Commentary: Seclusion and Restraint in Corrections—A Time for Change

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Seclusion and restraint are essential interventions in the acute psychiatric care of patients in correctional environments. When administered and monitored properly, they are safe and effective in reducing the risk of harm. However, correctional systems have not developed uniform practices that are consistent with current community standards. There has been no clear national standard of care for the use of seclusion and restraint in correctional mental health care. The need for a national standard of care is discussed, and sources for developing a standard of care are reviewed. The Resource Document produced by the American Psychiatric Association is presented as a significant step toward establishing a national standard of care.

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Be the change that you want to see in the world. —Mohandas Ghandi

The correctional system is a growth industry in this country. States and counties around the nation are building more prisons and jails. Ownership of correctional facilities has expanded from the public into the private sector as states and municipalities have sought to control the cost of producing and maintaining new state facilities. Over the past several decades, the number of incarcerated persons in the United States has been steadily increasing, while the proportion of mentally ill inmates has also been on the rise.[1]

Prisons and jails are challenging environments for the health care professional.[2] Facilities are often located in rural areas. Recruitment of an adequate number of health care personnel is difficult, and staff shortages are common. Psychiatric care and health care in general take a back seat to the primary mission of correctional systems: security, control, and containment. Public support for funding of correctional health care can be lacking, and mental health programs are often poorly funded as a result.

Given the large number of incarcerated persons with a mental illness in this country, it is extremely important to focus attention on the availability and quality of psychiatric services in correctional systems and on related policies and procedures. Psychiatric services can include a full spectrum, from chronic care "outpatient" clinics to acute psychiatric services provided in infirmaries or hospitals. In both jails and prisons, mentally ill inmates are housed in a variety of settings that include general population, segregation units, and specialized housing units (also known as residential treatment units). When inmates decompensate and require enhanced observation and treatment, they are frequently transferred to a clinical setting, which typically is a medical infirmary or a unit specialized for the care of the acutely mentally ill, until their condition is stabilized. In those specialized settings, seclusion and restraint are utilized to maintain safety when an inmate exhibits behavior that is dangerous to self or others and is related to a medical or mental illness.

Custody and Clinical Restraints

In a correctional environment, seclusion and restraint are used for both custodial and clinical purposes. Minimizing serious disruption to the milieu, preventing significant damage to the physical environment, and preventing harm are goals shared by both custody and clinical staff. The significant element that determines whether custody or clinical staff will administer seclusion and restraint is whether the disruptive and dangerous behavior stems primarily from a mental illness.

Custody restraints include steel handcuffs, leg irons, waist restraints, and in some jurisdictions, chair restraints. Custody restraints are applied to

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control an inmate's assaultive behavior when it represents a danger to others. In addition, restraints are utilized according to an institution's security classification policy, which may dictate their use during transport either within or outside of a facility. A maximum security designation typically mandates that movement outside of the cell be performed with the inmate in wrist, waist, and leg restraints and accompanied by a security escort.

When an inmate's disruptive, assaultive, and/or self-injurious behavior is related to a mental illness, he or she should be transferred to a clinical setting for assessment and stabilization. Correctional infirmaries and hospitals have enhanced staffing of nurses, mental health counselors, and psychiatrists. Clinical restraints utilized in this environment can include leather, rubber, or canvas hand and leg restraints with contact points on a specialized bed or a portable restraint chair.

Seclusion and restraint can be misused when applied for nonclinical reasons or by poorly trained custody or clinical staff. In the correctional setting, mentally ill inmates frequently disrupt the jail or prison environment. They are often charged with infractions of security policies. Potential consequences can involve removal from the general population and placement in punitive segregation units. The isolation and lack of sensory stimulation that characterize 23 hours a day of seclusion can lead to clinical deterioration, worsening of symptoms, and further behavioral outbursts. In a segregation unit, custody staff may respond to the disruptive behavior of a mentally ill inmate by applying custody restraints, which can compromise the inmate's psychiatric and physical condition. In the clinical setting, poorly trained staff may improperly administer physical restraints and fail to monitor the inmate's physical health status adequately, which may lead to fatal consequences.

The Need for Published National Guidelines

Seclusion and restraint are not benign interventions. Significant morbidity and mortality have been associated with their use. Seclusion involuntarily confines a potentially agitated, unstable person alone in a contained, controlled environment. Suicide attempts and self-injurious behavior in seclusion are not uncommon, given the acute nature of the patient's condition. The use of restraints involves the direct application of physical force to restrict freedom of movement. Physical restraint has been associated with an elevated risk of aspiration, positional asphyxia, dehydration, and restriction of circulation leading to possible pulmonary embolism.

When properly applied and monitored, both seclusion and restraint are essential clinical interventions that assist in stabilizing patients who are at high risk of harming themselves and/or others. Eliminating or abolishing the use of seclusion and restraint in a corrections department should not be a goal. Rather, the goal should be developing policies, procedures, and a national standard of care for their safe and effective use.

External reviewers of correctional health care systems frequently discover wide-ranging variability in how both seclusion and restraint are utilized in correctional environments. Clinical restraints are administered in non-health care settings in general population and segregation housing unit cells that are not adequately equipped to provide for the safety of the inmate. Clinical staffing levels are often not sufficient to provide adequate observation and monitoring of the inmate in restraints. Procedures for providing range-of-motion exercises and physical assessment are often applied inconsistently. Formal review processes may be lacking and, when present, frequently do not provide sufficient documentation to facilitate assessment of the quality and effectiveness of the restraint procedures.

Given the current inconsistency and variability in the use of seclusion and restraint, it is extremely important for the correctional mental health field to develop a standard that will serve as a resource for both administrators and clinicians working in jails and prisons. A standard of care will help direct policy, procedure, and program development. It can also serve as an important tool for psychiatrists to use in advocating for their patients. Psychiatrists working in correctional facilities are often called on to appeal to the custody chain of command for staffing enhancements and physical plant changes to benefit the care of their patients. It can be extremely helpful to cite a published national standard of care when encouraging custody staff and correctional administrators to make important changes. My experience in a department of correction where I previously worked taught me that it was easier to advocate for the system to spend a significant amount of money on a supply of "suicide smocks" when I could dem-

onstrate that other systems around the country had adopted its use as their standard. Staffing and physical plant changes can be expensive, and legislators can be reticent to increase spending in corrections. A national standard for the use of seclusion and restraint will provide prison and jail administrators with a reference point for developing programmatic changes and a tool to use when lobbying legislatures for necessary funds.

Which Standard of Care?

The standard of care for seclusion and restraint in correctional environments has been unclear. Hospital and health care facilities across the nation are accredited by the Joint Commission (formerly JCAHO), which provides performance standards and evaluates the quality of care delivered by health care organizations. The Center for Medicare and Medicaid Services (CMS) considers Joint Commission accreditation important in meeting the Medicare and Medicaid certification requirements necessary for gaining reimbursement for medical services. The Joint Commission and CMS have defined rules for the uses of seclusion and restraint in health care settings. While some correctional health care facilities have applied for and received Joint Commission accreditation, the vast majority have not. Correctional facilities typically seek general accreditation from the American Correctional Association (ACA). The ACA and the Commission on Accreditation for Corrections (CAC) administer a national accreditation program for adult and juvenile corrections. The ACA and CAC publish a set of standards that outline general requirements for mental health programs in correctional institutions. The requirements for accreditation include having identified policies and procedures for the use of restraints for medical and psychiatric purposes that address the types of restraints to be applied, identifying a qualified medical or mental health professional who may authorize their use, monitoring procedures, length of time for their application, and related documentation.[3] However, there are no specific recommendations about the monitoring process, timeframes, and documentation.

The National Commission on Correctional Health Care (NCCHC) establishes standards for health care services in correctional facilities. The NCCHC provides accreditation compliance standards that are more specific and detailed with respect to seclusion and restraint.[4] In addition to general statements about the need for policies and procedures regarding the type of restraints that may be used, conditions of seclusion, how long seclusion and restraint may be used, and how proper peripheral circulation will be maintained, there are more specific recommendations. These include the need for authorization by a physician or other qualified health care professional, documented 15-minute checks by health services staff while a person is in restraints, and range-of-motion exercises every 2 hours. Guidelines regarding timeframes are limited: "When clinically ordered restraint or seclusion is used, it is employed for the shortest time possible in keeping with current community practice. . . . Generally, an order for clinical restraint or seclusion is not to exceed 12 hours, but state health code requirements, if applicable, may vary" (Ref. 4, p 144). The NCCHC Standards and Guidelines are silent on recommended locations for seclusion and restraint.

Few correctional facilities participate in the Medicare and Medicaid programs, and the rules established by CMS for the use of seclusion and restraint have had little impact on correctional systems. The American Psychiatric Association, in its task force report on psychiatric services in jails and prisons, stated that a policy goal for correctional mental health care is to provide the same level of service to each patient in the criminal justice process that should be available in the community.[5] However, the task force report made no specific recommendations regarding the use of seclusion and restraint. In the interim, correctional systems have not developed uniform practices that are consistent with current community standards.

The Resource Document

The authors of the American Psychiatric Association's resource document[6] have taken a significant step toward establishing a national standard of care for the use of seclusion and restraint in corrections. The resource document maintains the APA's previous position that psychiatric services in correctional mental health systems be held to the same standard that should be available in the community. The authors adopted the CMS rules for seclusion and restraint for corrections with qualifications regarding location, proper documentation, property consider-

ations, and timeframes that are specific to the nuances of the correctional setting. Use of the CMS rules as a foundation is helpful, as they are comprehensive and give clear guidance on monitoring and caring for the patient, documentation, and seclusion/restraint room design.

Previous guidelines have been silent on the appropriate location for seclusion and restraint, while making only general statements about the timing and frequency of face-to-face evaluations and orders. The authors of the resource document recommend that seclusion and restraint be administered only in a health care setting and that CMS rules fully apply if it occurs in a hospital. However, if restraint or seclusion occurs in an infirmary or a specialized housing unit, the authors recommend adapting the CMS rules on timeframes to allow for a face-to-face assessment within 4 hours and then at least every 12 hours after the initial assessment. A physician must perform a face-to-face assessment every 24 hours.

An allowance for extended timeframes for face-to-face evaluation is very helpful. Correctional hospitals are typically located closer to major population centers and have enhanced psychiatric staffing, making adherence to the CMS rules more feasible. Most prisons and jails, with their infirmaries and specialized housing units, are located in rural areas, and psychiatric staffing is considerably sparser by comparison.

Rigorous internal and external review can help prevent correctional systems from falling short of the community standard. Ongoing quality assurance (QA) and improvement (QI) programs play an integral role in ensuring compliance with national standards. However, QA/QI programs are only as good as the data available to them. I agree with the authors' recommendation that each facility keep detailed logbooks of seclusions and restraints for internal and external review. The information captured in the process will be helpful in revealing site-specific challenges to adherence to the standard of care.

A Time for Change

Adopting the resource document as the new standard of care for corrections will result in two major shifts: a change in location/physical plant and a change in staffing patterns. Seclusion and restraint in correctional settings are currently applied in a variety of locations, including general population and administrative segregation housing units. Use of segregation units can occur when no infirmary or specialized housing unit is available for the mentally ill inmate within a facility. The authors have clearly outlined the disadvantages of this practice. The new standard of care would eliminate this practice, requiring correctional facilities to convert existing housing units into infirmary space with the associated physical plant changes necessary for safe seclusion and restraint use. Most specialized housing units do not have around-the-clock clinical and nursing staff. If seclusion or restraint is to occur in an infirmary or specialized housing unit, the new standard of care would require that 24-hour nursing staff be available when the intervention is in process. Improvements in physical plant design and staffing will enhance the safety and quality of psychiatric care in corrections.

Conclusions

It is essential for psychiatrists to advocate for improved quality of care for their patients wherever they reside. In corrections, there are many challenges to providing safe, effective clinical services that meet the standard of care available in community settings. Over the past several decades, there has been much progress in improving correctional mental health care. Change has been facilitated by attention paid to developing standards of care for the correctional environment. It is critical for health care administrators and psychiatrists on the front lines to have published national standards to assist in advocating for change within the correctional health care system. The APA's "Resource Document on the Use of Restraint and Seclusion in Correctional Mental Health Care" is a significant contribution to the development of a national standard and to improvement of the quality of care for patients in our nation's prisons and jails.

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