

Creating Violence Free and Coercion Free
Service Environments for the Reduction of
Seclusion and Restraint

Current Assumptions Regarding Physical Intervention, Seclusion and Restraint Use



Module created by Nihart, Huckshorn, LeBel 2003,
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**Conceptually excerpted in part from Mohr & Anderson, 2001.*

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Definition

Assumption: A belief that is supposed to be
factual; Something taken for granted. A
supposition.

(Webster, 1994)

*(Some assumptions are based on facts,
some are based on myths...)*

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Assumption

Restraints keep children safe

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Reality

- 142 deaths in the US from 1988 – 1998 due to S/R,
reported by the Hartford Courant *(Weiss et al, 1998)*
- 111 fatalities over 10 years in New York facilities due
to restraints *(Sundram, 1994 as cited by Zimbrot, 2003)*
- At least 16 children (<18 y.o.) died in restraints in Texas
programs from 1988 – 2002, reported by local media
(American-Statesman, May 18, 2003)
- At least 14 people died and at least one has become
permanently comatose while being subjected to S/R
from July 1999 to March 2002 in California
(Mildred, 2002)

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Reality

- 50 to 150 deaths occur in the US each year due
to S/R estimated by the Harvard Center for Risk
Analysis *(NAMI, 2003)*
- Federal Office of the Inspector General
identified 42 of 104 (42%) SR deaths from
08/99 – 12/04 were not reported. *(OIG, 2006)*

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Reality



Joey & his mother

- **James White, 17, & Joey Aletriz, 16,** died at the same residential program in Pennsylvania in December 2005 & February 2006, respectively, after being restrained by staff in the prone position. Both died from positional asphyxia.
- According to Joey's mother, Cynthia Allen: *"I didn't send my son there to be killed. My Joey needed help, and this is what he got instead."*

Retrieved from <http://www.nbc10.com/news/6885605/detail.html>

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Reality



- On **Tanner Wilson's, 9,** first day at a program his leg was broken when staff physically restrained him. After surgery, he returned to the program with a walker. His leg was later broken a 2nd time.

Eighteen months after being admitted, Tanner died while being restrained in a "routine physical hold." He died of asphyxiation – he suffocated to death. He was 11 years old.

Retrieved from <http://www.inclusiondaily.com/news/institutions/ia/iowa.htm>

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Reality: Day Treatment Program

In July 2006, in Wisconsin, Angellika Arndt, 7 years old, was held face-down by two clinic workers on nine different occasions in one month. After the last occasion, she passed out, and died the next day at the hospital. The coroner determined the cause of death to be chest asphyxia.

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Assumption

Seclusions keeps children safe

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Reality



- **Roshelle Clayborne, 16,** died at a residential treatment program. She wrote to her grandmother 7 months after being admitted, begging to come home, fearing she would die there. Later, Roshelle was physically restrained in the prone position and given IM medication. With 8 staff watching, she lost control of her bodily functions, was rolled in a blanket, and carried to the seclusion room. Five minutes passed before a staff member noticed she had not moved and was dead.
- According to her grandmother, Charlene Miles, *"I'll picture her lying on that floor until the day I die ... Roshelle had her share of problems, but good God, no one deserves to die like that."*

Retrieved from <http://www.charlydmiller.com/LIB05/1998hartfordcourant11.html>

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Reported Injuries and Deaths

- Injuries including:
 - Coma
 - Broken bones
 - Bruises
 - Cuts requiring stitches
 - Facial damage
- Deaths due to:
 - Asphyxiation
 - Strangulation
 - Cardiac arrest
 - Blunt trauma

(Mildred, 2002)

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Assumption

Restraints keep staff safe

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Reality

- For every 100 mental health aides, 26 injuries were reported in a three-state survey done in 1996
- The injury rate in health care is higher than what was reported for workers in:
 - Lumber
 - Construction
 - Mining industries

(Weiss et al, 1998; US Dept. of Labor, 2005)

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Reality

- In 2002, **Jean-Max Auguste, 50**, a mental health worker was kicked in the chest attempting to physically restrain a consumer at Greystone Park Psychiatric Center in New Jersey. He died from sudden cardiac arrest secondary to blunt force trauma to the chest.
- In 2006, **Lee McDuffy, 39**, a mental health worker at Spring Grove Hospital in Maryland collapsed and died after physically restraining a consumer.



Retrieved on June 23, 2006 from <http://querv.nvtimes.com/est/fullpage.html?res=9C06E1DE113FF932A05753C1A9649C8B63>
 Retrieved on December 15, 2006 from http://www.examiner.com/a-383324-Official_says_hiring_at_state_hospitals_is_difficult.html

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Reality

- Implementation of staff training to reduce the use of restraints resulted in:
 - 13.8% reduction in annual restraint rates
 - 54.6% decrease in average duration of restraint per admission
 - 18.8% reduction in staff injuries

(Forster, Cavness, & Phelps, 1999)

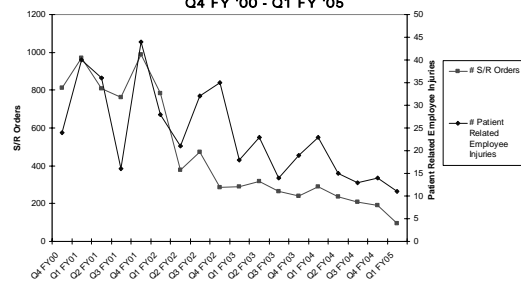
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Worcester State Hospital

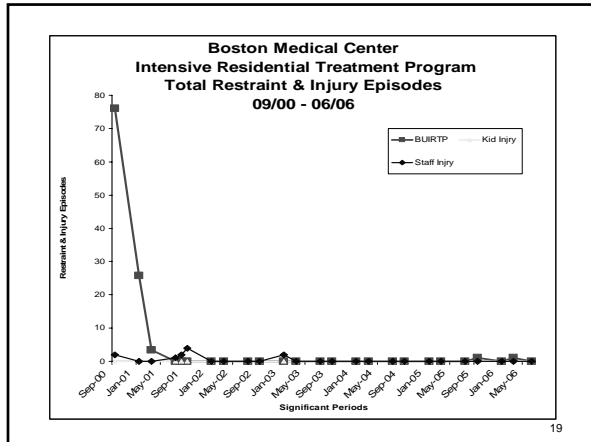
- Continuing care inpatient psych facility
- 156 Adult beds
 - 141 Continuing Care
 - 15 Court Evaluations (forensic)
- Public Sector, state funded/managed
- SMI diagnosis
- Age range: 19 and up

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Seclusion and Restraint Orders and Patient Related Employee Injuries
 Worcester State Hospital
 Q4 FY '00 - Q1 FY '05



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Assumption

*Restraints are only used when
absolutely necessary and for
safety reasons*

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Reality



- **Andrew McClain** was 11 years old and weighed 96 pounds when two staff sat on his back and crushed him to death.
- *Andrew's offense?*
- Refusing to move to another breakfast table.

(Lieberman, Dodd & De Lauro, 1999)

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Reality



- **Edith Campos**, age 15, 110 pounds suffocated to death after being held face down by 2 staff after resisting an aide at the Desert Hills Center for Youth and Families.
- *Edith's offense?*
- Refusing to hand over an "unauthorized" personal item. The item was a family photograph.

(Lieberman, Dodd & De Lauro, 1999)

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Reality

- Ray, Myers, and Rappaport (1996) reviewed 1,040 surveys received from individuals following their New York State hospitalization
- Of the 560 who had been restrained or secluded:
 - 73% stated that at the time they were not dangerous to themselves or others
 - ¾ of these individuals were told their behavior was inappropriate (not dangerous)

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Assumption

*Unit staff know how to recognize a
potentially violent situation*

(Mohr & Anderson, 2001)

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Reality

- Holzworth & Wills (1999) conducted research on nurses' decisions based on clinical cues of patient agitation, self-harm, inclinations to assault others, and destruction of property
- Nurses agreed only 22% of the time

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Reality

- When data was analyzed for agreement due to chance alone, agreement was reduced to 8%
- Nurses with the least clinical experience (less than 3 years) made the most restrictive recommendations

(Holzworth & Wills, 1999)

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Assumption

*Staff know how to
de-escalate potentially
violent situations*

(Mohr & Anderson, 2001)

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Reality

- In a study conducted by Petti et al. (2001) of content from 81 debriefings following the use of seclusion or restraint, staff responses to what could have prevented the use of S/R included:
 - 36% blamed the patient
 - Example: *"He could have listened and followed instructions"*
 - 15% took responsibility
 - Example: *"I wish I could have identified his early escalation"*

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Reality

- Other responses included:
 - 15% provided no response
 - 12% were at a loss
 - Example: *"I don't see anything else...all alternatives used."*
 - 11% blamed the system
 - Example: *"Need to make a plan for shift change"*
 - 9% blamed the level of medication

(Petti et al, 2001)

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Reality

- Luiselli, Bastien, and Putnam (1998) conducted a behavioral analysis to explore contextual variables related to the use of mechanical restraints
 - Setting: Children/adolescent inpatient
- Results: The most frequent antecedent to the use of mechanical restraints was a staff-initiated encounter with the person

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Reality

- Duxbury (2002) analyzed 221 reported incidents of aggression and violence over a 6 month period in 3 acute psychiatric units
- She found that de-escalation was used as an intervention less than 25% of the time
- Semistructured interviews identified lack of training

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Reality

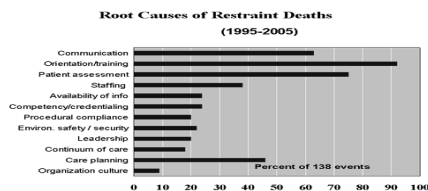
- McCall audit found that 31% of direct care staff sampled did not receive mandatory training in preventing and managing crisis situations over the last 3 years.

(NYAPRS, 2002)

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Reality

- JCAHO Sentinel Event Database of Restraint Deaths



- The single most frequent contributing factor to restraint deaths (> 90%) was a lack of **basic staff orientation & training** in managing behavioral crises

Retrieved from: http://www.jointcommission.org/NR/rdonlyres/E0619D1D-0548-4300-8C05-37049FCC62D5/0/se_rc_restraint_deaths.gif

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Assumption

Restraint and seclusion are not used as, or meant to be, punishment

(Mohr & Anderson, 2001)

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Reality

- Strictly defined “physical punishment consists of infliction of pain on the human body, as well as painful confinement of a person as a penalty for an offense”

(Hyman, 1995, 1996)

- The involuntary overpowering, isolation, application and maintenance of a person in restraints is an aversive event from both the standpoint of logic and from that of the victim

(Miller, 1986; Mohr & Anderson, 2001)

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Reality

- 41 patients who had been secluded during their hospitalization were interviewed
 - One year after discharge, they were asked to draw pictures related to their hospitalization
 - 20 of 41 spontaneously drew pictures of their seclusion room experience – none were specifically asked to do this
 - Revealed themes associated with fearfulness, terror, and resentment

(Wadeson & Carpenter, 1976)

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Reality

- Feelings of bitterness and resentment toward seclusion prevailed at one year follow-up sessions
- Material interpreted from drawings of hallucinations while in seclusion contrasted sharply, reflecting:
 - excitement
 - pleasure
 - spirituality
 - distraction and
 - withdrawal into a reassuring inner world

(Wadeson & Carpenter, 1976)

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Reality

Cambridge Hospital Child Assessment Unit

- Eliminated mechanical restraint, medication restraint and seclusion.
- Analyzed 28 episodes of physical restraint (“holds”) under 5 minutes over 3-month period
- 68% of holds < 1 minute
- Children perceive duration: 5 minutes – 1 hour
- Interviewed much later, the intensity of affect (fear, rage) returns

(Regan, 2004)

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Reality

- Research study found that people who were secluded experienced: vulnerability, neglect and a sense of punishment

(Martinez et al, 1999)

- People who were secluded also stated that “anger and agitation were the result of being placed in seclusion”

(Martinez et al, 1999)

- Secluded persons expressed feelings of fear, rejection, boredom and claustrophobia

(Mann, Wise, & Shay, 1993)

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Reality

- Analysis of six studies reported 58 – 75% conceptualized seclusion as punishment by staff
- Many persons-served believed:
 - Seclusion was used because they refused to take medication or participate in treatment program
 - Frequently, they did not know the reason for seclusion

(Kaltiala-Heino et al, 2003)

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Assumption

Seclusion and restraint are used without bias and only in response to objective behavior

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Reality

- Research indicates that cultural and social bias may exist.

- Those more likely to be secluded:

- Blacks and Asian descent (Price, David & Otis, 2004)

- Those more likely to be restrained:

- Younger and on more medications (LeGris, Walters, & Browne, 1999)

- Younger, male gender, and Black or Hispanic descent (Donovan et al, 2003; Brooks et al, 1994)

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Reality

David “Rocky” Bennett, 38

Died in restraint in a UK hospital in 1998. He was racially-abused by a white consumer in the hospital and lashed out at a nurse. He was held in a prone restraint by 5 staff for 25 minutes and died. An inquest into his death found significant “*institutional racism*” in the NHS.



(www.blink.org.uk)

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Reality

- Rocky’s death and Inquiry lead to national 5-year plan, *Delivering Race Equality in Mental Health Care*, to be fully implemented by 2010.
- Two of the Inquiry’s key recommendations included:
 - limiting restraint time (<3 minutes)
 - addressing **institutional racism**

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Reality

- UK publishes, *Count Me In*, the 1st national census of inpatient psychiatric hospitals in December 2005
- **African-Caribbeans** represent 3% of the general population but 10% of mental health patients. They are also:
 - 44% more likely to be committed
 - Twice as likely to be sent by the Court
 - 70% more likely to be referred for counseling
 - 20-25% more likely to be detained than whites
 - **29% higher restraint rate**
 - **50% higher seclusion rate**

Retrieved from www.blink.org.uk/print.asp?key=10522

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Reality

- Data from a New York study showed that the use of seclusion and restraint varied widely across all facilities in the state because of the “... *disparate clinical perspectives on the advisability of seclusion and restraint and the limited comparative monitoring of restraint and seclusion practices in institutional settings.*”

(Ray & Rappaport, 1995)

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Reality

- Fisher (1994) concluded that factors that had a greater influence on the use of seclusion than demographic and clinical factors were:
 - Clinical biases
 - Staff role perceptions, and
 - Administrator attitudes
- Supported by more recent Harvard Review
- Cultural disparities appear to exist

(Fisher, 1994; Busch & Shore, 2000)

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Assumption

*Seclusion and restraint
are “therapeutic interventions”
and based on clinical knowledge*

(Mohr & Anderson, 2001)

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Reality

- Cochrane Review (2000)
 - 2,155 articles, no controlled studies
 - S/R efficacy and therapeutic value not established
 - Serious adverse effects cited

(Saitas & Fenton, 2000)

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Reality

- Meehan, Bergen & Fjeldsoe (2004) studied seclusion perceptions in 3 units and found:
 - **Nurse's believe seclusion was:**
 - Very necessary
 - Not very punitive
 - Highly therapeutic
 - **Patient's believe seclusion was:**
 - Used frequently for minor disturbances
 - Used so staff could exert power and control
 - Made them feel punished
 - Had very little therapeutic value

(Meehan, Bergen & Fjeldsoe, 2004)

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Reality

- Semi-structured interviews with 24 previously secluded patients indicated:
 - 21% described it as dehumanizing and humiliating
 - 16% commented on loneliness and isolation
 - 54% reported nothing beneficial
- When asked what was bad about seclusion:
 - 42% commented on the physical starkness, lack of toilet and running water, sleeping on a mat on the floor
 - The majority reported that seclusion bothered them more than any other experience in the hospital

(Binder & McCoy, 1983)

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Reality

- Punitive and isolating behaviors tend to be associated with a significant increase in negative behaviors and significant decrease in positive behaviors
- Individuals who lack the capacity to understand contingency-based interventions may actually have counterproductive outcomes

(Natta et al, 1990)

(Papolos & Papolos, 1999)

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Reality

- Magee & Ellis (2001) studied classroom interventions used with adolescents who had mental retardation. When physical restraint was used as a consequence for inappropriate classroom behavior, rates of the problem behavior increased in all sessions for each student. Student's play and positive behavior also decreased.

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Conclusion

- Numerous unfounded beliefs exist
- Harm in restraints and seclusion are well documented; positives are not substantiated
- Biases exist in the system
- Not evidence-based practice
- Significant culture change is required

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Conclusion

- The worst punishment deemed possible in prisons is seclusion/solitary confinement
- In psychiatric hospitals and treatment settings, people who behave inappropriately are placed in seclusion
- Perhaps the only difference is that in psychiatry we call it “therapeutic”

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*“The breach between what we know
and what we do [can be] lethal.”*

Dr. Kay Redfield Jamison
Night Falls Fast

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