If the patient does not do as he or she is told, then at a predetermined signal from the leader, physical force commences, using techniques previously learned and practiced for their effectiveness and low likelihood of injury to either patient or staff. Each staff member seizes and controls the appropriate part of the patient and each limb is restrained at the joint. The patient's head should be controlled to prevent biting. With the patient completely controlled on the ground, additional staff may be called to secure the limbs and prepare to move the patient to the seclusion room or apply mechanical restraints. In very violent cases, staff may have to carry the patient into the seclusion room. This involves lifting the patient in the recumbent position with his or her arms pinned to the sides, legs held tightly at the knees, head controlled, and force applied uniformly to support the back, hips, and legs.

If the patient is taken to seclusion, he or she should be positioned on his back with the head toward the door. An assessment should be made regarding whether to remove his or her clothing and put on a seclusion-safe hospital gown. Special attention should be paid to rings, belts, shoelaces, and other potentially injurious objects. Medication may be given while the patient is physically restrained. The staff then exits in a coordinated fashion, one at a time, releasing the legs before the arms.

In acute restraint, a face-down posture is often safer because the patient is less apt to bite or aspirate, although the risk of positional asphyxia is increased. Monitoring breathing adequacy is critical to any restraint process. Compromised breathing is a particular risk in obese patients or those with a medical condition that can cause obstruction (such as a large goiter). Such patients should be restrained face up. Staff should also be cautious about placing knees on any patient's back, which can compromise breathing.

A debriefing follows each seclusion or restraint maneuver to review the technique and progress of the event and allow release of

staff feelings and tension. The event should also be discussed openly among the patient population, to uncover and allay their concerns associated with both the patient's behavior and the staff's use of force. The patient should also be asked later about the experience, including whether it contributed to or worsened his or her sense of control. The entire seclusion or restraint episode should be scrupulously documented, in detail, in the patient's chart and on appropriate facility forms.

Observation and Patient Protection

Patients in a restraint that prevents moving about (such as the four-point restraint), is combined with seclusion, may compromise breathing or circulation, or makes them vulnerable to abuse by other patients should be continuously observed. Continuous monitoring is also recommended for patients in seclusion, especially those who are intoxicated, psychotic, severely depressed, reasonably likely to be suicidal, known to be prone to self-injury, or unfamiliar to staff. In no event should a secluded patient be monitored less than every 15 minutes.

Documentation of observations should be continuous and contemporaneous (i.e., done at the time of the observation). Staff should be cautioned not to fill in monitoring checklists in advance, or to complete them all at once at the end of a shift or monitoring period.

Continuous video monitoring of patients in seclusion is common, but should not be the only form of monitoring unless a staff person is specifically assigned to watch the screen continuously, and the screen itself should be placed in an area conducive to patient privacy. Simply having the screen in a nursing area and expecting staff to check it is not sufficient.

Documentation of visual observation (not the same as periodic assessments, discussed below) should note the time and identity of the observer and comment briefly on the patient's general appearance and behavior and whether any problems or injuries are apparent (such as gross indications of exhaustion, overheating, or soiling).

Care of Patients in Seclusion or Restraints

When agitated patients are approached in the seclusion room, the same number of staff should enter the room as were required to safely control the patient earlier (e.g., one for each extremity). Once the patient is calm, and after considering staff safety, direct observation may be made with the seclusion room door open. This allows for better observation and communication and decreases the restrictiveness of the intervention.

To ensure the continuation of adequate circulation, nursing staff should physically check each extremity every 15 minutes for at least the first two hours of restraint. Every two hours, nursing staff should perform an assessment of the patient, including condition of skin and circulation, need for toileting, personal hygiene, and proper application of the restraint. Documentation of the two-hour evaluations should summarize the patient's overall physical condition, general behavior, and response to counseling/interviews. Vital signs should be taken at least every eight hours.

Range of motion exercises should be performed every two hours unless the patient is too agitated or assaultive for safe removal of the restraints. For range of motion exercises, restraints on each extremity shall be removed, one at a time. Performance of range of motion exercises shall be clearly documented and as well as the patient's behavior, respiration, and responsiveness. If range of motion exer-

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cises are not performed, nursing staff shall clearly document the reason.

Fluids and nourishment should also be provided every two hours except during hours of sleep. The patient's head and shoulders should be elevated, if needed, while being fed or receiving fluids, to reduce the risk of aspiration.

Toileting of the patient should be provided at least every four hours and more often if necessary. If the toilet facilities are outside the restraint or seclusion area, and/or safety concerns suggest that release would be unnecessarily dangerous, a urinal or bed pan should be used with appropriate considerations of both privacy and safety.

Fluids are vital for patients in restraint or seclusion, particularly those who perspire profusely or are otherwise prone to dehydration. Documentation of fluid intake, though often difficult with regressed patients, is required.

Meals should be brought to the patient at regular intervals when the other patients are served. All utensils should be blunt and unbreakable; plastic knives and forks can be used as weapons. Remember that some foods can be used as a weapon. In certain rare instances, such as with severely regressed patients, a food tray may be placed within the patient's reach without a staff person present. (The rationale for this solitary meal procedure should be documented in detail in nursing notes; meals should be a time of interaction between patient and staff whenever reasonably possible.)

Patients in restraint and seclusion may exhaust themselves from the physical activity of pushing or pulling against restraint devices or walking or running around the seclusion room. Attention must be given to the possibility of dangerous fatigue or dehydration, especially in older, obese, or medically compromised patients; those whose medications make them prone to poor temperature regulation; and those in high-temperature environments.

Some patients soil themselves in the process of menstruation, incontinence, or vomiting, or have other conditions that create some level of embarrassment or repugnance to themselves or others. While rarely dangerous, such conditions often cause feelings of humiliation to the patient and avoidance by others. It is important that such patients not be ignored or neglected, and that the problem is handled without unnecessary stigmatization.

Both seclusion and restraint can contribute to worsening of psychiatric symptoms, especially anxiety, isolation, and psychosis. Some level of sensory stimulation is inherent in most restrictive measures. This should be considered when discussing the possibility of future restriction upon admission and when choosing a mode of restriction when the patient's behavior requires it. The emotional impact of seclusion, for example, may be discussed with the patient, when feasible, during the experience and may be one of the topics addressed in the patient debriefing after release. Such discussions may help reduce adverse effects and prevent painful memories.

It is very important not to underestimate patients' abilities to find ways to harm themselves while in seclusion. The danger can be mitigated with careful attention to the construction of the room, attention to patients' clothing and possessions while confined, and close staff monitoring.

Decisions and Procedures for Removal from Seclusion and Restraint

Patients should be released from seclusion or restraint when the goals of the intervention have been achieved, and safety for the

patient and others can be reasonably assured. In some cases, the patient's ability to control his or her behavior can be inferred from observations during seclusion or restraint. In others, risk must be estimated in other ways. Each time staff enter or otherwise interact with the patient (e.g., feeding, bathing, or examining), the patient's behavior, responses to requests or demands, and verbal interchange may offer important clues to his affect and impulse control.

Removal from restraint and/or seclusion does not have to be abrupt. Graduated steps are often safer and allow staff to judge the safety and appropriateness of further decreasing the restriction. Restraints may be partially removed at first, or the seclusion room door opened while the patient is closely monitored.

Staff Training

Staff should be trained in the necessary safety precautions for all secluded or restrained patients, not just those with known or suspected contraindications. A training and certification process should be in place, with documentation that every staff member who will ever participate in a restraint or seclusion episode is recertified annually. The training should include hands-on experience with experienced instructors.

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