

SAMHSA's Commitment to Eliminating the Use of Seclusion and Restraint

Charles G. Curie, M.A., A.C.S.W.

I'm a social worker by training and inclination, and I have committed myself to do whatever I can to help people recover from mental and addictive disorders, which is why the use of seclusion and restraint as a so-called treatment goes against everything I believe in both personally and professionally. Why should practices that risk the lives of and inflict emotional and physical trauma on the people we are trying to heal be an option at all? They should not be. That's why I'm especially pleased to comment on the articles in this special section of *Psychiatric Services* on seclusion and restraint.

Reducing and eliminating the practices of seclusion and restraint has been a special passion of mine for nearly ten years, from my tenure as Deputy Secretary for the Office of Mental Health and Substance Abuse Services in Pennsylvania to my current role as Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services (HHS). At SAMHSA, we believe that the use of seclusion and restraint clouds our vision of a life in the community for everyone and impedes our mission of building resilience and facilitating recovery. This view squares with HHS Secretary Mike Leavitt's goal, as part of his 500-day plan, of protecting life, family, and human dignity.

Unfortunately, as the articles in this special section attest, traumatic and harmful experiences are all too com-

mon in psychiatric settings, and consumers perceive these events to be humiliating, dehumanizing, unreasonable, and distressing. Yet the picture is hopeful. Clearly, staff can learn and successfully use alternative behavioral approaches, particularly when supported by program leaders. The article by Gregory M. Smith M.S., and his coauthors, which is based on the Pennsylvania experience, shows that seclusion and restraint can be reduced and even eliminated, with no increase in staff injuries. In fact, one of the hospitals in Pennsylvania that became virtually free of seclusion and restraint saw a 67 percent decline in disabling injuries among patients and staff. In addition, Janice LeBel, Ed.D., and Robert Goldstein, M.P.H., have shown in their study that the elimination of seclusion and restraint not only saves money but also improves client outcomes and staff working conditions.

A vision of recovery

The goal of a transformed system of care, as envisioned by the President's New Freedom Commission on Mental Health, is recovery. The commission made clear that consumers must participate in the treatment process and be at the center of care. The use of seclusion and restraint keeps consumers at the margins; they can't learn to manage their illnesses and their lives when they are under external control—either physical or chemical. These

practices further their dependence and isolation, leading to learned helplessness and hopelessness. Worse, such practices may keep individuals from seeking needed treatment out of fear of loss of autonomy and control.

The answer is clear. We must stop thinking of seclusion and restraint as treatment. They are a product of treatment failure. In fact, seclusion and restraint, at best, should be a safety measure of last resort, used only when all other options have failed (1). Seclusion and restraint cannot co-exist with a recovery-oriented system.

The need for a culture change

Although the vision may be clear, its realization requires planning. Policy changes are necessary but not sufficient to eliminate the use of seclusion and restraint. Success begins with a change in culture, from one of power to one of empowerment, from coercion to caring, and from hopelessness to hope. Leadership at the top is essential, but, as we learned in Pennsylvania, these changes can't be implemented by fiat—the buy-in of key staff is essential. Indeed, as Smith and his coauthors point out in their article, the values of hospital staff and community advocates and their commitment to a nonrestraint philosophy were the major reasons for the changes in attitude, culture, and environment in Pennsylvania's state hospital system.

Some specific steps can help support this important shift in culture. They include:

- ◆ An adequate number of qualified staff to meet patient treatment needs
- ◆ Staff training, especially in ver-

Mr. Curie is administrator of the Substance Abuse and Mental Health Services Administration. Send correspondence to him at 1 Choke Cherry Road, Rockville, Maryland 20857 (e-mail, charles.curie@samhsa.hhs.gov). This commentary is part of a special section on the use of seclusion and restraint in psychiatric treatment settings.

bal crisis management, including de-escalation techniques

- ◆ Active treatment
- ◆ Active risk assessment and risk-based treatment planning
- ◆ Availability and use of appropriate antipsychotic medications
- ◆ An environment of care that promotes patient comfort, dignity, privacy, and personal choice
- ◆ State-level, aggregate data about each hospital's incidents of seclusion and restraint that are regularly used to inform management and quality improvement activities.

Policy changes that support these efforts must be flexible to allow for change and incorporate staff involvement. Some policy options consistent with current state or federal rules include:

- ◆ Seclusion and restraint must be used only when the potential exists for imminent physical danger to the patient or others
- ◆ Seclusion may not exceed one hour, and ongoing monitoring is needed so that the patient is out of seclusion as soon as possible
- ◆ A physician must physically assess the patient within 30 minutes of the first order and each reorder
- ◆ Physical restraint may not exceed ten minutes
- ◆ Persons in seclusion or restraint must be kept in constant face-to-face human observation
- ◆ The use of chemical restraint is prohibited
- ◆ Whenever seclusion or restraint is used, patient and staff debriefing must occur, and feedback must be included in the treatment plan to prevent the use of seclusion or restraint in the future
- ◆ Extensive staff orientation and education is required.

SAMHSA's response

At SAMHSA, we are very aware of the role that federal and national leadership has played and will continue to play in reducing and eliminating the use of seclusion and restraint for people of all ages who have mental disorders. Before I came to SAMHSA, my colleagues and I, as members of the National Association of State

Mental Health Program Directors (NASMHPD), helped lead the way with a position statement on the importance of eliminating seclusion and restraint (1). In 2003 SAMHSA convened a National Call to Action to Eliminate the Use of Seclusion and Restraint that involved multiple constituent groups. We have taken several steps toward achieving this important goal.

Evidence-based practices and guidelines. In October 2004, SAMHSA awarded eight State Incentive Grants totaling \$5.3 million over three years to support efforts in eight states to adopt best practices that will reduce and ultimately eliminate the use of seclusion and restraint in institutional and community-based settings that serve people with mental illnesses and co-occurring substance use disorders. In addition, we are funding a coordinating center operated by NASMHPD, the first of its kind focused on seclusion and restraint. The center will support the grantees, evaluate the program's impact, and promote effective, evidence-based alternative practices.

Training and technical assistance. In addition to the coordinating center, SAMHSA supports a number of other training and technical assistance activities. One such activity is a major training initiative with NASMHPD's National Technical Assistance Center for State Mental Health Planning, which holds executive training institutes for senior-level facility managers and state mental health agency staff. Delegations from 46 states, territories, and the District of Columbia have participated. Another activity is the Best Practices in Behavior Support and Intervention Project, a recently concluded three-year grant program designed to identify best practices in preventing and reducing the use of seclusion and restraint in facilities that serve children and adolescents. In addition, a consumer-centered staff training manual is currently being pilot-tested in two states. It will provide a practical training curriculum to help facilities develop alternatives to the use of seclusion and restraint.

Leadership and partnership development. SAMHSA's leadership role in reducing and eliminating seclusion and restraint begins within the agency itself, where a member of my executive team chairs our cross-cutting initiatives in this area; extends to other departments and agencies within HHS, such as the Centers for Medicare and Medicaid Services; and reaches other federal, national, and state partners in substance abuse, criminal justice, and education. We are working together to reduce and eliminate the use of seclusion and restraint in all settings.

Rights protection. To help protect and enhance the rights of people with mental illnesses to be treated with dignity and respect, SAMHSA funds, manages, and provides technical assistance to the Protection and Advocacy for Individuals with Mental Illness (PAIMI) program, which is currently funded at \$32 million. We also support self-advocacy training for consumers and promote the use of advance directives.

Data collection. The continued decrease in the use of seclusion and restraint in Pennsylvania is attributable, in part, to improved data collection and greater transparency in the way the information was shared and used. At SAMHSA, we are identifying and encouraging adoption of seclusion and restraint performance measures. In addition, the seclusion and restraint SIG requires the collection of specific data.

As important as data are, we don't need statistics to tell us that this is a life-and-death issue. We know that having even one person die or be injured from these practices is one too many. We know that there are effective alternatives that can be put in place to protect the health and safety of people of all ages with mental illnesses and addictions. The time to adopt these alternatives is now. ◆

Reference

1. Position Statement on Seclusion and Restraint. Alexandria, Va. National Association of State Mental Health Program Directors, 1999. Available at www.nasmhpd.org/general_files/position_statement/posses1.htm