

Commentary: On Regulation, Wishfulness, and Denial

John R. Lion, MD

Restraint and seclusion are unsavory topics within a discipline that cherishes verbal interventions. As such, the principles of use are haphazardly taught by in-house clinicians or private agencies. Policy standards were published in the 1980s, but they have not been officially updated, despite the fact that an American Psychiatric Association (APA) committee met in 2003 to overhaul the standards of care. In training programs, violence is given little syllabus space, compared with the treatment of mood and thought disorders. Aggression remains a stepchild symptom, even though it is frequently encountered in clinical practice.

J Am Acad Psychiatry Law 39:477–9, 2011

Few interventions in psychiatry have as dark a history as restraint and seclusion, and few continue to be as controversial. The subject will not go away, despite the dismay of regulatory agencies and family bystanders who are appalled to watch us physically grapple with the agitated states of those whom we commonly treat in hospital settings.

To enter the world of restraint and seclusion is to confront a host of fantasies on the part of those who review the behaviors. Well-distanced administrators throw up their hands in horror when a patient misbehaves. The patient should have been talked to, or time-outs should have been applied, or more or different medications should have been used, or the patient should not have had access to the ping-pong racquet that he ended up using as a weapon. During a heat-of-the-moment outburst, staff react, sometimes badly, but their own security is at stake. The balance between patient rights and staff safety is often skewed in favor of the former. Part of this is understandable, as staff are not patients; furthermore, they are hired and trained specifically to avoid violence, although it should be noted that there are no discipline-wide, standardized, training programs in aggression management. Assault prevention courses are typically taught in-house or by commercial organizations such as the Crisis Prevention Insti-

tute (Milwaukee, WI). This does not have to be the case. The American Psychiatric Association could enact membership training and certification for assault prevention much like the Red Cross sets practices for resuscitation. The problem, I believe, is that the American Psychiatric Association does not want to associate itself to any meaningful depth with the problem of violence, preferring instead to embrace the behaviors associated with the nobler mood disorders or the primary symptoms of thought disorders. In the early 1990s an American Psychiatric Association Task Force on Clinician Safety¹ discovered a disconcertingly high number of assaults on mental health workers of all disciplines. A request was raised to make the task force a standing committee, but the request was denied. Restraint and seclusion merit no less consideration as a concern within the profession.

The problem of violence prevention goes even deeper. Even today, most residency training programs do not expose trainees to jails or prisons where violence is the norm. In jail, correctional officers expect violence. They wear radios to summon help, and some carry pepper spray. Aggression is the expectation. A psychiatric ward should be a world away, but sometimes it simply is not. In their comprehensive article, Recupero *et al.*² make reference to the publication of restraint and seclusion standards for correctional facilities.³ The evolution of this publication is complex. In 2003, the American Psychiatric Association reactivated a former Task Force on Restraint and Seclusion that was first convened in the 1980s. The original group, in 1984, authored comprehen-

Dr. Lion is Clinical Professor of Psychiatry, University of Maryland School of Medicine, Baltimore, MD. Address correspondence to: John R. Lion, MD, 2 Village Square, Suite 217, Baltimore, MD 21210. E-mail: newtlion@aol.com.

Disclosures of financial or other potential conflicts of interest: None.

sive recommendations on use of the practice.⁴ Since 1984, conflicting regulations have been established by the Center for Medicare Services (CMS) and The Joint Commission (TJC) regarding time and monitoring parameters (i.e., how long after a restraint incident should a physician review the event?). Thus, the reconvened task force met and worked from 2003 through 2005 to reconcile standards and to update the 1984 report. Members prepared a document that was submitted to the American Psychiatric Association but was never formally approved (Tardiff K, personal communication, September 16, 2011). Instead, the body of work was used in 2007 as a guideline for correctional psychiatry, not general psychiatry.³ Whether the originally submitted document was lost amid other pressing matters facing the American Psychiatric Association or the organization was reluctant to enter the arena of conflicting agency and government protocols is a matter for speculation, but the net effect is that official American Psychiatric Association standard-of-care policies and principles for restraint and seclusion remain those of 1984 and hence are decades out of date.

Staff injuries during restraint are a complex matter. While overzealous and improper use of restraint is clearly dangerous, the ambivalent or tentative use of subjugation has its own dangers. The latter question highlights a contradictory cultural dimension of the use of restraint and seclusion. While visiting psychiatric facilities in other countries and describing our hesitant use of restraint and seclusion with violent patients, I meet with puzzlement. Why, in a country with so much media violence and such poor gun control would we choose to regulate the restraint of obviously aggressive patients so highly? Civil liberties in the United States are precious indeed, but they may impede the control of the aggressive patient. Even more of a problem is the psychological and litigation-driven belief in America that someone, somewhere, is to blame for all adverse outcomes of human behavior, including either the failure to control a violent patient or the overzealous control of that patient.

As to the matter of lawsuits that occur when a restrained patient is injured or dies, it is my experience that the successful defense of such a case is rarely possible, given a jury's inevitable belief that any patient in a psychiatric hospital ought to be perfectly regulated. I have often heard the suggestion that cameras be placed throughout all the spaces of a psy-

chiatric unit to monitor impending violence (or to review mishaps that occur). I doubt that cameras will work, although they may have an initial halo effect. This problem is a big one in the research well summarized by Recupero *et al.* Many research papers show a reduction in the need for restraint and seclusion when new interventions are placed into effect. The common denominator of all these protocols is acute hypervigilance on the part of staff. Whether rates of restraint and seclusion are still lower some years after the study is a large question, rarely addressed in publications. Occasionally, a clinician or administrator will boast of not having to use restraint and seclusion in his facility. My reaction is to suspect that the hospital staff either carefully screens out very disturbed patients or that it overmedicates such patients.

The following recent case illustrates the many quandaries surrounding this topic:

Consultation was requested by the family of a chronically psychotic patient who was highly assaultive in the hospital. Many staff injuries were incurred, and fellow patients were injured as well. The patient appeared to respond to internal stimuli and attacked without warning or provocation. A variety of medications in appropriate dosages did not help. While the patient occasionally kicked other patients and staff, he tended most often to use his hands, and struck others with his fists or attempted to strangle them. It was thus suggested to staff and hospital administration that the patient continually wear, on a trial basis, a restraint on his dominant hand. This restraint would consist of a belt around the wrist tethered to the waist that could be adjusted to allow for eating; the technique has been described in the literature.⁵ A behavior modification program could be devised that would allow for periods out of restraint depending on good behavior. The patient's family endorsed the idea, as did the staff. The hospital administration, however, was leery of violating the CMS and TJC regulations that disallow any prophylactic restraint. It was suggested that CMS officials be invited in to discuss the problem in a creative way, but the invitation was never issued. Instead, under staff pressure, a muscular male nurse was assigned full time to babysit the patient. Yet even this failed, as the patient got into an altercation and fractured his rib. He then could not lift his arm. Ironically, the outcome was the same as if he had been placed in the experimental restraint to begin with.

Restraint and seclusion are needed interventions. It is quite impossible to manage psychiatric inpatients without encountering an occasional outburst of behavior that requires physical subjugation and isolation.^{6,7} To think otherwise is to enter a world as compellingly wishful as the delusions and hallucinations of those we are asked to confront.

References

1. American Psychiatric Association: Clinician Safety: American Psychiatric Association Task Force Report 33. Washington, DC: American Psychiatric Association, 1993
2. Recupero PR, Price M, Garvey KA, *et al*: Restraint and seclusion in psychiatric treatment settings: regulation, case law, and risk management. *J Am Acad Psychiatry Law* 39:465–76, 2011
3. Metzner JL, Tardiff K, Lion J, *et al*: Resource document on the use of restraint and seclusion in correctional mental health care. *J Am Acad Psychiatry Law* 35:417–25, 2007
4. American Psychiatric Association: Seclusion and Restraint: The Psychiatric Uses. American Psychiatric Association Task Force Report 22. Washington, DC: American Psychiatric Association, 1985
5. Lion JR, Dubin W, Fortrell D, eds: *Creating a Secure Workplace*. Chicago, IL: American Hospital Association Press, 1996
6. Lion JR: Training for battle: thoughts on managing aggressive patients. *Hosp Community Psychiatry* 38:882–4, 1987
7. Lion JR, Reid WH, eds: *Assaults in Mental Hospitals*. New York: Grune and Stratton, New York, 1983