

# Reducing the Use of Seclusion and Restraint: A NASMHPD Priority

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As executive director of the National Association of State Mental Health Program Directors (NASMHPD), I appreciate the opportunity to comment on the five papers on reducing seclusion and restraint in this special section of the September issue of *Psychiatric Services*. This topic has been both NASMHPD's and my personal priority for the past decade.

Data gathered from more than 200 facilities by the NASMHPD Research Institute, Inc. between January 2000 and December 2004 (1) sets the context for my comments. The percentage of clients who were restrained at these facilities fell by 16 percent—that is, each month 400 fewer clients were restrained. The number of hours of restraint was reduced by 50 percent, or 26,000 fewer hours of restraint each month. The percentage of clients who were secluded was reduced by 45 percent—that is, each month 1,000 fewer clients were secluded. The number of hours of seclusion fell by 18 percent, or 3,000 fewer hours of seclusion monthly.

These data indicate that progress has been made in reducing seclusion and restraint. However, I believe that state facilities and other service providers must continue to make it a priority to reduce and ultimately eliminate these coercive practices in order to improve the quality of people's lives. The five papers in this special section will help the mental health community move further in

that direction. In particular, I would like to congratulate these authors on pushing for a trauma-informed and recovery-based system of care.

The studies of trauma by Dr. Frueh and his colleagues and by Dr. Robins and her colleagues are significant contributions to the literature, because they make a strong case for the deleterious effects of coercive measures on consumers. Furthermore, the authors discriminate between the terms "sanctuary trauma" and "sanctuary harm," which provides clarification for the dialogue between clinicians and administrators. In particular, the term sanctuary trauma applies only to events that meet formal *DSM-IV* criteria. However, identifying and assigning clinical value to events that have not reached this level—sanctuary harm—is refreshing, especially given that these events likely occur with greater frequency but often do not receive the level of administrative or clinical attention that they warrant.

Furthermore, the authors note that most of the literature on violence and conflict that lead to seclusion and restraint in inpatient settings has focused primarily on negative consumer characteristics, which creates an atmosphere in which staff identify the consumer as the sole cause of aggression and violence. Thus practitioners may tend to focus only on risk factors, such as childhood environment, abuse, chemical use and dependency, history of antisocial behavior, age, and race or eth-

nicity. But these factors are only part of the picture.

Since 2001, NASMHPD's stance has been that violence and aggression in inpatient settings may also have been caused by the characteristics of the institutional milieu. Institutions that focus on control, organizational rules, directions to staff to "keep order," homogenized "one size fits all" treatment approaches and institutions that do not provide good staff supervision and training may trigger aggressive behavior.

Continued research is needed on the antecedents of aggression and violence, with a focus on staff and consumer interactions and the institutional milieu in general. Furthermore, facility leadership should investigate incidents of seclusion and restraint with this focus in mind. South Carolina has been a leader in investigating trauma and its effects on the people served in the public mental health system.

The study by Dr. LeBel and her colleagues on the costs of seclusion and restraint is groundbreaking work and adds to the rationale to reduce use. Public funding for mental health services in most states is shrinking, and cost savings are increasingly important. This study provides a succinct rationale for inpatient facilities to decrease the use of these interventions, which, the authors accurately note, cause staff to spend time in non-treatment activities that can lead to injury and death—and to lawsuits. Massachusetts, a leader in seclusion and restraint reduction, is to be lauded for this work.

Pennsylvania has led the nation in setting an example of what can be accomplished in a state system when the senior state leadership takes on

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the task of reducing seclusion and restraint and does the work. As Mr. Smith and his colleagues describe in their article, the state created a system of care that became intolerant of coercive measures and restricted their use. Furthermore, the state leaders demonstrated that the role of leadership toward organizational change is mandatory and cannot be delegated. In addition, Pennsylvania's generosity in openly and transparently sharing the story of its journey, including data and descriptions of successful interventions, has been a tremendous benefit to other states.

Dr. Donat, in his contribution to the special section, notes the need for behavioral management and behavioral interventions to reduce the use of seclusion, restraint, and medication. The article provides a clear statement about the negative effects on consumers and staff when seclusion and restraint are used. Dr. Donat also makes a clear and convincing argument that the full and complete involvement of facility leadership is critical in reduction efforts. However, the call for behavioral management, specifically for token economies, is less convincing. The use of behavioral practices that shape other people's

behavior does not seem to resonate or be congruent with what we now know about recovery, respect, the full inclusion of consumers in their care, empowerment, or the provision of hope.

It is true that behavioral scientists have the tools to manipulate people to perform in certain ways and in controlled environments. In fact, programs still exist that use M & M's as reinforcers for adults. However, these practices are implemented without clarity about any lasting effects or outcomes. To me, this manipulation of behaviors seems too close to paternalism and coercion to be supported as an evidenced-based practice. It would be helpful to investigate consumers' experiences of these kinds of institutionally based programs and, more important, to look at generalizable outcomes. Many of these behavioral programs emerged in the 1970s. However, times have changed, and the national call for transformation of the mental health system means that our leadership needs to have the courage to look with new eyes at business as usual and be prepared to change traditional approaches.

NASMHPD encourages new approaches that endorse the following six strategies, which have been sup-

ported in the literature to reduce coercion in mental health settings, including seclusion and restraint (2): mandatory involvement of leadership; use of data to monitor change and inform practice; development of the workforce in terms of attitudes, behaviors and core competencies; assessment of risk for violence, antecedent events, death or serious injury and use of tools to teach self-management of illness and emotions; rigorous debriefing analysis of events that do occur; and complete inclusion of consumers in their own care.

By decreasing coercion and increasing choice, individuals involved at all levels of the system of care can help create a healing culture of hope and recovery and, ultimately, improve the quality of people's lives. ♦

### References

1. Behavioral Healthcare Performance Measurement System, 2005. Alexandria, Va, National Association of State Mental Health Program Directors Research Institute, Inc, 2005
2. National Executive Training Institute: Training Curriculum for Reduction of Seclusion and Restraint. Alexandria, Va, National Association of State Mental Health Program Directors, National Technical Assistance Center for State Mental Health Planning, Jul 2005

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