Practitioner Forum

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Seclusion and Restraint: A High-Risk Procedure With Alternative Methods

Today, individual states and the federal government have enacted standards, laws, regulations, and policies governing the use of seclusion and restraint as a way to eliminate or decrease its use. The American Psychiatric Association, American Psychiatric Nurses Association, and the National Association of Psychiatric Health Systems noted, "what is clear in all of these standards is a national intent to see that restraint and seclusion are used appropriately, as infrequently as possible, and only when less restrictive methods are considered and are not feasible."[1] Additionally, in 2003, the Substance Abuse and Mental Health Services Administration developed a national action plan to reduce and possibly end the use of seclusion and restraint in behavioral health care settings, because its practice can negatively impact the recovery of persons with mental illnesses.[2]

The use of seclusion and restraint is a high-risk procedure that may result in trauma, injury, or death of the patient. In addition, the method is nontherapeutic and reflects a breakdown in the treatment process. The practice of secluding and restraining patients may lead to staff or patient injury and can contribute to a longer stay for the patient. This practice should be used as a last resort, because it can increase patient aggression, increase the cost of care, and traumatize the patient. The staff at mental health facilities must be proficient at de-escalating and preventing aggressive situations that can lead to seclusion and restraint.

The practice of using seclusion and restraint remains controversial and is one of the oldest treatments of patients with a mental illness. In 1998, the *Hartford Courant* newspaper brought to the public's attention the confirmed deaths of 142 people (including children) housed in mental health facilities.[3] The *Courant* conducted a 10-year nationwide survey concerning the improper use of seclusion and restraint in mental health facilities and group homes and found that between 50 to 150 deaths were estimated to occur each year from the use of seclusion and restraint, but not all deaths were reported.[3] In 1999, Legris et al found locked seclusion could reduce the costs of additional nursing staff, but these savings were negated by extended hospital stays and the compromised quality of care.[4] A compromised quality of care affects all stakeholders and negatively impacts the community's perception of the health care organization. The move toward the reduction of seclusion and restraint hours seems to be working. According to a study by the National Association of State Mental Health Program Directors, between 2001 and 2006, the number of hours patients in state mental health hospitals spent in restraint decreased by 46%, and the number of hours in seclusion decreased by 26%.[5]

PHYSICAL EFFECTS OF SECLUSION AND RESTRAINT

The use of seclusion and restraint is deemed a high-risk procedure; therefore, standards for use of restraint have changed in the past decades. Previous restraints such as geri-chairs, vests, belts, and bed rails have been found to harm patients rather than help them. Long-term use of restraints can present problems such as muscle loss, pressure ulcers, incontinence, pneumonia, contractures, bone weakness, death due to asphyxia, aspiration, and cardiac events. Medical risk factors for placing a patient in seclusion and restraint include but are not limited to asthma, bronchitis, intoxication, obesity, pregnancy, and seizures. Because the risk factors of using seclusion and restraint outweigh any benefits, it is essential to understand and learn effective methods to de-escalate a patient rather than depend on seclusion and restraint.

PSYCHOSOCIAL EFFECTS OF SECLUSION AND RESTRAINT

When patients are restrained, they may feel dehumanized and isolated and withdraw from others. Additionally, subpopulations, such as hearing-impaired patients and abused patients need special considerations. For example, restraints prohibit hearing-impaired patients' ability to communicate using sign language, causing them to feel isolated and helpless. Restraints may traumatize sexually or physically abused patients, causing them to regress, because they are reliving an abusive situation. Moreover, restraints may impact patients' dignity and damage the therapeutic relationship, causing patients to have trust issues with the health care team. Excessive reliance on seclusion and restraint to minimize disruptive behavior in psychiatric settings decreases the likelihood that patients will develop the skills to live in an outpatient setting.

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POTENTIAL REASONS FOR AGGRESSIVE BEHAVIORS

Patients may become aggressive for many reasons other than anger. The symptoms of patients with a history of posttraumatic stress disorder may be exacerbated when they are placed in seclusion or restraint. A study found that 85% percent of females who have a history of abuse reported feeling unsafe in a psychiatric unit that had male patients.[6]

Harmful patient experiences happen in psychiatric units. For example, trauma that has occurred in adult psychiatric units include witnessing traumatic events (63%); being around potentially harmful, frightening experiences (54%); physical assault (31%); and sexual assault (8%).[7] Harmful experiences also include having medication used as a threat or punishment, name-calling by the staff, hearing name-calling of other patients by the staff, and being around violent patients. These experiences contribute to the psychological distress and traumatic experiences of patients. When patients feel threatened, they may act aggressively. Given the aforementioned, patients may feel the need to protect themselves and become aggressive. Therefore, the staff should display sensitivity when caring for patients with psychiatric disorders, because abusive and insensitive actions can contribute to patient aggression. Nevertheless, the staff generally attributes aggression to the patient's illness.

The staff should be encouraged to reflect on the belief that staff injuries will occur if seclusion and restraint are not used.[1] In contrast, "…research confirms that environments characterized by control and coercive interactions are more likely to result in staff injuries."[1] The staff must realize they are instrumental in the culture change toward patient-centered care in psychiatric settings.

ALTERNATIVES TO SECLUSION AND RESTRAINT

The reduction of seclusion and restraint hours involves creative changes to the physical environment.[8] For example, in contrast to a cold non-inviting room, comfort rooms can be used as a soothing milieu to help reduce a patient's stress level. Comfort rooms should be designed with comfortable furniture, soothing music and colors, along with soft lighting. Multisensory environments have been used in occupational therapy and are now taking root in psychiatric hospitals.[9] When the staff recognizes a patient is in distress, the comfort room, which promotes a therapeutic and safe environment, can be the first step in helping to calm the patient. In addition, reducing episodes of restraint may require the staff to be in the unit environment, anticipate crises before they occur, and be available to talk with patients.

Also, when a patient is having difficulty, information from the admission assessment can help by providing the staff with insights into environmental issues that may trigger the patient to decompensate. Being proactive in identifying triggers may help the staff to decrease seclusion and restraint. Other patient de-escalation techniques for the staff include staying calm, empathetic, reassuring, offering assistance, avoiding confrontation, providing personal space, offering choices, allowing patients to express their feelings, and providing clear direction and time for patients to think about their options. Simply asking a patient "What would help you at this time?" is often overlooked as a communication technique. However, this question can provide insight into what the patient needs and may avert the use of seclusion and restraint. Sometimes offering pastoral care, listening and communicating, and engaging the patient in an activity can de-escalate the situation. In addition, accurate documentation of events and interventions that helped the patient in the past can assist other health care professionals when they interact and provide care for the patient. Finally, building a therapeutic rapport cannot be overlooked as the foundation for de-escalating strategies.

Eliminating and reducing the use of seclusion and restraint requires an eclectic approach. First, the staff must recognize seclusion and restraint is not a treatment option and that there are viable alternatives. Second, the administration should be visible on psychiatric units and inform the staff of how well the unit is doing with seclusion and restraint hours. These visits to the unit may achieve buy-in from the staff, because they see that the administration has an interest in reducing seclusion and restraint hours. During the visit the staff has the opportunity to ask questions and express concerns to the administration.

EDUCATION IS THE KEY

In 1994, Liukkonen and Laitinen suggested education about restraint in an acute-care psychiatric setting was limited, but effective.[10] Subsequently, the October 11, 1998, article "11 Months 23 Dead" appeared in the *Hartford Courant* and brought additional public attention to the use of restraint. The article contended that poor staff training was one reason why restraint could be deadly.[11] In general, the administration must support the psychiatric staff by offering educational opportunities. Educating the staff can help change beliefs, perceptions, and attitudes toward seclusion and re-

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straint. Ongoing education can help the staff develop new strategies and problem-solving skills to effectively manage behavioral issues. The staff must focus on fostering a caring, not a controlling, environment.

In conclusion, by being proactive and decreasing the use of seclusion and restraint, the staff at mental health facilities can decrease the cost of patient care, injuries, and psychological trauma to the patient while increasing the quality of care. Patients with mental illness must be treated with dignity and respect. According to William Pflueger who experienced restraint:

I can't bring myself to describe the moment-by-moment struggles and sheer gut-wrenching terror of being put into 5-point restraint. The whole experience made me feel ashamed and that my soul had been dishonored. I sensed that some of that shame rubbed off on the people who were ordered to do that to me.[12]

As the nation moves into the 21st century, the treatment of patients with mental illness must change along with the attitudes of health care professionals. Patients need to be cared for in a therapeutic, supportive, and nonthreatening environment.

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