Restraint and Seclusion in Psychiatric Treatment Settings: Regulation, Case Law, and Risk Management

Patricia R. Recupero, JD, MD, Marilyn Price, MD, Keelin A. Garvey, MD, Brian Daly, MD, and Sarah L. Xavier, DO

Changing federal regulations, civil rights and malpractice cases, and new treatment methods have influenced the use of restraint and seclusion (R&S) in inpatient psychiatric treatment settings, such that restraint and seclusion today are among the most highly regulated practices in psychiatry. Despite increased pressure from regulatory bodies and litigation, the use of R&S remains controversial and risky. These procedures can compromise safety if performed incorrectly or monitored inadequately, but intervention by restraint or seclusion may be necessary to maintain safety on the treatment unit, especially during emergencies. Case law and medical research have demonstrated the importance of a patient-focused, treatment-oriented approach toward risk management. Analysis of specific clinical scenarios can help to develop risk mitigation strategies that are therapeutically conceptualized rather than driven by regulation. Insights drawn from clinical cases that have resulted in litigation can offer an opportunity to develop an approach oriented to patient care from a clinical or risk management perspective. In this article, we seek to provide a foundation for evaluation of current protocols, an analysis of adverse R&S events, and strategies to minimize risk.

J Am Acad Psychiatry Law 39:465–76, 2011

The use of restraint and seclusion (R&S) in noncorrectional psychiatric treatment settings is one of the most controversial and highly regulated practices in mental health treatment. The primary goal of R&S in inpatient psychiatry is to maintain the safety of everyone in the treatment environment. Because risks to patients can be severe, some scholars advocate the complete elimination of R&S. However, failing to use R&S in emergency situations can also result in adverse outcomes to the individual himself or to others in the milieu. Inpatient psychiatrists face intense scrutiny and pressure from regulatory agencies to reduce the use of R&S. In developing effective risk management strategies, it can be helpful to examine the case law from a therapeutic perspective rather than to develop policies in response to regulation. This discussion presents an overview of some of the major regulatory activity aimed at reducing R&S-related adverse events, success stories from the medical literature, and relevant case law to help clinicians and administrators manage risk through patient-centered, treatment-oriented strategies and analysis of case-specific clinical scenarios.

Dr. Recupero is Clinical Professor of Psychiatry, Warren Alpert Medical School of Brown University, and President/CEO of Butler Hospital, Providence, RI. Dr. Price is Clinical Instructor, Department of Psychiatry, Harvard Medical School, and Assistant Psychiatrist, Law and Psychiatry Service, Massachusetts General Hospital, Boston, MA. Dr. Garvey is psychiatrist, Massachusetts Department of Corrections, Bridgewater, MA. Dr. Daly is a Fellow in Forensic Psychiatry at the University of Michigan Medical School, Ann Arbor, MI. Dr. Xavier is a faculty member at the Warren Alpert Medical School of Brown University, Providence, RI. Address correspondence to: Patricia R. Recupero, JD, MD, Butler Hospital, 345 Blackstone Boulevard, Providence, RI 02906. E-mail: patricia_recupero@brown.edu.

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

Regulatory Bodies and Professional Organizations

In the 1990s, the *Hartford Courant*'s exposé of R&S-related deaths prompted an increase in regulatory activity and scrutiny of R&S.[1] Reports and policies calling for the reduction and regulation of R&S have been released by other agencies, including the Joint Commission (hereinafter TJC, formerly

JCAHO),[2] the American Psychiatric Association (APA),[3] the National Association of Psychiatric Health Systems (NAPHS), the American Hospital Association (AHA),[4] the National Mental Health Association (NMHA),[5] the American Psychiatric Nurses Association (APNA),[6] the National Association of State Mental Health Program Directors (NASMHPD),[7,8] the Substance Abuse and Mental Health Services Administration (SAMHSA),[9] and the U.S. General Accounting Office (GAO).[10]

As accreditation is often crucial to the financial success of a hospital, regulations released by TJC play an influential role in standards for psychiatric treatment facilities. In 1998, TJC published findings from a root-cause analysis (RCA) on restraint deaths in a sentinel event alert.[11] Among the most frequent root causes were failures in patient assessment, care planning, patient observation, inadequate training and staffing levels, and "[e]quipment-related factors, such as use of split side rails without side rail protectors; use of two-point rather than four-point restraints; use of a high-neck vest; incorrect application of a restraining device; or a monitor or an alarm not working or not being used when appropriate."[11] The alert contains suggested strategies for reducing the risk of restraint-related deaths. In 2000, TJC released new standards for the utilization of R&S for behavioral health reasons.[2] One study reviewed R&S data for a facility two years before and two years after the introduction of these standards, finding some variability in rates of R&S use after the new standards were released, but an overall trend toward reduced R&S.[12] TJC's website also features a set of FAQs about R&S, which include a timetable and guidelines for re-evaluations and monitoring of patients in restraint or seclusion. TJC has strict reporting requirements, but state laws may be even more stringent.

In 1985, a task force of the APA published a report on R&S,[3] addressing regulations, indications, contraindications, techniques, and factors to consider for the use of R&S in special populations, such as minors, developmentally disabled persons, and the elderly. Special laws and regulations apply to the use of R&S with children.[13,14] The APA report includes a literature review of quantitative studies and strategies for decreasing risk. Together with the APNA and the NAPHS, and with support from the American Hospital Association's section for Psychiatric and Substance Abuse Services, the APA also published a guide in 2003 to help administrators and clinicians reduce the use of R&S. The guide, *Learning from Each Other*: *Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health*, contains numerous insightful and practical suggestions for reducing the use of R&S in psychiatric treatment settings, with examples and ideas drawn from the experiences of facilities that successfully reduced their use of R&S.[15] An appendix, available through the NAPHS website, contains sample forms and advice, as well as links to relevant standards and additional resources.[16] A similar resource is the NASMHPD's Medical Directors Council three-part report, *Reducing the Use of Seclusion and Restraint*.[17] Part 1 includes a list of factors that contribute to a safe environment, several prevention and early intervention strategies, and general recommendations to decrease risk. Parts 2 and 3 address recommendations for special-needs populations and tips from the hearing-disabled community, respectively.

The Centers for Medicare and Medicaid Services (CMS) released new rules in 2007 prohibiting the use of R&S as measures to restore order in a unit but largely reverting to less restrictive standards.[18] The 2007 rules specify some guidelines for training hospital employees who order restraint or seclusion and include requirements for reporting R&S-related deaths.[19] In 2008, CMS published a revised set of interpretive guidelines for R&S. The new rule requires face-to-face examination by a physician, nurse, or physician's assistant within one hour of placement in restraints or seclusion. The revision also offers guidance about staff education requirements.

In late 2007, *The Journal* published an APA Resource Document on the use of R&S in correctional psychiatry.[20] The Resource Document takes CMS guidelines as a starting point and describes their application and relevance to mental health care in correctional settings. Standards for correctional settings represent at best a minimum of standards required for noncorrectional treatment settings. Case law addressing standards for R&S in prisons rarely distinguishes between treatment-oriented use and other justifications for R&S in the criminal justice system. As the APA Resource Document notes, restraint and seclusion in correctional settings are often used for custodial or punitive purposes. Therefore, guidelines for the use of R&S with prisoners can set a floor on which to build acceptable standards for noncorrectional, inpatient mental health care.

Minimum Standards and Patients' Constitutional Rights

Minimum standards for the use of R&S must protect patients' basic constitutional rights, such as life and liberty interests and freedom from cruel and unusual punishment or unnecessary bodily restraints. Violation of any of these rights may be grounds for damages in a case involving R&S. Table 1 lists several prominent cases in which courts ruled on patients' constitutional rights.

As the cases in Table 1 demonstrate, the use of R&S to control a patient who does not pose an imminent risk of harm can result in serious sanctions through the legal system. Not only is the punitive or custodial use of R&S potentially harmful to patients, mental health clinicians lack the legal authority to use R&S for punishment or control of a patient whose agitated or uncooperative behavior is troublesome but not dangerous.

In *Davis v. Rennie*, staff at a Massachusetts state hospital forcibly restrained a patient who had eloped earlier in the day to go drinking with another patient.[24] While restrained, the patient was assaulted by one staff member and sustained physical and psychological injuries. Noting the U.S. Supreme Court's holding in *Youngberg v. Romeo*,[21] the First Circuit rejected the argument that staff members should not be held liable for failing to intervene. Patients, even those who are involuntarily committed, have constitutionally protected liberty interests. As case law demonstrates (see Table 1), this fact is sometimes overlooked by clinicians seeking to maintain control over tension in the treatment environment.

Empirical Research and Success Stories

Although many psychiatric facilities have published descriptions of efforts to reduce the use of R&S and to improve the safety of the inpatient setting, there is substantially less published data showing documented success in these efforts.[28] Some efforts to reduce and improve on the incidence of R&S have had considerable success, however.

In 1997, Pennsylvania's Mental Health and Substance Abuse Services implemented new policies regarding the use of R&S.[29] The use of these measures was declared to represent treatment failure rather than a mode of treatment, and the system was challenged to find new ways of managing crises. The policy restricted the use of R&S to patients at imminent risk of harm to themselves and others and only after all other interventions had failed. A recent study examining the evolution of R&S in the Pennsylvania State Hospital system found that the rate and duration of R&S decreased dramatically between 1990 and 2000.[30] Key factors likely contributing to this trend included hospital staff and advocacy groups demanding regular reports and improved data collection; revised staff training to ensure that R&S would be used only as a last resort; and continued policy changes, beginning with those announced in 1997 and continuing throughout the studied period, including guidelines for annual staff training and procedures for debriefing sessions after every incident of R&S. These data have been thought by some to challenge the belief that R&S are necessary to ensure safety,[30] but the fact that the rate of staff injury was not reduced by a decrease in the use of R&S has been interpreted by others as representative of failure to improve staff security.[31] Despite dramatic decreases in rate and duration of R&S use over the 10-year period, the study found that there was no change in the rate of staff injury between 1998 and 2000.

Salem Hospital in Oregon found success after implementing the Engagement Model, which involves a framework for improving the therapeutic milieu to decrease potential precipitants to agitation and subsequent need for R&S. This model highlights the importance of trauma-informed care through staff training and psychiatric advanced directives to allow patients to specify preferred methods of de-escalation. The model also emphasizes the importance of creating therapeutic environments for care and involving patients in treatment planning. After implementation of this patient-centered, treatment-oriented approach in 2001, Salem Hospital experienced an 87 percent reduction in the incidence of R&S.[32]

In Massachusetts, tight regulation has forced a reduction in the use of R&S, particularly in child and adolescent treatment settings. LeBel and Goldstein[33] analyzed facility restraint data to calculate the cost of using restraint and the change in rates of injury and staff turnover following a reduction in its use. Their analysis yielded several unexpected findings: an overall improvement in adolescent outcomes, decreased staff-related costs (e.g., sick time, workers' compensation, and turnover), and a decline in injuries to patients. Hellerstein and colleagues[34] noted similar unexpected benefits (decreases in patient-related staff injuries and elopements) through staff training and

Table 1 Cases Reflecting Patients' Minimum Constitutional Rights

Case	Relevant Findings
Youngberg v. Romeo, 457 U.S. 307 (1982)[21]	Involuntarily committed patients have a substantive right to safe conditions of confinement, freedom from bodily restraints, and some training to protect their liberty interests. What constitutes adequate training is best decided on a case-by-case basis and is best determined by the judgment of a qualified professional. Liberty interest is not absolute, but must be balanced by the need for institutions to protect residents from the danger of violence. "Persons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish" (Ref. 21, pp 321-2).
Washington v. Harper, 494 U.S. 210 (1990)[22]	The use of R&S does not constitute a valid alternative to meaningful psychiatric treatment, even in a prison setting involving an inmate who does not want to receive antipsychotic medication. The ruling cited an *amicus curiae* brief filed by the American Psychiatric Association: "Physical restraints are effective only in the short term, and can have serious physical side effects when used on a resisting inmate, as well as leaving the staff at risk of injury while putting the restraints on or tending to the inmate who is in them . . . [R]espondent has failed to demonstrate that physical restraints or seclusion are acceptable substitutes for antipsychotic drugs, in terms of either their medical effectiveness or their toll on limited prison resources" (Ref. 22, pp 226-7).
Wyatt v. Stickney[23]	Involuntarily committed patients have a constitutional right to treatment that would cure or improve their mental conditions. The ruling called for adequate (increased) staffing levels and individualized treatment plans.
Davis v. Rennie, 264 F.3d 86 (1st Cir. 2001), cert. denied, *Rennie v. Davis*, 535 U.S. 1053 (2002)[24]	Staff at a mental health facility can be held to a higher standard than is applicable in correctional settings. " . . . [T]here is precedent for subjecting the conduct of a mental health worker to a more exacting standard than that of a prison guard controlling a riot" (Ref. 24, p 99). Not every incident of forceful restraint amounts to a violation of the patient's Fourteenth Amendment rights, but force should be used sparingly. ". . . [F]orce [should] be used as sparingly as possible" (Ref. 24, p 111).
Campbell v. Sikes, 169 F.3d 1353 (11th Cir. 1999)[25]	In a prison setting, evidence of staff members' good faith in applying R&S included compliance with prison procedures for restraints, extensive documentation, and monitoring when restraints were used, including the use of videotaped monitoring. A five-factor test was used in determining whether use of force was excessive.
People v. Harvey, 528 N.E.2d 1053 (Ill. App. Ct. 1988)[26]	A counselor was found guilty of involuntary manslaughter for the death of a teenaged boy who was forcibly restrained to punish him for nonviolent disobedience. The boy aspirated his vomit during the restraint. The court noted that the boy was not assaultive until the staff tried to restrain him. Punitive or custodial use of R&S may be acceptable in correctional or criminal settings, but punitive use in treatment settings violates the patient's constitutional rights.
Threlkeld v. White Castle Systems, Inc., 127 F. Supp. 2d 986 (N.D. Ill. 2001)[27]	A woman, forcibly injected with lorazepam by the physician-defendant in an emergency room, could "make a *prima facie* case for negligence based on a violation of the [Illinois] Mental Health Code" and also stated a claim for battery because her consent was not obtained for the injection. The patient had been brought to the ER by police officers and was locked in an observation room and restrained. She was upset and crying, but the physician who ordered the shot testified that he did not think that she was a threat to herself or others. He ordered a nurse to give the patient the shot to "calm her down" so that he could talk to her, but he never obtained consent.

changes to the organizational culture to decrease R&S episodes.

Recommendations based on the success of Pennsylvania's interventions emphasize adequate staff size and training in verbal crisis management and de-escalation strategies, optimizing the treatment environment to promote patient comfort and dignity, tighter monitoring of restraint procedures, and the

implementation of patient and staff debriefing, to discuss prevention strategies after incidents of R&S.[9] Systems seeking to follow the engagement model have had similar goals, emphasizing staff education and training, optimizing the physical environment, and increasing patient involvement in treatment planning.[28] These recommendations exemplify a patient-centered approach in which the focus is on risk management through sound clinical judgment rather than mere enforcement of regulations.

Programs have also successfully reduced the use of seclusion through strategic planning and ambitious changes to the organizational culture, especially in the treatment of children and adolescents. One facility reduced seclusion episodes in a child and adolescent service by 97 percent in two months through broad-based, extensive changes.[15] The collaborative problem-solving model for working with aggressive children and adolescents has been shown to dramatically reduce the use of R&S on a child-and-adolescent inpatient unit.[35] Behavioral management strategies have also been shown to be effective in reducing aggressive behavior among children and adolescents on psychiatric inpatient units.[36] In one hospital, an interdisciplinary behavior management committee that focuses on quality improvement reviews the treatment plans of all patients whose episodes of R&S exceed a certain number or duration; the committee acts in a consulting role, brainstorming ideas to improve the treatment plan and making recommendations to the treatment team. A study evaluating data six months before and after the committee review revealed a 62 percent reduction in mean episodes of R&S use.[37]

Policy and Administrative Change

Far-reaching and interdisciplinary policy changes are often necessary to effect change. Gaskin *et al.*[38] conducted an extensive literature review evaluating different strategies and interventions for reducing R&S use. Most facilities that have successfully reduced R&S-related risk have implemented several different interventions based on good clinical care, addressing leadership, examinations of practice contexts, staff education and integration, treatment plan improvement, increased staff-to-patient ratios, vigilant monitoring, psychiatric emergency response teams, pharmacologic interventions, involvement of patients as active participants in their treatment, changes to milieu and facility policies, and addressing the needs of clinical staff. The findings of Gaskin and colleagues[38] are supported by research conducted in Finland,[39] where legislative changes to restrict R&S were insufficient to result in an overall decrease in episodes of R&S. Effective management of risk requires that the emphasis be on treatment quality improvement rather than attempting to force change through strict regulation.

A facility-based, policy-level change might begin with an organization reviewing current policies for R&S,[40] determining whether current practice adheres to the written policies, and identifying target areas for improvement. Administrators and clinicians can review the treatment model and the therapeutic milieu, and changes should prioritize safety in addition to patient comfort and dignity. Some organizations choose to implement a treatment model, such as the engagement model and trauma-informed care, that has been successful in other settings.[41] Most facilities that successfully change R&S patterns involve some type of committee or workgroup to address R&S policy.[15]

Hospital policy can be revised to prohibit the use of higher-risk forms of restraint. Death during R&S often is due to asphyxiation, aspiration, or cardiac events.[40] Oversight by medical professionals and documentation of medical factors and clinical judgment are important for R&S, just as they are for other procedures.[42] Any form of restraint that involves compression of the patient's chest can increase the risk of death by asphyxiation. Prone restraint increases the risk of suffocation and supine restraint increases the risk of aspiration.[11] The use of face towels to prevent biting or spitting may also increase risk.[43] Any type of technique that obstructs airways or impairs breathing, any technique that obstructs vision, and any technique that restricts a patient's ability to communicate, "should not be used under any circumstances" (Ref. 17, p 10). Prolonged restraint can increase the risk of deep vein thrombosis and pulmonary embolism, particularly in patients already at risk for these conditions.[44] Choke holds[45] and pressure on the patient's neck or throat[26] also carry greater risk.

Internal strategic planning can be a valuable tool for policy changes, as risk management often requires adjustment to the specific needs and structure of the

organization. Haimowitz et al. recommend establishing:

> . . .a facility-wide task force including top management, staff, union representatives, and consumers to develop a plan to reduce restraint and seclusion that includes a public commitment to the goal of reduction, a strategy for workforce training, and the use of data to set outcomes targets and evaluate progress [Ref. 40, p ii].

Some hospitals invite patients and families to join patient safety committees or R&S reduction workgroups, thereby engaging consumers as partners in the process.

Family members who are more familiar with a patient can help the treatment team to learn about the patient's triggers and what helps to soothe the person when he or she is upset. In the 2009 Patient Safety Goals, TJC states that behavioral health care providers should encourage the active involvement of patients and their families in discussing safety concerns as a patient safety strategy.[46] Conversations with patients and families can perform an integral risk management function by enabling improved, individualized treatment planning.

In *Pisel v. Stamford Hospital*,[47] a state supreme court affirmed a $3.6 million verdict against a hospital after an agitated, acutely psychotic patient in seclusion suffered brain damage when she wedged her head between a mattress and a steel bed frame. An individual patient's clinical scenario (such as psychosis or suicidal/homicidal ideation) can yield clues about policies and practices that can be modified to manage risk. For high-risk scenarios, policies should require the removal of modifiable risk factors, particularly when R&S become necessary. The patient and room should be searched, and potentially harmful objects (e.g., cigarette lighters and cutlery) should be held in a secure location until the crisis has abated. When a patient is in seclusion, the room should be free of any pipes or other structures from which a patient could hang himself, as well as objects (such as belts or bed sheets) that could be used for self-harm.

Appropriate staff levels are necessary to maintain a safe treatment environment. Determining what constitutes adequate staffing, however, is not always a simple numerical calculation of staff-to-patient ratios. As Simon remarked, "Inpatient units may require temporary closure to new admissions when very ill or disruptive patients overwhelm the staff's ability to provide safety" (Ref. 48, p 100). It is very difficult, if not impossible, for clinical staff to effectively de-escalate a patient when staffing is insufficient. In addition to the need for adequate staffing levels, the organization must be careful about whom it hires and retains. Experts encourage hiring staff members whose attitudes and interpersonal style are consistent with the organization's philosophical approach toward support rather than coercion.[15] Staff members who take time to listen to patients and to try to understand them are more likely to recognize escalating problems early and to address them with nonrestrictive interventions, such as verbal de-escalation techniques or removal of excessive stimuli. These approaches are aimed at improving the quality of care that patients receive and also perform a critical risk management function. Facilities should set standards for accountability when safety policies are violated or disregarded.

Although many cases tend to underscore the risks associated with R&S, clinicians should not overlook the risks associated with failing to intervene. APA's recommendations for practice in a criminal detention setting are also helpful civilly:

> 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 [Ref. 20, p 418].

The overall effort must focus on improving the quality of treatment to increase the safety of patients and staff, while protecting individual liberty and autonomy.

Patient Assessment

Staff should identify patients whose conditions place them at greater risk of physical or psychological injury during an episode of restraint or seclusion, such as pregnancy or respiratory conditions. Steinert and colleagues[49] noted that a patient's history of trauma correlated with a nearly sevenfold increased risk for R&S episodes. Assessing anger management history and other biopsychosocial factors can help to identify patients at greater risk for escalation and al-

Table 2 R&S Cases Reflecting the Importance of Accurate Patient Assessment

Case	Relevant Findings
Scherer v. Waterbury, 2000 Conn. Super. LEXIS 481 (Conn. Super. Ct. February 22, 2000)[53]	Treatment providers' policies were held to violate the Americans with Disabilities Act (ADA). Crisis center physician had directed that emergency room staff forcibly detain a female patient who grew upset at being asked if she had been raped. There was no indication that the patient had suicidal or homicidal ideation. The patient was placed in seclusion and forced to strip in front of a male security guard. She was not seen by a doctor until more than an hour later, when she was found not to be a danger to herself or others and released by the hospital. Demonstrates importance of trauma-informed care, determining history of trauma, and accurate/thorough risk assessment before ordering R&S.
Hopper v. Callahan, 562 N.E.2d 822 (Mass. 1990)[54]	The patient died when an ectopic pregnancy was misdiagnosed as gastroenteritis, and the patient was placed (and ignored) in a seclusion room. Seclusion orders were continually renewed without examination by a physician, despite continued complaints of abdominal pain. The court wrote: "The two doctors could be found to have applied no medical judgment at all in entering the seclusion orders and to have abdicated any responsibility for investigating Hopper's medical condition, leaving the judgment concerning seclusion and medical care in each instance to inadequately trained, overworked staff" (Ref. 54, p 828).
Dolihite v. Maughon, 74 F.3d 1027 (11th Cir. 1996), cert. denied, *Dolihite v. King*, 519 U.S. 870 (1996)[55]	The 11th Circuit affirmed the lower court's denial of qualified immunity for a social worker, noting sufficient evidence for a jury to find that she had acted with deliberate indifference toward a teenage patient's self-injurious behavior. The patient was placed in R&S and attempted to hang himself, (causing permanent brain damage) after his observation status was reduced. Social worker had also failed to communicate effectively with other staff about the patient's risk of further self-harm. The patient had engaged in multiple suicidal gestures and attempts before/during hospitalization and had a family history of suicide, but clinicians had not taken his suicidal ideation seriously. He was viewed as "manipulative"; the social worker opined that he enjoyed the "shock value" of talking about suicide. A previous hanging attempt was noted in the time-out record but ignored.

low for intervention at the earliest signs of a problem. Grant[50] reports a case in which a 40-year-old man with schizophrenia jumped headfirst into a window of shatterproof glass, causing injuries that ultimately proved fatal. Although he had required at least two guards to escort him to the unit and had received a dose of haloperidol, he was left alone with one nurse who was unable to restrain him from acting on his auditory hallucinations. A jury award for the plaintiff was in the millions. Knowing a patient's preferences for treatment in an emergency (e.g., medication versus time out) and allocating treatment resources based on the unique clinical scenario can help avert R&S.[51] Patient assessment should be ongoing, and treatment plans should be updated to address changing clinical conditions, as needed, to minimize risk. The use of R&S is often a warning sign that treatment plans may require some evaluation or revision.

Accurate, ongoing patient assessment during R&S should clarify the degree of force required for safety. The First Circuit in *Davis v. Rennie*, referencing the Eighth Circuit's opinion in *Andrews v. Neer*,[52] wrote that: ". . .the usual standard for an excessive force claim brought by an involuntarily committed mental patient is whether the force used was 'objectively reasonable' under all the circumstances" (Ref. 24, p 108). The court inquired as to whether a reasonable person would have perceived a real threat to the safety of staff, whether staff had attempted to avoid the need for force, and whether the forceful restraint was necessary. Table 2 summarizes several cases that illustrate the importance of accurate, thorough patient assessment in preventing R&S-related adverse events.

Monitoring

Vigilant monitoring is essential when a patient is in restraints or seclusion. In *Unzueta v. Steele*,[45] a 16-year-old boy died after a restraint episode. The boy had been restrained on the floor for less than six minutes when staff noticed and called a medical emergency. The course of events in cases like *Unzueta* and *Pisel*,[47] described earlier, illustrate how

quickly an adverse event, even death, can occur when a patient is restrained or secluded. CMS and TJC both have strict requirements for monitoring during episodes of R&S. Standards for monitoring vital signs may vary between different regulating bodies and may change, but the clinical scenario and existing risks may require special monitoring. A patient with heart disease, for example, may require more frequent and more thorough monitoring than a healthy young patient with no medical risk factors. Monitoring for asphyxiation and aspiration[40] should be routine. Supervising staff should observe the entire R&S event and be prepared to intervene in the event that other staff members act inappropriately.

Masters and Wandless[43] recommend the use of pulse oximetry during episodes of restraint, as face-to-face evaluations may not provide accurate information about the patient's oxygen intake. Pulse oximetry can pose a risk for unsupervised patients, however, as the wires and equipment might be used for self-harm. These types of dilemmas illustrate the importance of case-specific risk management that addresses the patient's unique clinical needs. Regular monitoring of patients who are in seclusion is essential to reduce the risk of suicide or severe self-harm. Some psychotropic medicines increase the risk for hyperpyrexia in addition to neuroleptic malignant syndrome. Monitoring the patient's temperature and hydration during R&S can help to identify early warning signs of a problem. Thorough, well-documented monitoring decreases risks to patients and providers. A record of thorough and responsible observation not only helps to identify potential risks, but also confers some evidence that medical staff are not acting with indifference toward the patient's safety.

Communication and Support

Staff and managers must take a proactive approach toward communication within a treatment team. Poor communication can set in place a pattern that is difficult to change once problems have escalated. TJC specifically recommends the SBAR method (situation, background, assessment, and recommendation).[56] SBAR applies a standardized format for important communications and has been used in other high-risk settings, such as military operations. SBAR communication from shift to shift may help continuity of care and decrease the need for R&S.

Communication and support are critical steps after an episode of restraint or seclusion, particularly the process of debriefing. Debriefing is partly an attempt to identify what led to the critical incident and partly an opportunity to reduce the upsetting or traumatic effect of the incident for patients and staff. It is important to "give staff permission to be honest about their feelings" (Ref. 15, p 31). A debriefing should also allow patients to describe their experience and share information about what might have helped to prevent the need for restraint or seclusion and how treatment should proceed. It is important to ensure that debriefing is never used as a punitive measure.

Staff Training

Studies have shown a wide range in rates of R&S use in different hospitals, independent of patient characteristics. Some studies have found a poor correlation between the severity of patient aggression and the use of physical or chemical restraints.[29] Success stories consistently demonstrate the importance of staff training to help reduce overall rates of R&S, inappropriate use, and staff and patient injury. As the *Learning from Each Other* team expressed: "Training equals results. One facility developed an extensive staff competency package that must be completed by all nursing staff within six months of employment. This helped the facility to reduce the percentage of patients in restraint or seclusion by 82 percent over three years" (Ref. 15, p 14). The cases in Table 3 underscore the importance of proper training for any personnel who may be involved in R&S.

A thorough understanding of mental illnesses and their behavioral manifestations is essential for staff who work with difficult patients and tailor treatment interventions to an individual patient's needs. As Price and Recupero note:

> Staff education should. . .address the symptoms and behaviors exhibited by patients with different psychiatric illnesses so that staff members will be able to recognize manifestations of each patient's illness and report back to the treating physician rather than reacting [Ref. 58, p 419].

Failing to recognize worsening psychiatric symptoms can lead to undertreating the patient, thereby increasing the risk to himself and to others on the unit. Negative staff reactions resulting from a poor understanding of patients' illnesses can also increase the risk of abuse of patients. Testimony in *Dolihite v. Maughon*[55] described a pattern of physical abuse at

Table 3 R&S Cases Reflecting the Importance of Staff Training

Case	Relevant Findings
Andrews v. Neer, 253 F.3d 1052 (8th Cir. 2001)[52]	The Eighth Circuit held that the plaintiff's excessive-force claim should be reviewed under the objective-reasonableness standard for cases involving pretrial detainees. "The Eighth Amendment excessive-force standard provides too little protection to a person whom the state is not allowed to punish" (Ref. 52, p 1061). Hospital security aides had used excessive force in restraining a patient, resulting in his death due to airway compression during the takedown. The patient, agitated, backed into a corner and swung a book at those who approached. Security aides responded, but "one of the last aides to arrive at the scene testified that so many aides surrounded [the patient] that [he] could not see him" (Ref. 52, p 1056).
New York v. Simon, 157 A.D.2d 508 549 N.Y.S.2d 701 (N.Y. App. Div. 1 Dept, 1990)[57]	The court upheld the jury's verdict against a nurse for second-degree manslaughter and criminally negligent homicide in a restraint-related death of a psychiatric patient. The patient had undergone a tracheotomy and was grabbing at the tracheotomy wound (acutely agitated). She asked to see a doctor, citing difficulty breathing, and vomiting blood, but the nurse allegedly threatened her with violence if she (the patient) caused further trouble. The patient then engaged in disruptive behavior and was placed in a straitjacket with her feet tied to the bed and was given a sedative injection. During a check, the patient's condition was found to be critical. Code blue was called, but resuscitation failed. An autopsy found numerous R&S-related injuries; cause of death was asphyxiation by mechanical compression. The court commented: "[W]hile [the patient] was certainly agitated . . . she was not posing any physical threat to others present. Instead, [her] erratic behavior appears to have irritated the hospital staff rather than to have posed a threat, and defendant's violent reaction was an unwarranted response to what can essentially be characterized as annoying behavior" (Ref. 57, p 513).
Unpublished case (parties settled), reported by Grant[50]	A 32-year-old female patient died of asphyxiation while physically restrained face down by several guards and security personnel who had not been properly trained in the safe application of restraint.

the facility, and the record suggests that R&S were often used reactively and inappropriately.[55]

Unit supervisors should be trained to recognize problematic, reaction-based responses among staff members, and junior staff should be encouraged to find different ways to address problems. Some facilities have found staff mentoring programs helpful. Managers must be sensitive to fear and other countertransference that may affect staff reactions to patient behavior. Just as staff must be trained to identify "red flags" of escalating behavior in patients, they should also be trained to recognize warning signs among themselves and their colleagues. Some of the early warning signs of countertransference or staff reaction-related difficulties appear repeatedly in case law, such as the cases discussed herein and in the tables. Adverse events have occurred when staff attributed a patient's complaints or difficulties to personality problems. When staff members respond to patients with anger, indifference, impatience, fear, or judgment rather than compassion, these responses can increase the patient's agitation and increase the risk of adverse outcomes, even resulting in staff injury.

Staff training should also address practical aspects of R&S and its reduction. Training in verbal crisis management and de-escalation techniques is especially helpful. Overall, there has been a cultural shift within inpatient psychiatry toward nonphysical interventions.[15] Repeated training is needed to ensure that employees remember R&S protocols when an incident arises. In a moment of crisis, staff members do not have time to consult a manual or policy.[15] Procedures for the proper application of R&S, documentation, reporting, and debriefing are all important subjects to address in staff training.

Analysis and Risk Management

An organization may initiate a formal internal reporting policy with data collection to identify precipitating factors through quantitative analysis. Analysis of clinical data can help to identify variables strongly associated with the likelihood that a patient will be restrained or secluded.[59] Identifying patients at risk for R&S before an episode occurs can help clinical staff to remain vigilant and to address escalating agitation before an emergency intervention is required. TJC provides information on several formal risk

management tools on their website.[60] RCAs, introduced earlier in this article, are retrospective reviews that seek to identify the primary cause(s) of specific adverse events or near misses. TJC requires that RCAs be conducted within 45 days of a sentinel event. Both patient suicides and restraint deaths are sentinel events, but hospitals should set a lower threshold for events or near misses that would trigger an RCA.

Documentation

Ultimately, compliance with regulatory and professional standards and other protective steps requires documentation to confer maximum protection of facilities, providers, and patients alike. CMS and TJC both have specific requirements for documentation related to R&S. The chart should include a record of the patient's preferences for methods of de-escalation. Documentation of the patient's involvement in the treatment planning process, including recommendations and feedback, can be especially helpful. Staff should document any risk factors that emerge or precede an episode of R&S, particularly signs of increasing agitation. Prompt communications to other members of the patient's treatment team about these risk factors can be documented in the patient's chart. Documentation should include the steps taken to mitigate and monitor for risk and to protect the patient. Documenting that staff followed the patient's recommendations for interventions can confer protection against subsequent claims that R&S should have been avoidable.

Implications for the Future

Learning from Each Other notes several important challenges to the reduction of R&S, including dwindling behavioral health resources and intense and confusing oversight and regulation. Limited funding for mental health treatment is a significant problem. Many persons with serious and persistent mental illnesses such as schizophrenia and bipolar disorder do not get the treatment they need. Often, this is due to access problems. As law scholar Tovino noted: "The lack of access to, and funding for, basic mental health care contributes to emergency, inpatient, and acute mental health care, contexts in which restraints and seclusion are used more frequently" (Ref. 61, pp 557–8).

Poor funding for mental health services also contributes to staffing shortages on psychiatric hospital inpatient units. Inadequate staffing often increases the risk of emergent crises that require the use of R&S.

Risk management in psychiatric treatment facilities often poses difficult ethics-related problems for clinicians and administrators: "Many times. . .a health care provider's common law duty to prevent violent and assaultive patients from harming themselves and others will conflict with the provider's ethical and legal duty to promote patient autonomy" (Ref. 61, p 560). This problem is especially acute as the number of available hospital beds decreases, and more individuals with mental illness or substance use disorders lack access to the continued services that can help to prevent a crisis. Without sufficient access to mental health treatment, individuals with mental illness often lack basic self-soothing and problem-solving skills. Helping these patients will continue to be a challenge for clinicians.

Conclusions

This discussion has identified several important legal and ethics-related aspects of R&S in inpatient psychiatric treatment settings, noting examples and standards from regulations and case law. It is our hope that researchers and clinical staff will find this article a helpful starting point for discussions about R&S-related risk management in noncorrectional treatment settings. An important dialogue about R&S has begun, as evidenced by a growth of R&S-related research in recent years. The September 2005 issue of *Psychiatric Services*, a special issue devoted to discussion of R&S, contains several articles that may further assist risk management efforts in civil treatment settings.

Experience has shown and research has confirmed that attempts to reduce or eliminate R&S by means of regulation alone are unlikely to produce overall beneficial changes in the therapeutic milieu. Success stories from the literature illustrate the importance of comprehensive treatment-improvement strategies rather than attempting to enforce blind compliance with strict regulations. Case law contains numerous real-life scenarios that provide helpful examples for clinicians and administrators to consider when evaluating therapeutic programming and quality improvement. These cases demonstrate the need for individualized treatment plans and the application of

risk management strategies that are appropriate for the particular clinical scenario. Risk management for R&S requires a serious commitment to change at all levels. Further research into the legal, ethics-related, and economic aspects of R&S may help to identify specific targets for change and the resources required to effect those changes. Regulation, success stories, and case law all show that R&S should be considered in the context of therapeutic goals. Documenting that the treatment team has considered R&S as part of a therapeutic intervention rather than employing it to maintain law and order or for punitive reasons can confer some protection against claims that R&S were used in a negligent manner.

Acknowledgments

The authors wish to express thanks to Samara E. Harms for her assistance in the research and preparation of the manuscript.

References

1. Weiss EM, Altimari D, Blint DF, *et al*: Deadly Restraint: A Nationwide Pattern of Death. The Hartford Courant. October 19, 1998
2. Joint Commission on Accreditation of Healthcare Organizations: Comprehensive Accreditation Manual for Hospitals: The Official Handbook. Oakbrook Terrace, IL: Joint Commission Resources, 2000
3. American Psychiatric Association: Seclusion and Restraint: The Psychiatric Uses. American Psychiatric Association Task Force Report 22. Washington, DC: American Psychiatric Association, 1985
4. American Hospital Association and National Association of Psychiatric Health Systems. Guiding Principles on Restraint and Seclusion for Behavioral Health Services. Published online February 25, 1999. Available at http://www.naphs.org/news/guiding-princ.html. Accessed November 5, 2008
5. National Mental Health Association. Position Statement: The Use of Restraining Techniques and Seclusion for Persons with Mental or Emotional Disorders. NMHA Program Policy P-41, 2000
6. APNA: 2007 Position Statement on the Use of Seclusion and Restraint, revised 2007. Available at http://www.apna.org/files/public/APNA_SR_Position_Statement_Final.pdf. Accessed November 17, 2008
7. Glover RW: Reducing the use of seclusion and restraint: a NASMHPD priority. Psychiatr Serv 56:1141–2, 2005
8. National Technical Assistance Center for State Mental Health Planning. Six core strategies for reducing seclusion and restraint use. Draft example: policy and procedure on debriefing for seclusion and restraint reduction projects. Arlington, VA: NASMHPD, May 2005. Available at http://www.nasmhpd.org/general_files/publications/ntac_pubs/debriefing%20p%20and%20p%20with%20cover%207–05.pdf. Accessed November 14, 2008
9. Curie CG: SAMHSA's commitment to eliminating the use of seclusion and restraint. Psychiatr Serv 56:1139–40, 2005
10. Mental Health: Improper Restraint or Seclusion Use Places People at Risk. United States General Accounting Office Report to Congressional Requesters. GAO/HEHS-99-176, September 1999. Available at http://www.gao.gov/archive/1999/he99176.pdf. Accessed October 19, 2011
11. The Joint Commission. Preventing Restraint Deaths. Sentinel Event Alert. November 18, 1998, Issue 8. Available at http://www.jointcommission.org/assets/1/18/SEA_8.pdf. Accessed October 19, 2011
12. Pollard R, Yanasak EV, Rogers SA, *et al*: Organizational and unit factors contributing to reduction in the use of seclusion and restraint procedures on an acute psychiatric inpatient unit. Psychiatr Q 78:73–81, 2007
13. 42 C.F.R. § 441, § 483 (2008)
14. Children's Health Act of 2000, Pub. L. No. 106-310 (2000)
15. American Psychiatric Association, American Psychiatric Nurses Association, and the National Association for Psychiatric Health Systems. Learning from Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health. Arlington, VA, and Washington, DC: American Psychiatric Association, American Psychiatric Nurses Association, and the National Association for Psychiatric Health Systems. Available at http://www.psych.org/Departments/QIPS/Downloads/LearningfromEachOther.aspx. Accessed November 5, 2008
16. Appendix. American Psychiatric Association, American Psychiatric Nurses Association, and the National Association for Psychiatric Health Systems. Learning from Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health. Arlington, VA, and Washington, DC: American Psychiatric Association, American Psychiatric Nurses Association, and the National Association for Psychiatric Health Systems. Available at http://www.naphs.org/rscampaign/Learning.pdf. Accessed October 19, 2011
17. National Association of State Mental Health Program Directors Medical Directors Council. Reducing the Use of Seclusion and Restraint: Findings, Strategies, and Recommendations. Alexandria, VA: NASMHPD, July 1999. Available at http://www.nasmhpd.org/general_files/publications/med_directors_pubs/FirstTechnicalReport%20SR.pdf. Accessed November 8, 2008
18. LeBel J: Regulatory change: a pathway to eliminating seclusion and restraint or 'regulatory scotoma'? Psychiatr Serv 59:194–6, 2008
19. Centers for Medicare and Medicaid Services Finale Rule. Medicare and Medicaid Programs: Hospital Conditions of Participation: Patients' Rights. 42 C.F.R. § 482 (2006)
20. 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
21. Youngberg v. Romeo, 457 U.S. 307 (1982)
22. Washington v. Harper, 494 U.S. 210 (1990)
23. Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), hearing ordered 334 F. Supp. 1341 (M.D. Ala. 1971), orders entered, 344 F. Supp. 373 (M.D. Ala. 1972), aff'd in part, rev'd and remanded in part. Wyatt v. Aderholt, 503 F. 2d 1305 (5th Cir. 1974)
24. Davis v. Rennie, 264 F.3d 86 (1st Cir. 2001), cert. denied, Rennie v. Davis, 535 U.S. 1053 (2002)
25. Campbell v. Sikes, 169 F.3d 1353 (11th Cir. 1999)
26. People v. Harvey, 528 N.E.2d 1053 (Ill. App. Ct. 1988)
27. Threlkeld v. White Castle Systems, Inc., 127 F. Supp. 2d 986 (N.D. Ill. 2001)
28. Borckardt J, Grugabugh A, Pelic C, *et al*: Enhancing patient safety in psychiatric settings. J Psychiatr Pract 13:355–61, 2007
29. Busch A, Shore M: Seclusion and restraint: a review of recent literature. Harv Rev Psychiatry 8:261–70, 2000
30. Smith G, Davis R, Bixler E, *et al*: Pennsylvania State Hospital System's seclusion and restraint reduction program. Psychiatr Serv 56:1115–22, 2005

31. Liberman R: Elimination of seclusion and restraint: a reasonable goal? Psychiatr Serv 57:576, 2006
32. Bloom SL, Bennington-Davis M, Farragher B, *et al*: Multiple opportunities for creating sanctuary. Psychiatr Q 74:173–90, 2003
33. LeBel J, Goldstein R: The economic cost of using restraint and the value added by restraint reduction or elimination. Psychiatr Serv 56:1109–14, 2005
34. Hellerstein DJ, Staub AB, Lequesne E: Decreasing the use of restraint and seclusion among psychiatric inpatients. J Psychiatr Pract 13:308–17, 2007
35. Greene RW, Ablon JS, Martin A: Use of collaborative problem solving to reduce seclusion and restraint in child and adolescent inpatient units. Psychiatr Serv 57:610–12, 2006
36. Dean AJ, Duke SG, George M, *et al*: Behavioral management leads to reduction in aggression in a child and adolescent psychiatric inpatient unit. J Am Acad Child Adolesc Psychiatry 46:711–20, 2007
37. Donat DC: Impact of a mandatory behavioral consultation on seclusion/restraint utilization in a psychiatric hospital. J Behav Ther Exp Psychiatry 29:13–19, 1998
38. Gaskin CJ, Elsom SJ, Happell B: Interventions for reducing the use of seclusion in psychiatric facilities: review of the literature. Br J Psychiatry 191:298–303, 2007
39. Keski-Valkama A, Sailas E, Eronen M, *et al*: A 15-year national follow-up: legislation is not enough to reduce the use of seclusion and restraint. Soc Psychiatry Psychiatr Epidemiol 42:747–52, 2007
40. Haimowitz S, Urff J, Huckshorn KA: Restraint and Seclusion: A Risk Management Guide (White Paper). Alexandria, VA: National Association of State Mental Health Program Directors, September 2006. Available at http://www.nasmhpd.org/general_files/publications/ntac_pubs/R-S%20RISK%20MGMT%2010-10-06.pdf. Accessed September 11, 2008
41. Huckshorn KA: Re-designing state mental health policy to prevent the use of seclusion and restraint. Admin Policy Ment Health Ment Health Serv Res 33:482–91, 2006
42. Buckley v. Rogerson, 133 F.3d 1125 (8th Cir. 1998)
43. Masters KJ, Wandless D: Use of pulse oximetry during restraint episodes. Psychiatr Serv 56:1313–14, 2005
44. Dickson BC, Pollanen MS: Fatal thromboembolic disease: a risk in physically restrained psychiatric patients. J Forensic Legal Med 16:284–6, 2009
45. Unzueta v. Steele, 291 F. Supp. 2d 1230 (D. Kan. 2003)
46. The Joint Commission. 2009 National Patient Safety Goals. Joint Commission Perspectives 28:12–14, 2008
47. Pisel v. Stamford Hospital, 430 A.2d 1 (Conn. 1980)
48. Simon RI: Commentary: medical errors, sentinel events, and malpractice. J Am Acad Psychiatry Law 34:99–100, 2006
49. Steinert T, Bergbauer G, Schmid P, *et al*: Seclusion and restraint in patients with schizophrenia: clinical and biographical correlates. J Nerv Ment Dis 195:492–6, 2007
50. Grant JE: Restraint and monitoring of psychotic or suicidal patients. Curr Psychiatry 4:84–6, 2005
51. Sheline Y, Nelson T: Patient choice: deciding between psychotropic medication and physical restraints in an emergency. Bull Am Acad Psychiatry Law 21:321–9, 1993
52. Andrews v. Neer, 253 F.3d 1052 (8th Cir. 2001)
53. Scherer v. Waterbury, 2000 Conn. Super. LEXIS 481 (Conn. Super. Ct. February 22, 2000)
54. Hopper v. Callahan, 562 N.E.2d 822 (Mass. 1990)
55. Dolihite v. Maughon, 74 F.3d 1027 (11th Cir. 1996), cert. denied, Dolihite v. King, 519 U.S. 870 (1996)
56. Morin M: Patient safety efforts target communication at Rhode Island hospitals. Med Health Rhode Island 90:182–3, 2007
57. New York v. Simon, 157 A.D.2d 508, 549 N.Y.S.2d 701 (N.Y. App. Div. 1 Dept, 1990)
58. Price M, Recupero PR: Risk management, in Textbook of Hospital Psychiatry. Edited by Sharfstein SS, Dickerson FB, Oldham JM. Washington, DC: American Psychiatric Publishing, Inc., 2009, pp 411–28
59. DeRosier J, Stalhandske E, Bagian JP, *et al*: Using health care failure analysis: the VA National Center for Patient Safety's prospective risk analysis system. Joint Comm J Qual Patient Safe 28:248–67, 2002
60. The Joint Commission. Sentinel Event Forms and Tools. Available at http://www.jointcommission.org/sentinel_event.aspx. Accessed October 19, 2011
61. Tovino SA: Psychiatric restraint and seclusion: resisting legislative solution. Santa Clara L Rev 47:511–70, 2007