CHAPTER 11: Seclusion and Restraint

ADVOCATE'S ROLE

Patients' Rights Advocates (PRAs) should be familiar with the seclusion and restraint laws and the standards that apply. The duties of PRAs surrounding seclusion and restraint may include the following:

- receiving and investigating complaints from or about mental health clients regarding unnecessary, excessive, or punitive use of seclusion and/or restraint;
- monitoring mental health facilities, services, and programs for compliance with statutory and regulatory provisions regarding the use of seclusion and restraint;
- providing training and education about seclusion and restraint laws, standards, and applicable rights to mental health providers.

DEFINING SECLUSION AND RESTRAINT

Seclusion and restraint are defined in various state and federal laws and regulations, as well as in Joint Commission on Accreditation of Healthcare Organization (Joint Commission) standards. Definitions and standards may vary depending on the type of facility where seclusion and/or restraints are used. Advocates are encouraged to research the laws, regulations, or standards that apply to a specific setting when providing advocacy services during situations involving seclusion and/or restraints.

SECLUSION

In general, seclusion is the involuntary isolation or confinement of a patient in a room, or other limited part of the facility, where the patient is physically prevented from leaving. Definitions vary regarding whether the person needs to be confined to an area or a specific room, as well as whether the person needs to be isolated to the room or area by a locked door. Seclusion is used to limit a patient's movement and activities, as well as to limit contact with other patients.

Confusion often arises around "time-outs". A "time-out" is the patient voluntarily agreeing to remain in an unlocked room or area in order to calm themselves or regain composure. A patient on a "time-out" can voluntarily leave the room or area when they feel they are able to. This is different from seclusion where the

patient is physically prevented, or is given the appearance they are physically prevented, from leaving.

BEHAVIORAL RESTRAINT

In general, behavioral restraint includes any manual method/hold, or any physical or mechanical device/material/equipment that immobilizes or reduces a person's ability to move parts of their body. It does not include briefly holding to calm or comfort someone, or brief assistance to redirect or prompt a person.

Behavioral restraint can also refer to "chemical restraint", which is when medication is used to manage or control a person's behavior. This is generally unplanned and, in an emergency, does not include when the medication is part of a standard treatment or dosage for the patient's condition or symptoms.

Behavioral restraint does not include medical or postural/supportive restraint. These would include the use of orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for conducting routine physical examinations or tests. It also does not include devices or equipment used to protect a patient from falling out of bed, or to permit a patient to participate in activities without the risk of physical harm. The laws that apply to medical and postural/supportive restraint are beyond the scope of this chapter and are not discussed here.

SECLUSION AND RESTRAINT: MYTH AND REALITY

Some common beliefs about seclusion and restraint turn out to be inaccurate or incorrect. These include the idea that seclusion and restraint keep all patients and staff safe, that seclusion and restraint are therapeutic, and that seclusion and restraint are used only when absolutely necessary and as a last resort for safety reasons only.

The following are quotes, which challenge common beliefs about seclusion and restraint, from the Roadmap to Seclusion and Restraint Free Mental Health Services by SAMHSA, U.S. Department of Health and Human Services (2005):

> "Seclusion and restraint are not therapeutic. There is actually no evidence-based research that supports the idea that restraints are therapeutic."
>
> "Seclusion and restraints do not keep people safe. The harm is well documented; not only the physical harm, but also the emotional and mental harm. Restraints actually harm and can cause death. Broken bones and

cardiopulmonary complications are associated with the use of seclusion and restraint (FDA, 1992; NYS OMH, 1994)."

"Even though staff would say that seclusion and restraints are not used as punishment, 60-75 percent of consumers view it as punishment for refusal to take meds or participate in programs."

(Roadmap to Seclusion and Restraint Free Mental Health Services by SAMHSA, U.S. Department of Health and Human Services (2005))

SECLUSION AND RESTRAINT LAWS AND STANDARDS IN MENTAL HEALTH SETTINGS

As with the definitions of seclusion and restraint, the laws and standards guiding the use of seclusion and restraint vary depending on the type of facility where seclusion and restraint are used. Facilities that receive federal funding and/or are accredited from the Joint Commission may have additional standards. Advocates are encouraged to research the specific laws or standards that apply at a facility when providing advocacy services related to the use of seclusion and/or restraints.

PATIENTS' RIGHTS

All people with a mental illness have the right to be free from harm. This includes being free from unnecessary or excessive physical restraint, isolation, or medication. Medication cannot be used as punishment, for the convenience of staff, as a substitute for the treatment program, or in quantities that interfere with the treatment program. (WIC 5325.1(c))

Additionally, a person in a facility has the right to be free from the use of seclusion and behavioral restraints of any form imposed as a means of coercion, discipline, convenience, or retaliation by staff. This right includes, but is not limited to, the right to be free from the use of a drug used in order to control behavior or to restrict the person's freedom of movement, if that drug is not a standard treatment for the person's medical or psychiatric condition. (HSC 1180.4(k), 42 CFR 482.13(e))

All rights denied while the patient is in seclusion and/or restraint must be documented in the patient record, including date, time, and good cause for denial. The patient needs to be told the content of this notation. (9 CCR 865.3, 865.4(c))

SECLUSION/RESTRAINT STANDARDS

While the specific language of seclusion and/or restraint standards vary between different types of facilities, in general seclusion and/or restraint can only be used when immediately necessary to prevent the person from harming themselves or others, and only when there are no less restrictive alternatives available.

Additionally, seclusion and/or restraint may only be used for as long as it is immediately needed to protect the patient or others from injury. The patient must be released as soon as the immediate threat to self or others is no longer present. When a patient is placed in seclusion and/or restraints, the patient needs to be informed of the criteria they must meet for release and how that will be evaluated.

The use of seclusion and/or restraint requires an order by a doctor acting within the scope of their professional license. Seclusion and/or restraint may only be used in facilities authorized by regulation to use the intervention, and can only be used under circumstances and in the manner authorized by regulation.

Some facilities, such as Adult Residential Facilities and Social Rehabilitation Facilities, affirmatively prohibit the use of seclusion and behavioral restraint. Other facilities, such as Mental Health Rehabilitation Centers and Skilled Nursing Facilities, only permit specific types of restraint devices. (9 CCR 782.45; 22 CCR 72459, 80072(a)(7-8), 81072(a)(7-8))

Under federal regulations and Joint Commission standards, orders for seclusion and/or restraint may be for up to 4 hours for adults, 2 hours for adolescents 9-17, and 1 hour for children under 9 years old. These orders may be renewed for up to 24 hours, after which the doctor must see and assess the patient before writing a new order. Regardless of the length of the order, seclusion and/or restraint must be discontinued at the earliest possible time. (42 CFR 482.13(e)(8-9), Joint Commission standards PC 03.05)

Orders for seclusion and/or restraint should not be written as standing orders or written to be used on an as needed basis (PRN). (42 CFR 482.13(e)(6), 9 CCR 784.36(e), 22 CCR 77103(e))

DOCUMENTATION REQUIREMENTS

Much like definitions and other standards, documentation requirements for the use of seclusion and/or restraint also vary between types of facilities. In general, the following information must appear in the medical record in order to initiate and continue the use of seclusion/restraint:

- A signed order specifying date, time, type of seclusion/restraint, reasons for seclusion/restraint and specific criteria for release.
    - In many facilities, seclusion and/or restraint can be ordered by a licensed healthcare practitioner acting within the scope of their professional licensure. (22 CCR 70577, 71545, 72461, 73409)
    - In Mental Health Rehabilitation Centers and Psychiatric Health Facilities, seclusion/restraint can only be ordered by a physician or psychologist acting within the scope of their license. (9 CCR 784.36, 22 CCR 77103)
        - Although either a physician or a licensed clinical psychologist may authorize the use of seclusion or mechanical/physical restraint, only a physician may order the use of a drug for chemical restraint.
    - In facilities receiving federal funding, seclusion/restraint must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law. (42 CFR 482.13(e)(5))
- A description of the specific behavior justifying seclusion/restraint, including the patient's actions that pose a threat of injury to the patient or others.
- A description of the alternative methods of resolving the behavior attempted or considered by staff prior to the use of seclusion/restraint.
- A description of the patient's response to the less restrictive interventions, and the continuing behavior that poses a threat to the patient or others.
- A description of events during seclusion and/or restraint, including nursing/medical assessments, nursing/medical care, patient-staff interactions, separate justification for emergency medication (if applicable), and documentation of any patients' rights denied.

APPROPRIATE MONITORING AND NURSING CARE

Both state and federal law require careful monitoring of patients in seclusion and/or restraint. California law contains strict timelines for regular observation of someone in seclusion or behavioral restraint:

> Patients in seclusion or behavioral restraint in Hospitals, Acute Psychiatric Hospitals, Psychiatric Health Facilities, and Mental Health Rehabilitation

Centers must observed at least every 15 minutes. (22 CCR. 70577(j)(3), 71545(c), 77103(g); 9 CCR 784.37(c)(2)).

Patients in seclusion or behavioral restraint in Skilled Nursing Facilities with Special Treatment Programs must observed at least every 30 minutes. (22 CCR 72463).

State and federal law require that patients who are in both seclusion and some form of restraint be continually monitored face-to-face by an assigned, trained staff member or by trained staff using both video and audio equipment from a location in close proximity to the patient. (42 CFR 482.13(e)(15); HSC 1180.4(i)).

Facilities authorized to use seclusion and/or restraint are prohibited from using physical restraint or containment techniques which obstruct a person's airways or impairs a person's ability to breathe. This includes techniques in which a staff member places pressure on a person's back or places their body weight against the person's torso or back. (HSC 1180.4(c))

Facilities are also prohibited from using restraint or containment on a person with a known condition where there is reason to believe the use of restraint or containment would endanger the person's life or seriously exacerbate the person's medical condition. Prone mechanical restraint cannot be used on a person at risk for positional asphyxiation, unless written authorization has been given by the physician to either accommodate the person's stated preference or because other clinical risks take precedence. This written authorization cannot be a standing order and must be evaluated on a case-by-case basis. (HSC 1180.4(d-e))

REDUCING THE USE OF SECLUSION AND RESTRAINT

California Health and Safety Code 1180 et seq. was enacted with the expressed intent of reducing the use of seclusion and behavioral restraint in facilities in California. Towards that end, the law requires that facilities conduct an assessment with the patient on admission, or as soon as possible, for factors unique to the person related to the use of seclusion and restraint.

In addition, facilities must conduct two reviews of each episode of seclusion and/or restraint: a debriefing with the person placed in seclusion and/or restraint, and a clinical/quality review.

ASSESSMENT ON ADMISSION

The assessment must include input from the patient and any family member or friend that the patient has designated. The assessment includes the following:

- A person's advance directive regarding de-escalation or the use of seclusion or behavioral restraints.
- Identification of early warning signs, triggers and precipitants that cause the person to escalate, and identification of the earliest precipitant of aggression for persons with a known or suspected history of aggressiveness, or persons who are currently aggressive.
- Techniques, methods, or tools that would help the person control their behavior.
- Preexisting medical conditions or any physical disabilities or limitations that would place the person at greater risk during seclusion or restraint.
- Any trauma history, including any history of sexual or physical abuse that the patient feels is relevant.
- The individual's advance directive regarding de-escalation or the use of seclusion or behavioral restraint.

(HSC 1180.4)

POST-INCIDENT DEBRIEFING

Facilities must conduct a debriefing as quickly as possible, and no later than 24 hours after each episode of seclusion or behavioral restraint. While the patient's participation in the debriefing is voluntary, facilities should invite and encourage this participation. Also included in the debriefing are the staff involved in the episode (if reasonably available), a supervisor, and any family, friend, authorized representative, or other person designated by the patient.

The purposes of the debriefing are as follows:

- Help the patient to identify what lead up to the incident, and suggest methods of more safely and constructively responding to the incident.
- Help staff to understand the precipitants to the incident, and to develop alternative methods of helping the patient avoid or cope with those incidents.

- Help the treatment team develop treatment interventions to address the root cause of the incident and its consequences, and modify treatment plan accordingly.
- Help assess whether seclusion and/or restraint was necessary and whether it was implemented in a manner that consistent with staff training and facility policies.

Facilities must document the debriefing in the patient's record and any changes to the patient's treatment plan that resulted from the debriefing.

(HSC 1180.5)

WORKING WITH CLIENTS TO AVOID SECLUSION/RESTRAINT

Advocates can work with clients through training, community meetings, and individual consultations on ways to avoid seclusion and/or restraint. Collaborating with a peer-support or peer-mentoring group can be instrumental in teaching clients self-advocacy tools that will help them avoid situations that could potentially result in seclusion or restraint. These can include:

- Giving reminders to avoiding threatening (or the appearance of threatening) any type of injury to themselves or others.
- Suggesting alternative self-advocacy methods to avoid confrontation (or the appearance of confrontation) with staff.
- Recommending clients tell how they feel and ask for help in following the steps outlined in their "preference plan" or advanced directive if they feel upset.
- Encouraging clients to work with staff in creating their "preference plan" or advanced directive that will identify tools for the staff to use to assist the client in getting or remaining composed.
- Letting clients know if they find themselves in a situation where staff is warning them about their behavior, it is okay to attempt to talk to staff about what will help them feel better and negotiate for that.

When advocates encounter situations when a client is in seclusion and/or restraints, advocates can work towards facilitating the release of a patient from seclusion and/or restraint through staff education and advising the client. Advocates should make sure staff explains to the client the behaviors that led to placement in seclusion and/or restraint, and what the client must do in order to be released from seclusion and/or restraint. The client should be encouraged to

ask for what they need to regain control, and to communicate clearly and calmly to staff that they will not cause injury to themselves or others.

ADDRESSING COMMON PROBLEMS

While providing advocacy services, advocates should keep in mind the criteria for placement in seclusion and restraint is limited to protecting the patient or others from injury. Unlike the criteria for the denial of other patients' rights, "infringing on the rights of others" and "serious damage to the facility" alone, are not adequate justification for placing an individual in seclusion and/or restraint. (22 CCR 71545, 72457, 77103)

Patient behavior must meet legal criteria to be placed in seclusion or restraints. Documentation must show that seclusion or restraint was necessary to prevent injury to the patient and others and that less restrictive interventions were not able to control the behavior. A patient should not be placed in seclusion or restraint just for being unmanageable, unresponsive, hyper-verbal, or for violating a behavioral contract. There needs to be some tangible evidence of the need to protect the patient or others from injury. Seclusion and/or restraint may not be used coercively or as a means of facilitating treatment or gaining compliance.

Advocates should emphasize to physicians and staff that documentation must be specific and factually descriptive. Good documentation states what the patient did and said. Good documentation sets forth the patient's behavior, not the conclusions about the behavior. If the patient picked up something as if to throw it, the documentation in the medical record should state: "Patient attempted to throw wastebasket at staff." Although such behavior could be described as "dangerous", "threatening" and "combative", documenting such statements can be problematic because it does not describe the actual behavior of the patient.

A patient may not be kept in seclusion or restraints pending his development of an "understanding", or an ability to make a behavioral contract with his/her therapist. If a patient is kept in seclusion or restraint, the documentation should describe why continuing to keep the patient in seclusion or restraint is still needed to prevent harm to the patient or others, and why there are still no less restrictive alternatives available.

SAMPLE DOCUMENTATION

Problematic documentation: DS/DO, uncommunicative, refuses meds.

Better documentation: Patient picking and pulling at stitches in wrist, ignored this writer's request x2 to stop; staff

	approached patient a 3rd time to redirect her and ask her to join craft group in dayroom, pt. refused and began biting and pulling on stitches with teeth. When offered prn medication, pt. struck out and attempted to scratch this writer. Pt. placed in 4-pt. restraint.
Problematic documentation:	Patient agitated; nonredirectable.
Better documentation:	Pt. screaming/yelling unintelligibly in hallway x 15 minutes, did not respond to request to quiet, refused prn meds.; began intruding into other pts' rooms and stating to peers who approached him, "I will f—you up!" Pt. refuses to leave peer's room and stating to this writer, "I will f--- you up too!" Pt. placed in seclusion.

For more information about laws, standards, and advocacy tips related to seclusion and restraint in different health care settings, contact COPR. (COPRinforequest@disabilityrightsca.org)