PRIVATE PSYCHIATRIC HOSPITAL INITIATIVE:

Keeping Patients with Mental Illness Safe: Chicago Area Hospitals' Compliance with Restraint and Seclusion Laws

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Executive Summary

Restraint and seclusion remain some of the most controversial and dangerous measures used today in settings that provide services to people with disabilities, including hospitals serving individuals with mental illness. Restraint and seclusion are extremely intrusive, aversive, and dangerous interventions that have significant implications for the physical and emotional well-being of the individual. In spite of the passage of national standards in 1999 intended to reduce risks associated with and reliance upon such controversial measures, children and adults with disabilities continue to die as a result of these measures.

Restraints involve the immobilization of people through mechanical, physical or chemical means in order to restrict their freedom of movement or access to their bodies. Restraints can involve strapping an individual to a bed, using a lap tray, belt or other device, or involve staff physically holding an individual. Chemical restraints are used to restrict an individual's voluntary movement through the use of drugs that are not standard treatment for the individual's condition. Seclusion involves involuntary isolation of an individual in a room from which the individual is physically prevented from leaving.

In response to substantial evidence related to the inherent dangers that restraint and seclusion pose to people receiving mental health services and to staff, and the shift in the delivery of inpatient psychiatric services to the private hospital system from the public system, Equip for Equality conducted a study of 25 Chicago-area private hospital restraint and seclusion policies. This study answers the questions: Do hospital restraint and seclusion policies in a major metropolitan area comply with federal and state laws? Furthermore, do they incorporate best practice standards? In critical areas of safety, staff training and oversight, the study found a surprising lack of compliance with minimum federal and state standards enacted to reduce the risks associated with restraint and seclusion. The policies, in the same critical areas, overwhelmingly failed to incorporate best practices.

The significant level of noncompliance documented by this study illustrates that simply passing laws to regulate the use of restraint and seclusion by itself has not proven to be an effective mechanism to ensure compliance with the law or to prevent deaths and serious injuries. As initially reported in a 1998 series in the *Hartford Courant*, there was for many years—and continues to be—no effective oversight system in place for monitoring restraint usage and compliance. There is no federal or state

government agency responsible for collecting data on all restraint and seclusion usage and deaths. As recently as September 2006, the U.S. Department of Health and Human Services, Office of Inspector General, found that, in spite of regulations in place since 1999 requiring the reporting of restraint- and seclusion-related deaths, hospitals failed to report nearly half of the 104 documented restraint-related deaths that occurred nationally between August 1999 and December 2004.

State oversight of restraint and seclusion in Illinois has focused primarily on state hospitals and on regulations and the investigation and enforcement of minimum standards. As described in the *Hartford Courant* series and by the Office of Inspector General 2006 study, state licensure and accreditation processes neither prevent the dangerous practices nor provide much disciplinary or corrective intervention in response to deaths resulting from restraint and seclusion or in response to a lack of compliance with the law. Given the inherent dangerousness of restraint and seclusion, it is critical that their use be closely scrutinized and monitored through effective oversight to ensure compliance with federal and state laws and that the increasing call for affirmative steps to eliminate reliance on these measures as an accepted form of behavioral intervention be heeded.

In order to prevent the kind of tragedies illustrated through the deaths described in this report, the delivery of mental health services in the private hospital system must occur through a system of care that is recovery oriented, individualized, fully informed as to past trauma and other relevant medical and psychological histories and provided within a noncoercive environment. Alternatives to restraint and seclusion and effective primary prevention strategies must be developed by hospitals in order to ensure that the perceived need for restrictive measures simply does not arise. Staff training in these areas is critical. Equally critical is effective hospital administrative oversight and monitoring of those circumstances that continue to result in restraint and seclusion to ensure that when such measures are utilized, they are done in a manner least likely to cause harm, injury or death, and that each episode is promptly examined and critically analyzed to prevent future episodes and tragedies.

Significant Findings

While this study documents areas of compliance with aspects of federal and state laws and best practice standards, it also documents that hospital policies are weakest in the areas designed to protect people receiving mental health services and staff when restraint and seclusion are utilized and in areas designed to reduce or eliminate reliance on restraint and seclusion.[1]

General Policy and Philosophy

- Nearly 25% of the hospitals did not meet the requirement to have policies prohibiting the use of restraint or seclusion for the purposes of coercion, discipline, convenience or retaliation. (Centers for Medicaid and Medicare Services [CMS] and (Illinois Mental Health and Disabilities Code [State Code])
- Only slightly more than one-third of the policies included a process for using information from episodes of restraint or seclusion to reduce or prevent future use. (best practice standards)

Defining Restraint and Seclusion

- Hospitals are not meeting the requirement of providing adequate and clear information to their staff about the nature of these interventions. (CMS and State Code)
- Less than half of the policies met the requirement to address medication as a restraint and less than half clearly distinguished seclusion from timeout. (CMS and State Code)

Conditions for the Use of Restraint and Seclusion

- Only 42% of the policies met the requirement that prior to the restraint or seclusion the person's medical condition be considered for additional risks associated with the use of such measures. (CMS)
- Few policies included consideration of other conditions, such as psychiatric conditions or a history of physical or sexual abuse, as contraindicating the use of restraint or seclusion. (best practice standards)

Authorization for the Use of Restraint and Seclusion

- Very few policies met the requirement that a face-to-face assessment be performed when a person is released early. (CMS)
- Only 31% of the policies met the requirement that the written order include the clinical justification for the length of time of the restraint. (State Code)
- Only 58% required documentation of how less restrictive interventions were ineffective and that verbal orders can be valid for only one hour. (best practice standards)

Time Limits on the Use of Restraint and Seclusion

- Very few policies contained the requirement for a new order before initiation of another restraint or seclusion episode if a person was released from restraints or seclusion prior to the expiration of the first order. (CMS)

Application of Restraints and Seclusion

- Only 19% of the policies prohibited prone positions, which present additional known risk of death during restraint. (best practice standards)
- Only 23% of the policies limited techniques for managing aggressive behavior and escorting to those that had been approved. (best practice standards)
- Policies generally did not address, as required, environmental conditions. (State Code)

Monitoring and Documentation

- Only 42% of the policies required that the time of assessments, evaluations and care provided to an individual in restraint or seclusion be documented. (CMS)
- Provisions related to evaluating the need for additional monitoring for individuals who are pregnant, abuse substances or have respiratory or other medical conditions were rare. (best practice standards)

Debriefing Following Restraint or Seclusion

- While over half of the policies did have a process for debriefing (a process to reduce restraints) an individual within 24 hours after the restraint or seclusion, only 19% had a process for debriefing staff. (best practice standards)
- Even when policies included provisions related to debriefing an individual, those provisions did not provide for a discussion of the events leading to the restraint or seclusion. (best practice standards)
- Less than one-third of the provisions included a discussion of how to avoid future episodes, alternative interventions that the individual would prefer or what staff could have done differently that may have prevented the restraint or seclusion. (best practice standards)

Oversight of the Use of Restraint or Seclusion

- Only 23% of the policies met the requirement that CMS be notified of any restraint- or seclusion-related death, and only 8% included the provision that the death must be reported by the next business day. (CMS)

- Policies contained few provisions regarding oversight of the use of restraint and seclusion, especially in regard to conducting inquiry into the routine use of restraints. (State Code)

Staff Training

- Policies contained few of the required provisions for staff training relevant to the application and prevention of restraint and seclusion or as related to primary or secondary measures to prevent restraint or seclusion. (CMS, State Code, best practice standards)

Recommendations

Equip for Equality strongly recommends that action be taken at the state and federal levels to ensure compliance with the laws related to restraint and seclusion while taking the action necessary to reduce and ultimately eliminate reliance on such measures by developing and implementing effective external oversight and monitoring systems, including systematic data reporting and collection on restraint and seclusion episodes, injuries and deaths.

Equip for Equality also strongly recommends that all hospitals in Illinois not only incorporate the recommendations set forth below by ensuring that hospital policies and practices are consistent with the laws and include best practices identified in this report, but that the hospitals take the measures necessary to develop a plan to reduce and ultimately eliminate reliance on restraint and seclusion as acceptable forms of intervention and remove any barrier that would prevent the hospitals from accomplishing that goal.

Recommendations for the State and Federal Governments:

Reduce the use of restraint and seclusion and prevent physical and psychological harm accompanying the use of such measures suffered by individuals with mental illness and staff by:

- Amending the Illinois statute to be consistent with federal law to explicitly include the misuse of restraint and seclusion as abuse;
- Expanding the federal definition of abuse to include the use of seclusion that is in violation of federal or state laws;

- Requiring public disclosure of hospital restraint and seclusion data; and
- Mandating implementation of the best practice standards identified in this report through passage of laws and regulations.

Ensure reporting of restraint and seclusion deaths and compliance with the law by:

- Creating or strengthening joint federal/state administrative oversight systems through federal legislation that includes effective sanctions for failure to report restraint- and seclusion-related deaths and failure to comply with federal and state laws governing restraint and seclusion.

Ensure that if restraint and seclusion are used, they are used in a manner least likely to cause death or serious injury by:

- Mandating staff education and training on at least an annual basis related to primary and secondary preventative measures and, when less restrictive interventions have failed and restraint or seclusion is used, that such measures are used in a manner consistent with the law.

Increase scrutiny of restraint and seclusion usage by:

- Implementing a system for the collection and analysis of data related to restraint and seclusion use and related deaths;
- Requiring the reporting of all restraint- and seclusion-related deaths, including the reporting of deaths resulting from the use of restraint for medical purposes;
- Requiring that direct reporting of all restraint and seclusion deaths to the Protection and Advocacy System in the state where the death occurred include not only the names of the hospital and the individual who has died, but also information related to the manner of death, involvement of other investigatory agencies, status of hospital review, staff involved and relevant hospital policies;
- Expanding the capacity of the Protection and Advocacy System to respond to and address such deaths; and

- Taking the action necessary to ensure that individuals who are restrained and whose rights have been violated have access to an effective system to address the violation.
- Ensure effectiveness of the reforms instituted by creating a mechanism for policymakers to monitor changes in policies and practices so that such reforms have the desired effects.

Recommendations for Hospital Leadership:

Create an organizational culture that ultimately eliminates reliance on restraint and seclusion for behavioral interventions and focuses on providing mental health services that are individualized, recovery oriented, fully informed as to trauma and other relevant medical and psychological histories and provided within a noncoercive environment by:

- Establishing a comprehensive hospital policy in compliance with all applicable laws and incorporating best practice standards as set forth in this report.

Ensure that the necessary changes in organizational culture become routine practices of the hospital by:

- Enhancing monitoring and oversight of restraint and seclusion episodes by hospital administrators and key executive staff, including prompt review of episodes as a means to ensure safety of individuals and staff and to prevent other episodes;
- Establishing an effective debriefing process for individuals and staff as a means to address the trauma of the episode and prevent other episodes;
- Enhancing the hospital's internal audit system to ensure collection and analysis of restraint- and seclusion-related data and utilize that information as a method to prevent other episodes; and
- Educating staff on an ongoing basis on effective primary and secondary preventative measures, including assessment tools to identify triggers, use of individualized early-intervention strategies or safety plans, alternatives to restraint and seclusion, recovery-oriented and trauma-informed models of care and de-escalation techniques.

PRIVATE PSYCHIATRIC HOSPITAL INITIATIVE:

Are Illinois Hospitals' Restraint and Seclusion Policies and Procedures in Compliance with Federal and State Laws?

Introduction

In the late 1990s, the *Hartford Courant* newspaper conducted the first national review of restraint-related deaths, documenting 142 deaths over a 10-year period, as part of that review, the Courant requested that the Harvard Center for Risk Analysis review the available information and estimate an annual rate of deaths. Based upon its analysis, the Harvard Center estimated an annual rate of between 50 and 150 deaths, or a total of 500 to 1,500 deaths during that same 10-year period.[2] A subsequent U.S. General Accounting Office (GAO) Report emphasized that neither government agencies nor private accreditation organizations were collecting any systematic data on restraint use or even any data on restraint-related deaths.[3] The report concludes that without an effective framework for oversight of restraint usage, there exists a strong possibility of a much larger problem.

In studies of people who have been restrained, not surprisingly, most viewed the episode very negatively, describing feelings of being disoriented, fearful, sad, bitter, humiliated and demoralized by the experience.[4] People who have been restrained often disagreed with staff perceptions of what precipitated the restraint episode and whether the restraint was in fact warranted.[5] Further, people who have histories of physical or sexual abuse are at high risk for being retraumatized by restraint. A New York survey found that people who are restrained are overall twice as likely to view their care negatively.[6]

State-operated mental health hospitals have been the primary target of efforts to reduce abuse, neglect and restrictive interventions both in Illinois and nationally. However, the majority of inpatient psychiatric care has shifted from the public to the private sector. The Office of Inspector General of the U.S. Department of Health and Human Services identified the need for increased attention to the private psychiatric

hospital system in its report *The External Quality Review of Psychiatric Hospitals*.[7] Citing deficiencies in existing quality assurance review, the report concluded that "the extent to which the system of oversight is holding facilities accountable for patient care is questionable, especially in the areas of discharge planning and restraints and seclusion."[8]

Until 1999, public and private psychiatric hospitals' use of physical restraints was governed exclusively by state law and/or policy. Furthermore, monitoring and other oversight activities to ensure compliance with state standards, to the degree they existed, were left to the states. To be accredited, hospital policies were reviewed against standards of the private accreditation entity.

As a result of the shift in care to the private hospital system, Equip for Equality's Advisory Council for the Protective and Advocacy (P&A) program serving individuals with mental illness recommended an increased focus on that hospital system. In response, Equip for Equality established an initiative to increase awareness of the P&A System and its services and to enhance safety and protection of individual rights within the private psychiatric hospital system in Illinois by examining the extent to which free-standing psychiatric hospitals and private hospitals with psychiatric units in the greater Chicago metropolitan area comply with federal and state laws governing restraint and seclusion.

This report presents the findings of this research by Equip for Equality and recommendations to federal and state policymakers to remedy documented problems.

Recent National and Illinois Events and Studies

The *Harford Courant*'s National Exposé on Restraint-Related Deaths

In 1998, the *Hartford Courant* published a series of newspaper articles documenting the dangers and tragic consequences associated with the use of physical restraint on individuals with disabilities. The restraint-related deaths described in the series occurred across a variety of settings, including schools, hospitals and residential treatment centers, impacted a variety of disabilities and involved children as young as 6 years of age up to adults age 45.

As described in the series, the deaths clearly illustrated systemic failures by facilities serving individuals with disabilities, in understanding behavior, in identifying antecedents of behavior and in utilizing less intrusive behavioral interventions, such as de-escalation

techniques, as alternatives to restraint usage. The deaths demonstrated a lack of understanding by staff charged with the safety and well-being of the individual, of the impact restraint procedures have on the individual's respiratory system and how any additional pressure applied to the chest or back further compromises the respiratory system and further endangers the individual's health. The deaths also demonstrated a lack of knowledge by staff charged with monitoring the health and welfare of the individual while in restraints, of symptoms of respiratory distress, and illustrated failure by staff, in some instances, to initiate emergency procedures such as CPR or calls for emergency medical assistance.

The review of the restraint-related deaths revealed situations that quickly escalated into power struggles between staff and the individual, ultimately resulting in the use of restraints and the individual's death. Tragically, the deaths highlighted a system of care that was not individualized, recovery oriented or informed of the person's trauma history and other relevant histories and contraindications, but one that was more aptly characterized as a system based upon treatment failures. Sadly, the series estimated that numerous other deaths had occurred across the nation but went unreported due to the absence of a mandated reporting requirement and a designated enforcement authority.

Congressional and Executive Response to Media Exposé of Medicaid Services

In response to the series of articles published by the Hartford Courant, Senators Lieberman and Dodd each introduced a bill (S. 736 Freedom from Restraint Act of 1999 and S. 750 Compassionate Care Act of 1999, respectively) and Representatives DeGette, Stark and DeLauro introduced a bill, (H.R. 1313 Patient Freedom from Restraint Act of 1999) designed to safeguard the use, monitoring and reporting of restraints in a variety of settings.

The most comprehensive of the bills, H.R. 1313, was introduced by Representative DeGette et al., and would have regulated restraint-related activities in all adult and child facilities receiving Medicaid or Medicare funds. The proposed legislation specifically protected individuals from the use of physical or chemical restraints or seclusion for purposes of discipline or staff convenience. It required that staff receive restraint-related training on an annual basis and required that guardians be notified not only of the restraint episode, but also of the existence of, purpose of and contact information for the state P&A program.

Additionally, the legislation proposed that restraint usage be limited solely for the purpose of the immediate safety and protection of the individual and others, and only as a last resort. Restraint orders were not to exceed two hours and had to identify the circumstances for the restraint and criteria for release from the restraint. Standing and PRN (as needed) orders for restraint were prohibited, as was the simultaneous use of restraint and seclusion. It also required facilities to remove restraints at the earliest possible time.

Also set forth were requirements for documenting the type, duration and rationale for the restraint episode and the requirement for documenting that less restrictive alternatives were used prior to the restraint. In response to the restraint incident, the individual's treatment plan was to be revised and provided, along with the restraint episode information, to the state's P&A system. Periodic reports to the Secretary of Health and Human Services and the P&A agency specifying the number of times restraints or seclusion were used during the reporting period (at a minimum annually) would also be required of facilities receiving Medicare or Medicaid funds.

The proposed legislation required that sentinel events involving deaths or serious injuries that occurred while an individual was in restraints or in close proximity in time to the restraint, or any death that occurred within 14 days of a restraint episode, were to be reported within seven days to the P&A agency and included in an annual report to the Secretary. More importantly, the proposed legislation also authorized the withholding of funds and sanctions for noncompliance with the regulations.

Senate Bill S. 736 presented by Senator Lieberman also pertained to all Medicare and Medicaid facilities, but excluded home health agencies. The bill included prohibition of restraints for purposes of discipline and convenience, and limited restraint use solely for the protection of patients (not safety of staff). In addition, the proposed legislation required a physician to order the restraints with time, duration and circumstances documented.

Reporting of restraint episodes would be submitted to the agency's accrediting body or to the Secretary of Health and Human Services or the delegate. The Secretary or the delegate would be required to investigate any sentinel event and conduct a root cause analysis with an accompanying plan of correction. In the event of a death, the appropriate investigatory agency would be notified, as well as the P&A agency, licensing body and the Illinois attorney general. Finally, this legislation would also create a national database of sentinel events.

Senate Bill S. 750, presented by Senator Dodd, offered more expansive coverage by requiring that any facility that falls under Protection and Advocacy (P&A) programsfor individuals with mental illness to report sentinel events to the P&A within seven days of the event, and offered some of the specific protections noted in other proposed legislation. The additional requirement of this bill was the maintenance of federally mandated staffing levels and language authorizing the withdrawal of federal funds from a facility for failure to comply.

Despite the need for additional safeguards, there was strong opposition to the legislation. A number of organizations and hospital associations voiced opposition to the proposed legislation, citing various reasons. Professional associations voiced opposition to Congress's legislating a medical treatment and opposed some of the suggested time frames as being unfeasible and creating an undue financial burden on certain facilities. There was also opposition from unions to the bill's reporting requirements, especially those reports that would be provided to investigatory agencies. Privacy concerns were also voiced.

Each of the bills as drafted was sent to various congressional committees for review. None of the bills made it out of committee, so each subsequently died.

Despite the failure of the bills to be enacted into law, the focus that the *Hartford Courant* and the debate on the proposed legislation brought to the issue of restraints did have an effect. In 1999, a year after the *Hartford Courant* series, Centers for Medicaid and Medicare Services (CMS) for the first time introduced mandatory national standards for the use of restraint and seclusion that included many of the protections proposed in the legislation. The standards established new Patients' Rights Condition of Participation, which all hospitals participating in the Medicaid and Medicare programs must meet. The CMS regulations require hospitals to report any death of a patient while in restraint or seclusion, or when it is reasonable to conclude the death was related to restraint or seclusion, to CMS. In response, CMS notifies the P&A and the state Medicaid agency (the Illinois Department of Public Health), which conducts an on-site complaint survey of hospitals reporting deaths related to restraint or seclusion.

However, no additional funding was made available to the P&A system to investigate these deaths. When notified by CMS of a restraint-related death in a hospital or other setting, Equip for Equality conducts an investigation, develops facility-specific recommendations and recommends systemic reform and best practices, including the reduction or the elimination of the use of restraint, to the state oversight authority to ensure the safety of the individual and to prevent future tragedies.

President Clinton signed the Children's Health Act in 2000 (to date, aspects of this act have not been implemented). This act was modeled on the restraint and seclusion standards in the Dodd/Lieberman Acts and created two sets of standards, one for public and private hospitals, ICFs and other health facilities receiving federal funds, and a second for public or private nonmedical community–based agencies for children and youth. This act protects children and requires reporting a death to the Secretary of Health and Human Services within 24 hours of the event.

In 2001, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards were also amended to offer many of the protections included in the initial proposed legislation. JCAHO, in response to the *Hartford Courant* series, issued new standards that applied to all health care facilities, including acute-care hospitals that used restraints or seclusion for behavioral reasons. Previously, the standards applied only to behavioral health care facilities.

However, several critical aspects of the proposed legislation were missing from the Children's Health Act and the revised federal regulations and accrediting standards. Missing was the broad application of the reporting requirements to all facilities providing services to individuals protected by Protection and Advocacy programs for individuals with mental illness under the PAIMI program. PAIMI; legislation mandating adherence to safe staffing levels; legislation that would require a physician to order restraints (rather than a "licensed independent practitioner"); legislation that would create a national database for restraint use and injuries; and legislation that would have expanded the role of the state P&As by increasing their supervisory authority and giving them primary investigative responsibilities.

Equip for Equality Research on Restraint in State Hospitals

In 2000, Equip for Equality released a report detailing the results of a study conducted in response to concerns raised by dozens of consumers and family members affiliated with the National Alliance for the Mentally Ill (NAMI) Illinois Chapter. Equip for Equality, in collaboration with Labor Relations Alternatives (LRA), designed and conducted research on restraint practices at the state-operated mental health facilities. The project included two major components: 1) a study of state-operated hospital compliance with state law and state policy directives governing the use of restraint; and 2) a review of national restraint policy initiatives related to restraints. Project activities included a review of records of a representative sample of restraint episodes occurring over a six-month period from July 1 to December 1, 1997, in 10 state hospitals to determine their compliance with the requirements of the Illinois law and policy.[9]

Equip for Equality's research documented significant areas of noncompliance with state law and policy (although much less than the nearly 100% noncompliance found by Equip for Equality as part of its court monitoring activity several years earlier in Nathan v. Levitt, litigation involving the use of restraints of people with developmental disabilities). The study found deficiencies that made it clear that more needed to be done to reduce reliance on restraint usage by:

- Preventing high-risk situations;
- Identifying and de-escalating behavioral crises;
- Increasing the use of alternative interventions; and
- Limiting the length of restraint episodes.[10]

Equip for Equality identified critical areas in which significant improvement in practice was necessary and recommended that:

- The hospital system ensure that staff understand that restraint use reflects problems in assessment and treatment planning amounting to a treatment failure and should be utilized only in true emergencies;
- Staff be provided with clear guidelines and behavioral criteria regarding restraint use and release;
- State hospital management assess the interventions being used prior to restraint to determine whether staff are identifying high-risk situations and are intervening promptly, utilizing a wide range of intervention and de-escalation techniques; and
- Preventive approaches such as screening, advance directives, environmental improvement and violence prevention be emphasized.[11]

Equip for Equality also recommended that all staff dealing with individuals receiving mental health services be given comprehensive training in:

- Restraint law, policies and procedures, early intervention and de-escalation strategies;
- Safe application techniques;
- Monitoring during restraint; and
- Release assessment and documentation requirements.[12]

Substance Abuse and Mental Health Services Administration (SAMHSA) Efforts

In 2003, the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) in partnership with the National Association of State Mental Health Program Directors (NASMHPD) established restraint

as a key priority and initiated a National Call to Action: Eliminating the Use of Seclusion and Restraint. Notably, restraint was perceived not as a necessary practice, but as a treatment failure. Leaders from federal and national mental health organizations; professional and provider organizations; state and local mental health agencies; clinical training programs; advocacy organizations, including Equip for Equality; federally funded research; and training and technical assistance centers, as well as consumers and family members, were invited to learn more about efforts that were under way in determining what worked in reducing the use of restraint and seclusion and to collaborate in developing a shared national agenda to reduce and ultimately eliminate restraint and seclusion use in mental health systems.

Seminars were conducted to educate leaders in the field on alternatives to restraint and ways to reduce restraint usage. Trainings focused on overcoming barriers to reducing restraint and seclusion, consumer and staff experiences with restraints, best practices in behavior management and changing the "culture" of the treatment setting to one which is noncoercive. In addition, the state of Pennsylvania shared its work plan that has resulted in the elimination of restraint in its state hospitals.

SAMHSA also afforded states an opportunity to apply for funding and for a grant to receive monies and technical assistance surrounding restraint reduction in their mental health hospitals. With a letter of support from Equip for Equality, Illinois was one of eight states awarded a three-year grant to reduce the use of restraint in state-operated mental health hospitals. Equip for Equality serves as a member of Illinois' grant advisory committee monitoring progress on the grant objectives and restraint reduction activities, including staff training.

In the first year of the grant, two of the nine state hospitals in Illinois initiated restraint reduction activities, including staff training, witnessing and debriefing programs and a culture change within the hospital to a noncoercive environment. At the conclusion of the first year, both hospitals reported significant reduction in restraint usage, reduction in patient and staff injuries and increase in empowered staff and individuals receiving services, which resulted in improved, safer and more humane treatment.

In the second year of the grant, these hospitals continued to further reduce restraint usage, to give staff trainings and to incorporate trauma-informed care and recovery into the treatment milieu. Four additional hospitals joined the project and have implemented processes and procedures related to establishing a noncoercive, recovery-oriented and trauma-informed systems of care . In the third year of the grant, the three remaining hospitals joined the project and have begun to implement action to meet the objectives of the grant.

Equip for Equality continues to monitor the state's effort and progress in reducing restraint and seclusion use in its state hospitals and continues to provide input regarding the quality of mental health services by actively participating as a member of the grant's advisory committee and as a member of each hospital's steering committee. In addition, Equip for Equality reviews restraint usage data and each hospital's progress in developing a noncoercive, trauma-informed recovery-oriented system of care. Equip for Equality's monitoring activities have continued in the third year of the grant as the three remaining state hospitals joined the restraint reduction initiative.

Restraint Deaths in Illinois

Despite the increased media and congressional attention paid to the dangers of restraints, Equip for Equality's findings and recommendations outlined in its report on the use of physical restraints in Illinois state hospitals and SAMHSA's national call to action, restraints continue to be used, and deaths related to restraint use continue to occur.

Since 1999, Illinois has reported 12 deaths of individuals while in restraints. Four deaths occurred in state mental health hospitals, one in a private home during an arrest, and seven in private psychiatric hospitals, in hospitals with a psychiatric unit or in hospital emergency rooms. Although regulations have been established to maintain the safety of the individual, individuals continue to die. Individuals continue to be restrained for behaviors that do not clearly indicate that the individual is dangerous to self or others, continue to be restrained when alternative interventions have not been tried, continue to be restrained even though they are calm and have met the criteria for release, and continue to be restrained even when there are visible signs that the restraint is significantly impacting the individual's respiratory system. Regulations require that staff must be trained in the procedure; however, the lack of training, as evidenced by Equip for Equality's investigations into the deaths and the lack of understanding by hospital staff regarding this dangerous procedure, is particularly alarming.

A review of these deaths illustrates significant compliance issues surrounding established state and federal regulations, and a system in need of significant improvements, scrutiny and oversight. The magnitude of the problems and the extent to which reforms are necessary is revealed by the tragic events leading to each of the deaths, three of which are described below:

Death #1

In January 2005, a 72-year-old individual died while in 3-point mechanical restraints on the psychiatric unit of a private hospital.

At the time the individual was placed in restraints, the documentation revealed an individual who was obese, had a history of hypertension and of sexual abuse, and was exhibiting signs of congestive heart failure. Although the hospital had a policy to assess patients at the time of admission to the psychiatric unit for a recent history of respiratory and cardiac disease to determine if these conditions posed an undue risk related to restraint use, the registered nurse on duty identified no undue risk related to the use of restraints for this individual. The assessment was not properly done because it did not include a review of additional pre-existing medical and psychological conditions that would also preclude restraint use, such as advanced age, obesity, seizure disorder, recent surgery, a history of osteoporosis and certain trauma experiences, such as rape or sexual abuse.

Additionally, contrary to CMS and state standards, the hospital's governing policy stated that restraints were to be applied loosely unless the patient is a danger to self or to others when in fact restraints should be used only when a person is a danger to self or to others.

Death #2

In April 2005, a 49-year-old male was uncooperative, agitated and threatening to kill and assault staff at the time of his arrival at the emergency room of a private hospital. Approximately three minutes after arrival, he was placed in restraints and remained in restraints for nearly 12 hours until his death.

CMS regulations require that hospitals notify it of any restraint-related death or any death in which it is reasonable to expect that the death was related to the use of restraints. In this case, the hospital did not notify CMS until nearly a month after the individual's death.

A review of the documents related to the restraint episode revealed an order that indicated that the individual was restrained for the protection of self and others from injury. Despite these behavioral facts, hospital staff failed to identify the use of restraints for a behavioral purpose and instead assessed the restraint as a medical restraint. This failure to properly identify the purpose for the use of restraints resulted in inadequate monitoring of the individual's condition during the time he remained in restraints until his death.

Although restraint-related records indicated that police and security officers placed the individual in restraints approximately three minutes after arrival in the ER, staff documented in the record that alternative interventions prior to the use of restraints were utilized. Contrary to the records, when interviewed, the staff member who allegedly employed the alternative interventions indicated that she was tending to another patient at the time the individual was brought in and therefore could not have provided any of the alleged less restrictive interventions.

The doctor who signed the restraint order failed to sign a correct restraint order stating that it was the RN's determination as to the type of restraint order to use. The restraint order signed by the doctor did not include a purpose, an appropriate time limitation or the conditions necessary for release as mandated by CMS and

state standards. Consequently, the individual remained in restraints for nearly 12 hours without a single renewal order, even though the purpose for which the individual was restrained required a maximum restraint time of four hours per order. When interviewed, the doctor stated that the "RNs grab an order form and the doctors sign it."

CMS and state standards require that staff continually monitor, assess and re-evaluate individuals restrained for behavioral purposes. The hospital staff failed to properly monitor the individual as revealed by the restraint records that document assessments of his conditions and vital signs in intervals of one to three hours.

CMS and state regulations require that all staff who have direct patient contact must have ongoing education and training in the proper and safe use of restraints. The doctor involved in the restraint indicated that the hospital had provided him with no formal training as to restraint use. Additionally, the doctor's two assessments did not support continued use of restraints. The doctor was unaware of the requirements for release from restraints stating that patients must "prove that they are going to be able to cooperate" before they can be released. Neither the RNs nor the staff trainer was able to provide a reasonable understanding of any medical or psychiatric conditions that would preclude restraint use. The staff responsible for restraint training indicated that "there is no behavioral reason for a person to go into restraints—there is always a medical reason." Additionally, the trainer indicated that she was unfamiliar with CMS regulations and the Illinois Mental Health and Developmental Disabilities Code.

Security staff involved in the restraint indicated that their training was conducted by police officers and was presented under a "continuum of force" model. The hospital indicated that it provides its security officers with no restraint-related training, yet it also reported that security "frequently" assists in restraining patients.

The hospital failed to ensure that all staff that may be asked to provide direct-care services are adequately trained in CPR. When the individual ceased breathing and a code was called, the security staff member who assisted by giving chest compression indicated that he had not been given CPR training by the hospital but had been certified some years earlier when he was in high school and in college.

Death # 3

In August 2005, a 95-year-old resident of a nursing home, weighing less than 100 pounds and suffering from chronic obstructive pulmonary disease and lung cancer, was sent to the ER following the sudden onset of agitation, paranoia and delusions. When she arrived at the ER, she was agitated, kicking and fighting and was placed in soft wrist restraints. Shortly afterwards, while remaining in wrist restraints, she was placed in a Posey vest. The individual was restrained allegedly for medical reasons to protect an intravenous site, a Foley catheter and the individual's oxygen tubes, as well as protection of self and others.

Emergency room staff documentation of alternatives attempted prior to the use of restraints was simply a box checked for "Decrease sensory stimulation." The "intervention" was documented at 11:30 a.m. The restraint order indicated that the individual was placed in restraints at 11:30 as well. When asked what interventions were employed prior to the use of restraints, the nurse stated that the individual was being attended by two RNs but could not identify any interventions that were attempted prior to the use of restraints.

After six hours the individual was transferred to an oncology unit, where she remained in restraints on that unit for approximately seven hours until she was discovered unresponsive on the floor with her arms raised above her head and her wrists and chest still tied to the bed by the restraints and Posey vest. At no point during those seven hours on the oncology unit did staff monitor the individual's vital signs.

The restraint records do not reveal any attempt by staff to remove the restraints or conduct further assessment of their need. Staff statements and restraint records contradicted the purported justification for the restraints—protection of the intravenous site, a Foley catheter and the individual's oxygen tubes, as well as protection of self and others. The physician stated that the Foley catheter could have been removed, as the individual's urinalysis was unremarkable. The IV was removed when the individual was admitted to the oncology unit, and there was no documentation suggesting that the individual attempted to remove the nasal cannula while on the unit. A nurse on the unit documented that the individual was calmer and no longer kicking. Three hours later, staff documented that the individual was resting quietly, but again there was neither an attempt to release her from restraints, nor any documentation supporting the continued use of restraints.

The hospital failed to properly train staff regarding the use of restraints, the inherent dangers associated with restraint use and alternatives to restraints. The ER physician stated that he had never received training from the hospital related to the safe use, monitoring and application of restraints. He was unable to distinguish between a medical restraint and a behavioral restraint and stated that it was his understanding that the degree of monitoring for a medical restraint was greater than that for a behavioral restraint. He was unable to identify any medical conditions that would cause him concern with respect to restraint use and he was unable to state any concerns related to restraint use with a patient who has respiratory issues.

None of the RNs were able to clearly articulate the differences between a restraint used for a behavioral purpose versus a restraint used for a medical purpose. One RN stated that a medical restraint was used for the protection of the patient, while a behavioral restraint was used for the protection of staff and added that behavioral restraints were more of a "psych issue." Another nurse stated that medical and behavioral restraints are "one and the same."

With respect to restraint-related risks, the doctor failed to identify a single medical condition that would cause him particular concern. He stated, "All medical procedures have risks," clearly illustrating a lack of appreciation of the unique risks inherent in the use of restraints. A staff member stated, "There was a board at the education fair that listed risks," but that she could not remember any of them. The RN stated that her training was more focused on physically applying restraints correctly.

Staff members were unable to provide meaningful examples of alternatives to restraint use or interventions that could be employed to avoid use of restraints. An RN stated that she was unable to recall receiving any de-escalation training or strategies, and stated that de-escalation techniques included, "Try to get her to cooperate" and "Try not to make her more agitated." Another RN stated, "There are policies in place geared toward reducing restraints," but was unable to provide any specific examples. When interviewed, the doctor stated that restraints are used only when other measures are not effective, and when asked to share those other measures, stated that in the ER such interventions are frequently not possible.

Equip for Equality's Private Psychiatric Hospital Review

Given the substantial shift of inpatient psychiatric care to private-care facilities and at the urging of Equip for Equality's Advisory Council for the P&A program for individuals with mental illness, Equip for Equality began to focus attention on private-sector hospitals and psychiatric units at general hospitals to ensure that adequate protections were in place for individuals regardless of the system in which they received care. This review answers the questions: "Do hospital restraint and seclusion policies in a major metropolitan area comply with federal and state laws? Furthermore, do they incorporate best practice standards?

Review Process

In 2001, Equip for Equality initiated an outreach to the private psychiatric hospital system that included a comprehensive review of policy compliance with the mandated national and state standards for the use of restraint and seclusion in private psychiatric hospitals or settings.

By the end of 2001, Equip for Equality had provided information about the organization to all hospitals in Illinois that had a psychiatric unit or that operated as a free-standing psychiatric hospital. Twenty-five Chicago-area hospitals with psychiatric units and

nine free-standing psychiatric hospitals, 3 in the Chicago metropolitan area and 6 at various locations throughout the state, were visited. Requests were made of the hospitals for their policies and procedures governing the use of restraint and seclusion.

During 2002 and 2003, Equip for Equality collected and reviewed policies and data related to restraint usage. In cooperation with Labor Relations Alternatives, Equip for Equality and LRA designed a Restraint and Seclusion Checklist tool by which the hospital's policies and procedures could be measured against federal and state standards related to the use of restraint and seclusion. Outreach to the patients and hospital staff regarding the programs and services offered by Equip for Equality continued. Equip for Equality's Training Institute also provided disability rights training to staff, patients and family members.

In 2004, an initial review of the policies and procedures of 25 hospitals was conducted. To ensure that any changes or updates to the policies and relevant hospital directives related to restraint and seclusion were considered, the hospitals were asked to submit any such documentation related to restraint and seclusion use. Analysis of each restraint policy, including the updates, was thereafter completed. In 2005, compliance data for all the participating hospitals was compiled, analyzed and summarized.

The findings of this report are presented as follows:

- Overview of the survey results
- Results of the review for CMS standards
- Results of the review of state statutes
- Results of the review for best practice standards

Data are reported by category of activity for all standards. All starred (*) items shown in the tables are ones that were not applicable to all of the hospitals, so the total number of policies is less than the 25 hospitals that submitted policies for review (e.g., hospitals that only serve adults or ones that use restraint but not seclusion). Percentages for these items are calculated using only the number of policies to which the item applied.

Methodology

Policies and procedures in psychiatric hospitals provide specific instruction regarding the care and treatment of patients, including the use of restraint and seclusion. Eighty hospitals in Illinois were asked to submit all written policies and procedures related to the use of restraint and/or seclusion to evaluate the extent to which these policies and procedures were in compliance with federal regulations and state statutes. Twenty-

two hospitals with psychiatric units and three free-standing psychiatric hospitals submitted all policies and procedures related to the use of restraint and/or seclusion. While 25 hospitals submitted policies for review, one hospital submitted substantially different policies for restraint and seclusion so that it was not possible to perform a single review for that facility. Consequently, the data shown below will indicate that 26 sets of policies were reviewed. Further review was conducted to determine whether hospitals exceeded those statutes and regulations by incorporating additional standards that delineate greater protections 1) that ultimately promote the use of noncoercive interventions and the reduction and elimination of the use of restraint and seclusion; 2) that ensure that restraint and seclusion are used in the manner least likely to cause injury or death; and 3) that these methods are used only as a last resort.

Development of the Restraint and Seclusion Checklist

The review process developed by Equip for Equality and LRA involved a process to review restraint and seclusion policies and procedures related to restraint and seclusion in private psychiatric hospitals and other settings governed by the Centers for Medicaid and Medicare Services (CMS). The methodology consisted of a checklist of standards that were written to facilitate an accurate and reliable analysis of policies and procedures. The purpose of this survey of policies was to obtain quantifiable results with regard to the degree to which private hospitals have achieved comprehensive policies and procedures for the most limited use of restraint and seclusion, as mandated by federal and state laws, including necessary and appropriate safeguards to prevent injuries and deaths. In developing the checklist, Equip for Equality and LRA first identified all CMS regulations on the use of restraint and seclusion under patient rights. In addition to the regulations, the guidelines and probes provided by CMS were used to develop more specific and operationally defined standards. Other standards were based on the Illinois Mental Health and Developmental Disabilities Code (5/2-108 and 5/2-109). These federal and state statutes and regulations represented minimum requirements that hospitals must comply with when utilizing restraint and seclusion.

The hospitals submitting policies for review are also accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and must comply with the standards established by JCAHO regarding restraint and seclusion to maintain accreditation. While many JCAHO standards overlap federal and state regulations and the standards developed in conjunction with this review related to best practices,

not all JCAHO standards are included as part of this review, given that compliance with these standards is already determined by JCAHO during periodic review of the hospitals.

To identify "best practices" beyond those requirements mandated in state and federal regulations, other policies and reports on restraint and seclusion were reviewed and best practice standards common to these materials were extrapolated to derive the best practice standards. These included 1) a model policy on restraint and seclusion developed by a law firm under contract to the California Protection and Advocacy System; 2) “Reducing the Use of Seclusion and Restraint: Findings, Strategies, and Recommendations,” a technical report produced by the NASMHPD Medical Directors Council in 1999; 3) the Pennsylvania (Department of Public Welfare) Mental Health and Substance Abuse Services Bulletin (2001) "Use of Restraint, Seclusion, and Exclusion in State Mental Hospitals and Restoration Center”; and 4) the Illinois Department of Human Services Policy and Procedures Directive (1997) "Restraint in Mental Health Facilities."

Standards were organized by the following categories of activities:

- General Policy and Philosophy: These standards pertain to the extent to which the hospital has established the foundation for identifying expectations of and guidance to staff with regard to restraint and seclusion use. Of course, these elements must also be consistent with any federal and state laws and regulations. In addition to establishing the philosophical principles that underlie the more specific procedures contained in the policy, this section of the policy should identify broad policy elements. Standards in this section also pertain to the clarity with which policy is written. The correct implementation by staff of hospital policy is facilitated when policies and procedures are internally consistent and unambiguously written.
- Defining Restraint and Seclusion: Clear definitions of restraint and seclusion assist hospital staff in correctly and appropriately implementing these interventions. Definitions of restraint should include a definition of chemical mechanical restraint as well as one for physical restraint, and a definition of seclusion should make a distinction between "timeout" and seclusion.
- Conditions for the Use of Restraint and Seclusion: These standards identify those issues that must be considered prior to implementing restraint or seclusion, such as whether a person's medical condition contraindicates use of the intervention, as well as actions by the hospital that ensure the appropriateness of the intervention for each individual and that it is absolutely necessary in the judgment of medical personnel.
- Authorization for the Use of Restraint and Seclusion: These policy elements identify the procedures that should be followed in obtaining authorization for restraint or seclusion, including all required documentation to support that authorization.

- Time Limits on the Use of Restraint and Seclusion: Standards in this category establish maximum times that may be specified in orders, the renewal of orders and other factors that determine the time a person may spend in restraint or seclusion and the criteria for release.
- Application of Restraints and Seclusion: These standards identify the manner in which the person is placed and held in restraints or seclusion, establishing conditions that promote the correct application and that address safety concerns. This category also includes state statutes requiring notification of the person or outside entity chosen by the patient to be informed upon the patient's placement in restraint or seclusion.
- Monitoring and Documentation: Once the patient has been placed in restraint, he or she must be closely monitored to ensure his or her comfort, safety and readiness for release, and these monitoring activities must be documented
- Termination of Restraint and Seclusion: These standards identify the circumstances and criteria under which the patient's release is required.
- Debriefing the Person Following the Restraint or Seclusion: Following the restraint or seclusion, a debriefing with the patient can help identify what led to the incident and what could have been done differently, as well as provide information to staff about what they can do differently to reduce restraint or seclusion use and the trauma and negative effects patients may experience as a result of these interventions.
- Debriefing Staff Following the Restraint or Seclusion: Similar to the debriefings with patients, a debriefing with staff provides an opportunity to process episodes of restraint and seclusion to determine the effectiveness of the inventions used and to identify other interventions or other issues that may help prevent future occurrences.
- Oversight of the Use of Restraint or Seclusion: To monitor and evaluate the use of restraint and seclusion, quality assurance processes must be established that will inform staff of how these interventions are being used and how their use can be minimized.
- Staff Training: Standards related to staff training should address three major areas: 1) how to avoid restraint or seclusion with the use of other interventions or techniques such as conflict resolution, anger management and de-escalation techniques; 2) how to appropriately and safely implement restraint or seclusion in the safest way possible; and 3) how to monitor the patient's comfort, safety and readiness for release.

Compliance with CMS Regulations and State Standards

CMS regulations and interpretive guidelines comprise a major portion of the standards developed for this review. CMS interpretive guidelines and probes provided the basis for the more specific procedures expected to be found in hospital policy. In some cases, CMS interpretive guidelines defer to state law, and in several instances, state code and CMS regulations have the same or similar provisions. The results of the review below will include both those standards derived from CMS regulations and interpretive guidelines as well as those standards based on State Code.

General Policy and Philosophy

Four standards related to general policy and philosophy were based on CMS regulations. While a majority of hospital policies included all four elements, the prohibition of restraint and seclusion for the purpose of coercion, discipline, convenience or retaliation was slightly less likely to be included in hospital policies (77%) but only in comparison with the greater rates of compliance with the other standards, which ranged from 85% to 100%. The data for these four standards are shown in Table 1 below.

Table 1. General Policy and Philosophy

Standard	#	%
Does the policy:		
Prohibit the use of restraint and seclusion for the purposes of coercion, discipline, convenience or retaliation by staff? (CMS and State Code)	20	77
Specify that restraint and seclusion are to be used only in emergency situations and how their use will be kept to a minimum? (CMS and State Code)	22	85
Specify that restraint and seclusion are used only when the patient is imminent danger to self or others? (CMS and State Code)	26	100
Specify that other less restrcitive alternative interventions will always be attempted first? (CMS)	25	96

Defining Restraint and Seclusion

The findings shown in Table 2 below indicate that policies do not fully define either restraint or seclusion. While most policies (84%) include general definitions of restraint and seclusion, many do not specifically address medication as a form of restraint, with only 47% of the policies providing a definition of both a physical hold and use of medication as a restraint. Hospitals are more likely to provide a definition of seclusion that delineates that it is the restriction of a person to a specific location such that he or she is prevented from leaving in order to regain self-control, with 72% of the hospitals that use seclusion including this element in their policies. Only 44% of the hospitals that use seclusion distinguish it from time-out as defined by JCAHO.[13] [14] [15]

Table 2. Defining Restraint and Seclusion

Standard	#	%
Does the policy provide definitions of restraint and seclusion? (State Code)*	21	84
Does the definition of restraint include specific definitions of both physical restraint and the use of a medication as a restraint? (CMS)*	9	47
Does the definition of medication as a restraint indicate that this is medication used to control aggressive or destructive behavior or to restrict movement, and is not part of the person's treatment plan for any medical or psychiatric condition? (CMS)*	9	45
Does the policy indicate the following shall not be considered a restraint:		
The "partial or total immobilization" for purposes of medical, dental or surgical procedures? (State Code)*	13	52
"Momentary periods of physical restriction by direct person-to-person contact without the aid of material or mechanical devices, accompanied by limited force, and that are designed to prevent a recipient from completing an act that would result in potential physical harm to himself or another shall not constitute restraint, but shall be documented in the recipient's clinical record"? (State Code)*	7	28
Does the definition of seclusion include that it is the restriction of a person to a specific location where he or she is prevented from leaving in order to regain self-control? (CMS)*	13	72
Does the definition of seclusion distinguish it from time-out (i.e., when an individual is restricted from leaving an unlocked room or area)? (CMS and State Code)*	8	44

Conditions for the Use of Restraint and Seclusion

CMS regulations provide four guidelines regarding those conditions that should be considered prior to the use of restraint or seclusion. (See Table 3 below for these findings.) One CMS probe suggests that a person's health needs or problems be considered prior to the implementation of the intervention. Most facilities require that a physician examine the person soon after the restraint has been implemented to ensure that the intervention does not pose a risk to the person's health, but only 42% require that the person's medical condition be considered prior to the initiation of the restraint or seclusion. Most hospitals (92%) do require that staff attempt all other less restrictive interventions prior to the use of restraint or seclusion. The third CMS regulation was less likely to be addressed either as a general policy statement or procedurally. Only 16% of the hospitals included the provision that the risk of using restraint should be less than the risk of not using it. Surprisingly, given the specificity of the regulation, only a little more than half of the hospitals (54%) include a procedure that prohibits PRN or standing orders for the authorization of restraint or seclusion.

Table 3. Conditions for the Use of Restraint and Seclusion

Standard	#	%
Does the policy specify that the following be considered prior to implementation of restraint or seclusion:		
Whether the person's medical condition contraindicates its use? (CMS)	11	42
That all possible other less restrictive interventions have been attempted? (CMS)	24	92
"That the risks associated with the use of the restraint are outweighed by the risk of not using it"? (CMS)*	4	16
Does the policy state:		
That PRN or standing orders for the authorization of restraint or seclusion are prohibited? (CMS)	14	54

Authorization for the Use of Restraint and Seclusion

CMS does provide a number of guidelines regarding the authorization required for the implementation of restraint or seclusion, specifically those requirements for obtaining a written order including verbal orders. Table 4 shows the extent to which hospital policies complied with state and federal regulations pertaining to the authorization of the use of restraint or seclusion.

Generally, hospitals include several procedures for obtaining authorization for the use of restraint or seclusion, an area in which standards were generally met. CMS regulations include a requirement that all restraints must be ordered by a physician or "other licensed independent practitioner permitted by the State." In addition to physicians, the Illinois state code allows clinical psychologists, clinical social workers and registered nurses to write an order for restraint or seclusion. All but one (96%) of the policies reviewed complied with state and CMS regulations. In accordance with CMS regulations, all hospitals require that a physician or other licensed practitioner must observe and determine the necessity of the intervention within one hour of its implementation.[16] The state code has a similar provision for examination of the patient to determine the need for restraints, which was found in all of the policies reviewed. In addition, state code requires that a physician or nurse with supervisory experience must personally perform an examination within two hours of applying the restraint to ensure that the restraint does not "pose an undue risk to the recipient's health in light of the recipient's physical or medical condition." Nineteen of the 26 policies reviewed (73%) met this standard. CMS regulations also requires that a physician or other licensed practitioner perform a face-to-face assessment when a person is released within one hour, which in many cases may precede the physician or practitioner examining the person for the necessity of the restraint. This requirement ensures that any person restrained or secluded for even short periods of time is seen by a physician or licensed practitioner. Few hospitals (15%) include this requirement in their policy. Finally, CMS specifies that when restraint or seclusion is ordered by someone other than the treating physician, the treating physician must be consulted as soon as possible. Sixty-nine percent of the policies had an element requiring the involvement of the treating physician (in most policies referred to as the attending physician).

State code specifically addresses emergency orders. These are situations in which an individual's behavior is such that he or she or others are placed in imminent danger. In such cases, state code allows for the application of restraint or seclusion when a physician or the other three qualified disciplines are unavailable; it also requires that an order be obtained from one of the qualified disciplines as soon as possible. In

addition, CMS recommends that policies indicate who can initiate restraint and seclusion in an emergency. For all three standards, 85% to 88% of the policies reviewed contained procedures in compliance with state code and CMS.

Only half of the policies reviewed had procedures related to verbal orders as required by CMS.

As specified in CMS interpretive guidelines, hospitals were generally consistent in meeting requirements that information related to the initiation of the restraint or seclusion be documented in the person's medical record, such as a description of behaviors or events leading up the intervention (81%), the less restrictive interventions attempted (85%), the purpose of the restraint (88%), the type of restraint (68%) and the maximum length of time for which the intervention may be employed (81%). The state code also requires that clinical justification for the length of time ordered for restraint or seclusion be documented in the patient's medical record. Only 31% of the policies met this requirement.

Table 4. Authorization for the Use of Restraint and Seclusion

Standard	#	%
Does the policy require that:		
The restraint and seclusion shall be applied only when a written order is obtained from a physician, clinical psychologist, clinical social worker or registered nurse with supervisory responsibilities? (State Code)	25	96
The person must be personally observed and examined by one of the above disciplines to determine whether in the examiner's clinical judgment the person is in need of restraints to prevent physical harm to self or others? (State Code)	26	100
A physician or other licensed independent practitioner must observe and evaluate the necessity of the restraint or seclusion within one hour of application. (CMS)	26	100
This face-to-face assessment be performed even in those situations where the person is released early (prior to one hour)? (CMS)	4	15
A physician or nurse with supervisory experience performs a personal examination of the person within two hours of application of the restraint to ensure that the restraint "does not pose an undue risk to the recipient's health in light of the recipient's physical or medical condition"? (State Code)	19	73
"The treating physician must be consulted as soon as possible, if the restraint or seclusion is not ordered by the treating physician"? (CMS)	18	69
Does the policy specify that the written order or person's medical record document the following:		
A description of events and specific behaviors leading up to the aggressive or destructive behavior? (CMS and State Code)	21	81
The less restrictive interventions used? (CMS)	22	85
The purposes (or rationale) of the restraint? (CMS and State Code)	23	88
The type of restraint?*	17	68
The maximum length of time the restraint may be employed? (CMS and State Code)	21	81
The clinical justification for the length of time the restraint is to be employed? (State Code)	8	31
In cases of emergency restraints, are the following procedures specified in the policy:		
That an emergency restraint can only be ordered when the four qualifying disciplines noted above are not available? (State Code)*	22	88
That an order must be obtained by one of the four qualifying disciplines as soon as possible? (State Code)*	22	88
Who can initiate restraints or seclusion prior to obtaining an order? (CMS)	22	85
Does the policy:		
Address the use of verbal orders?	13	50

Time Limits on the Use of Restraint and Seclusion

CMS provides specific time limits on the use of restraint and seclusion. Written orders may not be written to exceed maximum time specified by CMS, and time may be further limited by the continued need for the intervention, not just these maximum time limits. Findings regarding compliance with these time limits are shown in Table 5 below. Almost all of the hospital policies (92%) clearly specify that the maximum time limit for an order is four hours for adults. The policies indicated that not all of the hospitals served individuals under 17: children and adolescents ages 9 to 17 (three policies) and children under nine (7 policies). For those policies reviewed that did serve these age groups, 91% specified the time frames for children and adolescents ages 9 to 17, while 89% specified the time frames for children under the ages of 9.

CMS also provides additional guidance regarding release of individuals prior to these maximum time frames. These guidelines are intended to reduce the time in restraints or seclusion to only that considered necessary. To fully comply with the time limits established for restraint and seclusion, hospitals must implement the regulations such that staff members understand that the intervention can be ordered for less than the maximum time frames set by CMS and that staff must continuously monitor individuals so that they can be released as soon as possible. Seventy-three percent of the hospital policies reviewed clearly indicated that restraint or seclusion could be ordered for less than the stated maximum limits, and 88% had provisions for release as soon as possible regardless of the length of time specified in the order. CMS also has provisions for the length of time for which the order can be renewed, which 85% of the policies included, and any person in restraints must be evaluated face-to-face by a physician to renew the order, which was found in 92% of the policies. CMS also requires that if a patient is released prior to the expiration of the order, a new order must be obtained; only 12% of the policies included this requirement.

The Illinois State Code also requires that after a patient has been restrained for all or part of a 24-hour period, a facility director must give consent for restraint to be re-employed during the next 48 hours. This same requirement applies to patients who have been in seclusion for all or part of a 16-hour period. Nineteen of the 26 (73%) policies reviewed included this requirement.

Table 5. Time Limits on the Use of Restraint and Seclusion

Standard	#	%
Does the policy specify the time limit of an order for restraint or seclusion for the following groups:		
Four hours for adults? (CMS)	24	92
Two hours for children and adolescents ages 9 to 17? (CMS)*	21	91
One hour for children under 9? (CMS)*	17	89
Does the policy:		
Clearly state that the restraint or seclusion can be ordered for less than the above stated maximum? (CMS)	19	73
Clearly state that the length of the restraint or seclusion is limited by the continued need for the intervention rather than the length of the order? (CMS)	23	88
Allow the order to be renewed for a maximum of 24 hours? (CMS)	22	85
Require that after a restraint has been ordered during all or part of a 24-hour period (16 hours for seclusion), it may not be re-employed during the next 48 hours without consent of the facility director? (State Code)	19	73
Does the policy require that if a person is released from restraints or seclusion prior to the expiration of the order, a new order must be obtained to re-employ restraint or seclusion. (CMS)	3	12
After being in restraint or seclusion for 24 hours, does the policy state that the physician must evaluate the person face-to-face to renew the order? (CMS)	24	92

Application of Restraints and Seclusion

CMS and state code provide both general and specific guidance with respect to the safest application of restraints or placement in seclusion. Findings for this category are contained in Table 6 below. Both CMS and state code address the way in which restraints are applied. The Illinois State Code states that restraints must be applied in a "humane and therapeutic manner." Less than half the policies (44%) addressed this requirement. More specifically, state code includes the statement that the restraints "shall be loosely applied to permit freedom of movement unless doing so presents a danger to the person or others." Only 16% of the policies alluded to this provision.

CMS states in its interpretive guidelines that restraints must not cause harm or pain and that staff should immediately assess the patient "to ensure that restraints were safely and correctly applied." Only 19% of the policies specifically noted that restraints must not cause harm or pain, while 42% included a provision to assess the patient with regards to the correct application of the restraints.

State and CMS regulations also delineate more specific requirements for the initiation of the restraint or seclusion and the environment within which restraint and seclusion occur. State code requires that the facility ensure that the seclusion area is adequately lighted, heated and furnished to promote patient safety. Only 16 of the hospitals utilized seclusion and of those, only 2 (11%) clearly stated that the seclusion room must meet these requirements. State code also requires that a staff member with a key must be in close proximity to the seclusion room at all times while the seclusion room is in use. Only 5 of the 18 (28%) hospitals included this as a procedure in their policy. CMS also prohibits the simultaneous use of restraint and seclusion unless the following conditions are met: that the person is "continually monitored face-to-face by an assigned staff member, or that the person is "continually monitored by staff using both video and audio equipment" and that such monitoring must be in close proximity to the person. Of the 14 facilities where both interventions are used simultaneously, 8 (57%) had provisions in their policy that reflected CMS requirements.

Finally, the Illinois State Code requires that all patients must be advised of their right to notify the person of their choosing when they have been restrained or secluded, including Equip for Equality or the Guardianship and Advocacy Commission. Eighty-one percent of the policies gave clear instructions regarding this right. State code also specifies that patients with guardians maintain this right even if the guardian is opposed. Only 19% of the policies included this provision.

Table 6. Application of Restraints and Seclusion

Standard	#	%
Does the policy require:		
That the restraints shall be applied in a "humane and therapeutic manner"? (State Code)*	11	44
That restraints "shall be loosely applied to permit freedom of movement" unless doing so presents a danger to the person or others? (State Code)*	4	16
That the restraints must not cause harm or pain to the person? (CMS)*	5	20
That the staff immediately assess the person "to ensure that the restraints were safely and correctly applied"? (CMS)*	11	44
That the facility must ensure the safety of seclusion such that it is adequately lighted, heated and furnished? (State Code)*	2	11
That during any seclusion episode that a staff member with a key is in close proximity at all times? (State Code)*	5	28
That restraint and seclusion cannot be used simultaneously unless the following conditions are met: 1) that the person is "continually monitored face-to-face by an assigned staff member, or 2) that the person is "continually monitored by staff using both video and audio equipment" and that such monitoring must be in close proximity to the person? (CMS)*	8	57
That the person be advised of his or her right "to have any person of his choosing, including the Guardianship and Advocacy Commission or the agency designated pursuant to the Protection and Advocacy for Developmentally Disabled Persons Act," to be notified of the restraint? (State Code)	21	81
In cases in which the person has a guardian, that this right of notifying a person or agency of their choosing cannot be overridden by the person's guardian for either restraint or seclusion episodes? (State Code)	5	19

Monitoring and Documentation

CMS regulations provide explicit instructions regarding expectations for monitoring patients while they are in restraints or seclusion as well as the documentation of those monitoring activities (see Table 7 below.)[17] Hospital policies were generally consistent with the requirements for monitoring delineated by CMS regulations, interpretive guidelines and probes. Both CMS and state regulations require that individuals in restraint or seclusion must be monitored and observed face-to-face at least every 15 minutes; 96% of the policies contained procedures that reflected this regulation. For the standard related to monitoring the patient's vital signs, respiratory and cardiac status, and skin integrity, 85% of all policies included procedures that required nursing staff to perform these assessments. Most policies were also consistent with other CMS regulations, including the offering of meals, fluids, bathroom use, personal hygiene, etc. (96%); procedures for removal of the person from restraints as soon as the criteria for release had been met (77%); evaluating the patient's behavior and mental status to assess whether the person should remain in restraints or seclusion (69%); and identifying the staff members who are responsible for monitoring the person (73%).

CMS provides only two specific monitoring activities that must be documented; the state code has no provision for documentation in this area. CMS requires that the time of all monitoring checks, any care provided and the results of any assessment must be documented. Forty-two percent of the policies instruct staff to document these activities. CMS regulations require that the results of all assessments and evaluations be documented while the person is in restraint or seclusion, and 65% of the policies adhere to that.

Table 7. Monitoring and Documentation

Standard	#	%
Does the policy specify that staff must do the following during restraint or seclusion:		
Continuously assess, monitor, observe and evaluate the person face-to-face as often as clinically appropriate but in no event less than every 15 minutes"? (State Code and CMS)	25	96
Monitor the person for vital signs, respiratory and cardiac status, and skin integrity? (CMS)	22	85
Remove restraints to allow the person meals and use of a toilet "except when freedom of action may result in physical harm to the recipient or others"? (State Code)	16	62
Offer the opportunity for fluids, meals, bathroom use, personal hygiene, exercise, range of motion and the "systematic release of restrained limbs" at some specified frequency? (CMS)	25	96
Remove the person from restraints or seclusion as soon as the criteria for release have been met? (CMS)	20	77
Evaluate the patient's behavior and mental status to determine the continued need for restraints or seclusion? (CMS)	18	69
Identify which staff members are responsible for monitoring patients in restraint or seclusion? (CMS)	19	73
Does the policy require that all monitoring and evaluation be documented in the person's record, including the following:		
The time of all monitoring checks, any care provided, the results of assessments or evaluations, etc.? (CMS)	11	42
Results of all assessments and evaluations, including vital signs? (CMS)	17	65

Termination of Restraint and Seclusion

In CMS interpretive guidelines, termination of restraints must occur when the following conditions exist: 1) the person has met criteria that would indicate that he or she is no longer in need of restraint or seclusion; or 2) a written order has not been obtained for renewal (although this standard is less explicitly stated in CMS regulations). Respectively, 81% and 96% of the policies met each of these standards.

Table 8. Termination of Restraint and Seclusion

Standard	#	%
Does the policy specify when the person shall be released from restraint and seclusion, including the following:		
As soon as the person has met the criteria for release regardless of the length of the order? (CMS)	21	81
When the order has expired and a renewal has not been authorized? (CMS)	25	96

Debriefing the Person/Staff Following Restraint or Seclusion

Governmental regulations currently do not address a debriefing process for either patients or staff.

Oversight of the Use of Restraint or Seclusion

Three standards related to the oversight of the use of restraint and seclusion were derived from state code. First, staff members are required to notify the facility director of all restraints within 24 hours of their initiation. Approximately three-quarters (73%) of the policies included this requirement. Facility directors are then required to review all restraint and seclusions daily; 58% of the policies identified this as a facility director responsibility. Finally, the facility director must conduct an inquiry into any routine ordering of restraint or seclusion to determine the reasons for their use. Only 27% of the policies mentioned this as a responsibility of the facility director.

CMS has few regulations related to oversight of the use of restraint and seclusion with the exception of those episodes that result in death. In such cases, CMS requires that hospitals report deaths that occur during a restraint or seclusion to their office no later than the next business day following the death. Few policies indicated that hospitals had procedures for making this report within the time frames established by CMS. Only 23% of the policies contained a specific procedure that said this report was required, and only 8% mentioned the time frame within which the report must be made. Results are provided in Table 9 below.

Table 9. Oversight of the Use of Restraint or Seclusion

Standard	#	%
Does the policy require:		
That the facility director must be notified by the staff ordering the restraint or seclusion of any application within 24 hours? (State Code)	19	73
That the facility director must review all restraints and seclusions daily? (State Code)	15	58
That the facility director make an inquiry to determine the reasons for routine ordering of restraint or seclusion by any staff? (State Code)	7	27
That the facility must report to CMS any death that occurs while a person is being restrained or secluded or where it is "reasonable to assume" that the death was the result of the restraint or seclusion? (CMS)	6	23
That reports of these deaths must be made to the CMS regional office by the next business day following the death? (CMS)	2	8

Staff Training

Table 10 contains findings for those standards related to staff training in the area of restraint and seclusion. State code specifies that restraints can be applied only by staff trained in the use of the specific restraints being used. Almost three quarters (73%) of all policies included language that complied with state code. State code also requires that all training on the use of restraint must be documented, including the dates of training and the types of restraints that staff members have been trained on. Only 24% of the policies include this state code requirement.

Similar to state code, CMS requires that staff members with direct patient contact must be provided with ongoing training on the "proper and safe use of restraint and seclusion application and techniques." Twenty-seven percent of the policies include this specific training requirement. Staff must also demonstrate competency in the use of these interventions before being allowed to participate in their application; only 15% contain this training element. Staff must also receive training on alternative methods for controlling behavior and preventing the use of restraint and seclusion. Twenty-seven percent of the policies included a specific provision for training on these topics. Finally, few policies (8%) specify that staff should be trained on recognizing psychological or physical distress in patients while they are in restraints or seclusion.

Table 10. Staff Training

Standard	#	%
Does the policy require:		
That restraints can be applied only by staff who have been trained in the application of the specific type of restraint to be used? (State Code)	19	73
That "all staff who have direct patient contact must have ongoing education and training in the proper and safe use of restraint and seclusion application and techniques"? (CMS)	7	27
That all staff must demonstrate competency in the use of restraint and seclusion before being allowed to assist in their application? (CMS)	4	15
That training must include alternative methods for controlling aggressive behaviors and preventing restraint and seclusion? (CMS)	7	27
How to recognize if a restraint or seclusion is causing physical or psychological discomfort or distress? (CMS)	2	8
That training records be maintained that document which employees have received training and are authorized to employ restraint, the dates of training and the type(s) of restraint they are trained in? (State Code)	2	24

Beyond CMS and State Code: Best Practices to Ensure Reduction or Elimination of Restraint and Seclusion

This section will address those standards identified by Equip for Equality and LRA as best practices. To identify "best practices" beyond those requirements mandated in state and federal regulations, Equip for Equality and LRA reviewed other policies and reports on restraint and seclusion, and best practice standards common to those materials were extrapolated to derive the best practice standards that would lead to the elimination of such measures. These included 1) a model policy on restraint and seclusion developed by a law firm under contract to the California Protection and Advocacy System; 2) "Reducing the Use of Seclusion and Restraint: Findings, Strategies, and Recommendations," a technical report produced by the National Association of State Mental Health Program Directors' Medical Directors Council in

1999; 3) the Pennsylvania (Department of Public Welfare) Mental Health and Substance Abuse Services Bulletin (2001) “Use of Restraint, Seclusion, and Exclusion in State Mental Hospitals and Restoration Center;” and 4) the Illinois Department of Human Services Policy and Procedures Directive (1997) “Restraint in Mental Health Facilities.”

Overall, we found that many of the best practice standards are currently not included in these hospitals’ policies, particularly in the areas of primary prevention, patient and staff debriefing, oversight of restraint and seclusion use, and staff training.

General Policy and Philosophy

For a statement of the guiding principles and philosophy with regard to the use of restraint and seclusion, results were mixed for the inclusion of elements identified as best practices. (See Table 11.) Policies were likely to include a statement of purpose and philosophy (88%); a commitment to creating a therapeutic milieu in which patients are treated with dignity and respect, although this principle was primarily stated as respecting the patient's dignity when implementing restraint and seclusion (62%); and promotion of the use of a variety of other interventions in response to aggressive behavior (85%).

Those elements that policies were less likely to include were processes for the following: using information from episodes of restraint and seclusion to reduce their use (38%); identifying patients at risk of restraint or seclusion (19%); including specific goals, objectives and methodologies in the treatment plans of all patients at risk of restraint or seclusion to prevent their use (19%); and obtaining an advanced directive regarding the type of intervention preferred by the patient when needing to regain self-control (23%).

Policies can be effective only if they are written in such a way that clearly conveys the principles and procedures that staff must adhere to. In writing policies, administrators must delineate procedures that are free from ambiguity, including avoiding the use of vague language (e.g., “appropriate,” and “immediate”). The policies reviewed did have some problems with providing clear instructions to staff, with 46% of the policies containing procedures free from ambiguity and 58% judged to be free from ambiguous language. The organization of policies is also important in achieving clarity in the instructions given to staff. Almost all policies (92%) were written such that the general elements precede more specific ones and were internally consistent.

Table 11. General Policy and Philosophy (Best Practices)

Standard	#	%
Does the policy require:		
Begin with a statement of purpose and the facility's philosophy with regard to the use of restraint and seclusion?	23	88
Clearly state that the facility and its staff are responsible for creating a therapeutic milieu that treats all patients with dignity and respect?	16	62
Promote the use of a variety of strategies and interventions in response to aggressive or destructive behavior?	22	85
Provide for mechanisms that will use information from episodes of restraint and seclusion to reduce their use?	10	38
Does the policy include in its definition of an emergency situation the following:		
Does the policy provide a process for:		
Identifying patients at risk of restraint or seclusion?	5	19
Including in the treatment plan of all patients at risk of restraint and seclusion, goals, objectives, methodologies and interventions to prevent the need for their use?	5	19
Ascertaining the type of intervention preferred by the patient to regain self-control (advanced directive).	6	23
With respect to clarity of the entire policy:2		
Are the procedures free from ambiguity?	12	46
Does the policy avoid using words and phrases that are inherently ambiguous [e.g., timely; appropriately]?	15	58
Do the more general portions of the policy precede the more specific?	24	92
Are the policies and procedures internally consistent?	24	92

Defining Restraint and Seclusion

All but one standard were ones required by state or federal regulation. The one standard based on best practices recommended that restraint and seclusion policies and procedures contain a set of definitions for general terms (e.g., licensed independent practitioner, least restrictive alternative, imminent danger, etc.) in addition to those pertinent to restraint and seclusion. Only 35% of the policies contained definitions of general terms.

Conditions for the Use of Restraint and Seclusion

With the exception of the standard that addresses the issue of presenting other interventions to help individuals regain self-control (50%), few policies incorporated the best practice standards related to conditions to be considered prior to implementing restraint or seclusion. Results are shown below in Table 12.

Table 12. Conditions for the Use of Restraint and Seclusion (Best Practices)

Standard	#	%
Does the policy specify that the following be considered prior to implementation of restraint or seclusion:		
Whether the person's psychiatric condition contraindicates its use, including the use of seclusion for a person with suicidal ideation?	1	4
Whether the person has a history of physical or sexual abuse, which may contraindicate its use?	5	19
Whether current medications may contraindicate its use?	1	4
That every attempt should be made with the person to present other interventions to help the person regain self-control?	13	50
That the facility consult the person's record to determine if the interventions used were those specified by the patient in his or her advanced directive?	1	4
Does the policy require:		
That all of the above information be documented in the person's record?	2	8

Authorization for the Use of Restraint and Seclusion

Most standards for the authorization of restraint or seclusion were ones derived from state or federal regulations. Those few based on best practices were generally not addressed in the policies reviewed, with two exceptions. Fifty-eight percent of the policies contained these two standards: that staff must document in the patient's medical record how the less restrictive interventions attempted were ineffective and that verbal orders are valid for only one hour, after which a written order must be obtained. Results for all best practice standards are shown in the table below.

Table 13. Authorization for the Use of Restraint and Seclusion (Best Practices)

Standard	#	%
Does the policy specify that the written order or person's medical record document the following:		
How the less restrictive interventions were ineffective?	15	58
The specific criteria for release from restraint or seclusion?	8	31
Whether the person should be released from restraints if he or she falls asleep?	1	4
In cases of verbal orders, does the policy require:		
That sufficient information (i.e., the person's behaviors and other events leading up to the restraint) will be provided to the physician or other disciplines authorized to order restraint to evaluate the need for restraint or seclusion and whether all less restrictive interventions have been attempted?	1	8
That phone orders should include the date and time, the specific reasons for the restraint or seclusion, and the criteria for release?	1	8
That verbal orders are valid for only one hour, after which a written order must be obtained?	7	58

Time Limits on the Use of Restraint and Seclusion

All standards on time limits for the use of restraint and seclusion were based on state and federal regulations.

Application of Restraints and Seclusion

The standards based on best practices in this category pertain primarily to the way in which the restraint or seclusion is implemented, focusing on application in the manner least likely to cause injury or death. Overall, few of the policies contained these elements, with one exception. Ninety-two percent of the policies did contain instructions regarding the removal of dangerous attire or contraband prior to placement in restraint or seclusion. The two standards shown at the bottom of Table 13 are ones that are not included in state code but that do relate to the implementation of the state regulation. State code requires that the patient be allowed "to have any person of his own choosing" notified of the restraint or seclusion. Less than half (42%) of the policies contain a written procedure for making this notification, and only 12% address the time frame within which this notification is made. Equip for Equality and LRA recommended that this notification be made within 8 hours.

Table 14. Application of Restraints and Seclusion (Best Practices)

Standard	#	%
Does the policy require:		
That staff use approved techniques for managing aggressive behavior and escorting?	6	23
That staff check the person to ensure that any dangerous attire or contraband is removed from the person or from the restraint and seclusion room?	24	92
That at least 3 staff members shall participate in application of physical or mechanical restraints?	6	24
That prone (face-down) positions are prohibited?	5	19
That individuals who are placed in a prone position for the purpose of medication administration shall be moved to their side immediately?	1	4
That staff members should never place a towel or any other such cover over a person's face during any restraint or physical management procedure?	1	4
That any procedure used in the process of restraint is monitored to ensure that the person is breathing without difficulty?	5	19
That the facility has a procedure for implementing the notifications required by state code?	11	42
That the procedure ensures that the notifications are made in a timely manner, but no more than 8 hours after the restraint or seclusion was initiated?	3	12

Monitoring and Documentation

Table 15 below contains two best practice standards related to monitoring individuals in restraint or seclusion. Sixty-two percent of the hospital policies were likely to delineate the process for discussing the reason for the restraint or seclusion with the person, the reason for the continued need for the intervention and how staff could assist the person in meeting the criteria for release. None of the policies addressed the need for

additional monitoring for individuals with special conditions that may make the person more at risk of harm, such as pregnancy or substance abuse, or a newly admitted patient or someone with a respiratory problem.

While CMS and the state code provide guidance regarding the process by which a hospital should monitor patients who are in restraint or seclusion, little instruction is provided for the documentation of monitoring activities. Results for best practice standards related to the documentation of monitoring activities are mixed. Most required documentation of the time that meals, fluids, and bathroom breaks were offered and accepted (73%). Few policies contained documentation requirements for justification of the continued need for the intervention (35%); the name of the staff person performing those functions (27%); and staff verbal interactions with the patient (4%). None of the policies contained a requirement that at shift change the staff leaving discuss the restraint or seclusion with the staff who are relieving them.

Table 15. Monitoring and Documentation (Best Practices)

Standard	#	%
Does the policy specify that staff must do the following during restraint or seclusion:		
Provide an ongoing opportunity to discuss with the person the behaviors that necessitated the restraint or seclusion, why their behaviors continue to require this intervention, the specific behaviors required for release and how staff can help the person meet the criteria for release?	16	62
Evaluate the need for additional monitoring and attention for individuals who are pregnant, are newly admitted, have used street drugs or alcohol, have a respiratory condition or have any other condition placing them at risk?	0	0
Does the policy require that all monitoring and evaluation be documented in the person's record, including the following:		
The name of the staff person(s) performing any of the above functions?	7	27
A description of the person's behavior and mental state?	20	77
Justification for continuing the restraint?	9	35
A description of any verbal interactions with the person.	1	4
The time that meals, fluids, bathroom use, etc., were offered and whether the person accepted that opportunity?	19	73
Does the policy require:		
That at shift change the qualified staff leaving meet with the qualified staff who are relieving them to discuss the restraint or seclusion and jointly observe the person?	0	0

Termination of Restraint and Seclusion

Only one standard related to termination of the intervention was not based on federal or state regulations. Eighty-six percent of the policies implied, if not specifically stated, that a restraint or seclusion for which a written order had not been obtained within one hour of a verbal order must be terminated.

Debriefing the Person Following Restraint or Seclusion

Federal and state regulations do not require debriefing with the patient following restraint or seclusion. Table 15 below contains those standards developed by Equip for Equality and LRA to address a debriefing process designed to elicit information about the intervention to promote safety during restraint or seclusion and reduction in the use of these interventions. While a majority of policies (65%) provide a process for debriefing patients following the restraint or seclusion, they contain few details for doing so. Forty-six percent do include in the debriefing a discussion of the person's feelings regarding the intervention.

Table 16. Debriefing the Person Following Restraint or Seclusion (Best Practices)

Standard	#	%
Following the restraint or seclusion, does the policy require that an appropriate staff member discuss as soon as possible but not later than 24 hours the following with the person:	17	65
The specific behaviors that led to the person's restraint or seclusion?	10	38
Any precipitating events or factors that may have influenced the person's behaviors or caused them to escalate?	0	0
The reasons for the length of the restraint?	0	0
The person's feelings regarding the restraint or seclusion?	12	46
How the person can avoid future episodes, including alternative behaviors or other methods of coping or calming down?	4	15
How staff could have made the restraint or seclusion more comfortable or less demeaning?	7	27
What other alternative interventions the person would like staff to attempt in similar circumstances in the future?	2	8
What staff could have done differently that may have prevented the restraint or seclusion?	7	27
Does the policy require:		
That the details of this discussion must be documented in the person's medical record?	7	27

Debriefing of Staff Involved in the Restraint or Seclusion

While many policies prescribed a procedure for debriefing patients, few had a separate debriefing process for staff or a process to address the staff members' trauma. Results for the standards developed by Equip for Equality and LRA are shown in Table 17 below.

Table 17. Debriefing of Staff Involved in the Restraint or Seclusion (Best Practices)

Standard	#	%
Does the policy require:		
That all staff members who were involved in the restraint or seclusion should meet within 24 hours of the episode?	5	19
Does the policy require that the staff discuss the following:		
The circumstances that led up to or may have contributed to the restraint or seclusion?	3	12
Which of the alternative interventions specified in the person's treatment plan were attempted?	0	0
Why staff believe these interventions as well as any other alternative interventions attempted were unsuccessful?	1	4
Based on their discussion of the above issues, what strategies the staff members recommend to prevent future episodes?	2	8
Does the policy require:		
That the contents of the staff debriefing be documented and forwarded for use by the treatment team and any facility review mechanism?	3	12

Oversight of the Use of Restraint or Seclusion

Few of the elements defined as best practices in the area of oversight were found in these policies. Results are shown in Table 18 below.

Table 18. Oversight of the Use of Restraint or Seclusion (Best Practices)

Standard	#	%
Does the policy require:		
That all restraint and seclusion episodes be reviewed by the treatment team to determine whether alternative strategies should be tried to prevent future occurrences?	5	19
That the discussion by the treatment team and its decision regarding changes in the person's treatment plan use information provided during both the staff and person debriefing?	5	19
That all restraint and seclusion episodes be reviewed by an interdisciplinary review committee that includes direct-care staff?	4	15
Does the policy require that this review determine the following :		
What the circumstances were that led up to the episode?	1	4
Whether there were events or other circumstances within the environment/location of the events leading to the restraint that may have contributed to restraint or seclusion being utilized?	0	0
The behaviors exhibited by the person that resulted in restraint or seclusion?	1	4
Whether these behaviors met the imminent danger standard for the use of restraint or seclusion?	2	8
Whether the order was properly authorized and documented?	1	4
Whether the required monitoring activities were properly conducted and documented?	1	4
Whether alternative interventions were attempted prior to the episode and were documented?	2	8
Why these interventions were unsuccessful?	0	0
What other interventions could have been tried?	0	0
Could this restraint or seclusion have been prevented by changes in procedures, the unit's schedule, rules or structure, or the environment?	0	0

Standard	#	%
Does the policy require that the review committee:		
Make recommendations based on its finding regarding how any of the episodes may have been prevented?	0	0
Forward any recommendations related to the individual to the treatment team?	1	25
Review an aggregate report of restraint and seclusion episodes on a periodic basis to examine data for trends and patterns?	3	12
Make recommendations to the director of the facility regarding systemic changes that would help prevent or reduce the use of restraint and seclusion?	1	4
Conduct an in-depth review for any person who is in restraint or seclusion for more than 12 continuous hours or who has been restrained or secluded more than 3 times in a 7-day period?	3	12
If yes to in-depth review, does it include examination of all episodes that the person has been involved in during the previous 3 months and his or her full medical record?	0	0

Staff Training

Similar to oversight of restraint or seclusion use, few policies address the issue of staff training. It is possible that staff training is addressed in other policies not submitted to Equip for Equality. Results are shown in Table 19 below.[18]

Table 19. Staff Training (Best Practices)

Standard	#	%
Does the training curriculum include the following elements:		
The facility's restraint and seclusion policies and procedures related to their use, authorization, monitoring, documentation and debriefing?	3	12
Identifying precursors to aggressive behaviors?	2	8
Identifying those who are at risk of presenting a danger to self or others?	1	4
Skill building in conflict resolution, verbal or therapeutic interventions, crisis management and problem solving?	2	8
Medical contraindications to restraint or seclusion?	0	0
The use of treatment interventions to reduce the risk of aggressive behavior?	3	12
The use of stress and anger management techniques to reduce the risk of aggressive behaviors?	0	0
How direct-care staff and the treatment team coordinate their efforts to identify effective strategies to reduce aggressive behavior?	0	0
How to recognize when a restraint or seclusion is causing physical or psychological discomfort or distress?	2	8
Determining when the criteria for terminating the restraint or seclusion have been met and must be released?	3	12
Does the policy require that staff also receive the following training prior to assisting in the application of restraint or seclusion:		
CPR?	1	4
The use of appropriate and safe physical management techniques?	4	15
Does the policy require:		
That training records be maintained that document which employees have received training and are authorized to employ restraint, the dates of training and the type(s) of restraint they are trained in?	2	8
That refresher training in the proper use of restraints be required annually?	5	19

Discussion of Findings

In constructing the list of standards from CMS and state regulations and other sources for best practices, one significant impression emerged: that state and federal regulations, while certainly essential to providing a framework for developing policy and procedures within individual hospitals, should be considered minimal standards as hospitals move toward reduction and elimination of restraint and seclusion usage. While the JCAHO has developed standards that exceed state and federal regulations, Equip for Equality and LRA have identified additional standards that we recommend hospitals adopt in developing a comprehensive policy designed to ultimately eliminate reliance on restraints and seclusions by ensuring that they are viewed as indicative of a treatment failure, utilized only to prevent serious physical harm and only as a last resort when all other appropriate less restrictive measures have been tried and have failed.

This survey of private psychiatric hospitals' restraint and seclusion policies and procedures provided a vast array of data regarding the content of these policies and the extent to which hospitals have achieved compliance with state and federal regulations as well as exceeded these regulations. In conducting this review, it was discovered that private psychiatric hospitals in the Chicago metropolitan area, while mandated to comply with state and federal regulations and accredited by the Joint Commission, vary widely in the degree to which they have successfully implemented policies and procedures in accordance with these oversight and accrediting bodies. Four different rates of compliance were computed based on the following groups of standards: CMS regulations alone, CMS and state regulations combined, best practice standards and all standards.

Rates of compliance with CMS regulations and guidelines range from 42% to 91%, with an average rate of compliance of 65%. When compliance rates were computed for combined state and federal regulations, even greater variation was evident. Compliance rates for CMS regulations and state code combined range from 37% to 97%, with an average of 63%. An examination of the differences between the CMS compliance rate with the combined CMS and state code compliance rates for individual hospitals indicates that some hospitals had developed policies that closely mirrored CMS regulations and guidelines, while others were more successful in complying with state code. For example, one hospital's compliance rate with CMS regulations was 60%, but rose to 80% for compliance with both CMS and state code. For another hospital's policy on restraint only, these findings were reversed, with an 82% compliance rate with CMS regulations and only 67% compliance when CMS and state code–derived standards were combined.

The extent to which hospitals are incorporating best practices, as delineated by Equip for Equality and LRA, into policies also varies widely, but at a significantly lower range, 7% to 52%, and an average rate of inclusion within the policies of only 24%. When combined with state and federal regulations, the overall compliance rates drop sharply, reflecting the number of best practice standards included in the survey, many of which hospital policies did not include. Overall inclusion of best practices ranges from 23% to 67%, with an average of 40%.

In reviewing the data by category of activity for compliance with state and federal regulations, findings show that hospitals met standards in the following areas with minor discrepancies: general policy and philosophy, authorization for the use of restraint and seclusion, time limits on the use of restraint and seclusion, monitoring and documentation, and termination of restraint or seclusion. It is in these areas, with the exception of philosophy, that CMS standards provide more specific guidelines. As indicated above, many hospital policies incorporated only a few of the best practice standards, particularly in the area of oversight of restraint and seclusion use, staff training and debriefing of patients and staff.

The following is a summary of findings for all standards, including those based on best practices, by category:

- General Policy and Philosophy. Most hospitals were found to comply with federal and state regulations for this category. The lowest percent compliance was found for the standard that prohibits the use of restraint or seclusion for the purposes of coercion, discipline, convenience or retaliation, at 77%.

  Unlike other categories, the hospital policies included a number of best practice standards from this category.

- Defining Restraint and Seclusion. Results indicate that hospitals are not providing adequate and clear information to their staff about the nature of these interventions. Only 45% of the policies addressed medication as a restraint under the circumstances specified by CMS, and only 44% clearly distinguished seclusion from time-out.

  This category contained only one best practice standard related to the inclusion of definitions of general terms; only 35% of the policies incorporated this standard.

- Conditions for the Use of Restraint and Seclusion. CMS provided few guidelines regarding those conditions that should be considered prior to implementing restraint or seclusion. Almost all policies (92%) specified that all other less restrictive interventions must be attempted first; however, only 54% of the policies prohibited the use of PRN or standing orders. While 73% of the policies required that the person be examined within two hours after the initiation of the restraint or seclusion (see the section on authorization below), only 42% of the policies required that the person's medical condition be considered prior to the restraint or seclusion.

Few of the best practice standards were incorporated in this category. Best practice standards included the consideration of the patient's current medications, a history of physical or sexual abuse and the presence of suicide ideation when implementing seclusion.

- Authorization for the Use of Restraint and Seclusion. Policies showed compliance with state and federal regulations for most of these standards in this category, with the exception of the following: that a face-to-face assessment be performed in those situations in which a person is released early (in less than one hour) (15%) and that the written order indicate the clinical justification for the length of time the restraint is to be employed (31%).

  Many best practices were not included in the policies, although 58% of the policies did require documentation of how less restrictive interventions were ineffective and that verbal orders were valid only for one hour, after which a written order must be obtained.

- Time Limits on the Use of Restraint and Seclusion. With the exception of one standard, policies contained many of the elements required by state and federal regulations. Only 12% of the policies required that if a person was released from restraints or seclusion prior to the expiration of the order, a new order must be obtained before initiation of another restraint or seclusion episode.

  No best practice standards were included in this category.

- Application of Restraints and Seclusion. This category of standards contained several standards based on federal and state regulations that provide both general and specific guidance in an effort to reduce the likelihood of serious injury or death from the application of restraints or placement in seclusion. Many of the policies failed to address standards in this category. For example, CMS interpretive guidelines states that the restraint must not cause harm or pain to the person; this statement or a similar one was found in only 20% of the policies.

  The standards related to the environmental conditions under which restraint and seclusion should occur were also not generally addressed in the policies. For example, the standard that the seclusion room must be adequately lighted, heated and furnished was found in only 11% of the policies, and the standard requiring that staff be in close proximity during a seclusion with possession of a key to the seclusion room was contained in only 28% of the policies

  Few best practice standards were incorporated. For example, the standard that prohibited prone positions during restraint was met by only 19% of the policies, and 23% of the policies state that only approved techniques for managing aggressive behavior and escorting be used. However, one standard had the greatest rate of inclusion; 92% of the policies required that the staff check the person to ensure that any dangerous attire or contraband is removed from the person or the restraint or seclusion room.

- Monitoring and Documentation. Rates of compliance with state and federal regulations ranged from 62% to 96%, with one exception. Only 42% of the policies required that the time of all assessment, evaluations and care provided be documented.[19]

  Policy elements related to best practice standards were generally not found in the policies, including additional monitoring for patients who are pregnant, abuse substances or have respiratory or other medical conditions. However, two best practice standards that were included more frequently in this area specifically related to staff discussions with patients during restraint regarding the restraint and how to facilitate their release (62%) and the documentation of the times that meals, fluids, bathroom use, etc., were offered (73%).

- Termination of Restraint and Seclusion. Compliance rates are greatest for both those standards based on CMS regulations as well as on best practice standards. Release from restraint or seclusion under CMS regulations is required when the person has met the criteria for release or the order has expired without renewal, with 81% and 96% of the policies meeting these standards respectively.

  The best practice standard required that a restraint must be terminated when a written order was not obtained within one hour of a verbal order; 86% of the policies included this provision.

- Debriefing the Person Following Restraint or Seclusion. Federal and state regulations do not address a debriefing process for either patients or staff.

  A number of best practice standards were applied to the policies, with 65% of the policies having a process for debriefing the patient within 24 hours after the restraint or seclusion. The most common element of the debriefing process was inclusion of a discussion of the person's feelings regarding the intervention (46%).

- Debriefing Staff Following Restraint or Seclusion. Compared with debriefing patients, fewer policies (19%) had a process for debriefing staff.

- Oversight of the Use of Restraint or Seclusion. Few federal or state regulations exist regarding the oversight of restraint and seclusion use, and the compliance with these is low. CMS standards require that CMS be notified of any deaths that occur while a person is being restrained or secluded or where the death is likely the result of the intervention. Alarmingly, only 23% of the policies contain this requirement, and only 8% include the provision that the death must be reported by the next business day following the death. Compliance rates with standards based on state code regarding oversight of the use of restraint and seclusion indicated minimal adherence by hospitals, especially in regard to conducting an inquiry into the routine use of restraints, with results as follows: that the facility director must be notified of all restraints or seclusion within 24 hours (73%), that these must be reviewed daily by the facility director (58%) and that the facility director should conduct an inquiry into the routine ordering of restraint or seclusion (27%).

Given the limited guidance from government regulations, several best practice standards were included in this policy survey, including the referral to and review of all episodes by the treatment team to determine whether alternative strategies should be tried to prevent future occurrences and the establishment of a interdisciplinary committee to review all episodes of restraint and seclusion, including the specific review activities to be conducted by the committee. Few policies contain the oversight mechanisms recommended in these standards.

- Staff Training. The policies contained few provisions for staff training relevant to the application and prevention of restraint and seclusion and, as a result, the compliance rates for standards in this category were low. It is possible that hospitals may have a process for staff training that is described in policies and procedures other than those sent to Equip for Equality for review. While 73% of the policies met the state regulation requiring that restraints may be applied only by staff who have been trained in the application of the specific restraint used, all other CMS and state code–derived standards had low compliance rates, ranging from 8% to 27%.

  Few policies contained those training activities specified in the best practice standards.

Conclusions and Recommendations

In order to prevent the kind of tragedies illustrated through the deaths described in this report, the delivery of mental health services in the private hospital system must occur through a system of care that is recovery oriented, trauma informed and within a non-coercive environment. Alternatives to restraint and seclusion and effective primary prevention strategies must be developed by hospitals in order to ensure that perceived need for such measures simply does not arise. Staff training in these areas is critical. Equally critical is effective hospital administrative oversight and monitoring of those circumstances that continue to result in restraint and seclusion to ensure that when such measures are utilized, they are done in a manner least likely to cause harm, injury or death, and that each episode is promptly examined and critically analyzed to prevent future episodes and tragedies.

Given the problems and known dangers of restraint usage, it is also critical that there be sufficient external oversight until these practices are eliminated. As reported initially in the Hartford Courant series, there was for many years—and continues to be—no effective oversight system in place for monitoring restraint usage and compliance. There is no federal or state government agency responsible for collecting data on restraint and seclusion usage and deaths. State oversight of restraint and

seclusion in Illinois has focused primarily on state hospitals and on regulations and the investigation and enforcement of minimum standards. As illustrated by the Courant series, and most recently by the Health and Human Services, Office of Inspector General study, state licensure and accreditation processes neither prevent the dangerous practices nor provide much disciplinary or corrective intervention in response to deaths resulting from restraint and seclusion.

Equip for Equality strongly recommends that action be taken at the state and federal levels to ensure compliance with the laws related to restraint and seclusion, and to develop and implement effective external oversight and monitoring systems, including systematic data collection on restraint and seclusion episodes, injuries and deaths.

Equip for Equality also strongly recommends that all hospitals in Illinois not only incorporate the recommendations set forth below by ensuring that hospital policies and practices are consistent with the law and include best practices as well, but that the hospitals take the measures necessary to remove any barrier that would prevent the hospitals from reducing and ultimately eliminating reliance on restraint and seclusion as acceptable forms of intervention.

Recommendations for the State and Federal Governments:

Reduce the use of restraint and seclusion and prevent physical and psychological harm accompanying the use of such measures to individuals with mental illness and staff by:

- Amending the Illinois statute to be consistent with federal law to explicitly include the misuse of restraint and seclusion as abuse; and
- Requiring public disclosure of hospital restraint and seclusion data.

Ensure reporting of restraint and seclusion deaths and compliance with the law by:

- Creating a joint federal/state administrative oversight system that includes sanctions for failure to report restraint- and seclusion-related deaths and failure to comply with state law governing restraint and seclusion.

Reduce the use of restraint and seclusion and ensure that if such measures are used, they are used in a manner least likely to cause serious injury or death by:

- Mandating staff education and training on at least an annual basis related to restraint practices including de-escalation techniques and alternatives to restraint, and, when less restrictive interventions have failed and restraint is used, that it is used in a manner consistent with the law.

Increase scrutiny of restraint and seclusion usage by:

- Implementing a system for the collection and analysis of data related to restraint use and restraint-related deaths; and
- Requiring the reporting of all restraint-related deaths to include the reporting of deaths resulting from the use of restraint for medical purposes as well as restraints for behavioral purposes.

Recommendations for Hospital Leadership:

Create an organizational culture that ultimately eliminates reliance on restraint and seclusion for behavioral interventions and focuses on providing mental health services that are individualized, recovery oriented, fully informed as to trauma and other relevant medical and psychological histories, and provided within a noncoercive environment by:

- Establishing a comprehensive hospital policy in compliance with all applicable laws and incorporating best practice standards as set forth in this report.

Ensure that the necessary changes in organizational culture become routine practices of the hospital by:

- Enhancing monitoring and oversight of restraint and seclusion episodes by hospital administrators and key executive staff, including prompt review of episodes, as a means to ensure safety of individuals and staff and prevent other episodes;
- Establishing an effective debriefing process for individuals and staff, as a means to prevent other episodes, that includes not only a review of the events leading to the incident and the incident itself, but also an assessment of the trauma caused by the incident for the individual and involved staff;
- Enhancing the hospital's internal audit system to ensure collection and analysis of restraint- and seclusion-related data and utilizing that information as a method to prevent other episodes; and
- Educating staff on an ongoing basis on primary preventative measures, including effective de-escalation techniques and alternatives to restraint and seclusion use.

Endnotes

1. Release of the Final Rule related to Hospital Conditions of Participation, 42 CFR Part 482.13, occurred following completion of Equip for Equality's examination of hospital policies under the Interim Final Rule. Had the examination of the policies included the recent amendments to the rule, it is likely that similar rates of noncompliance would have been found, even though aspects of the amendments appear to provide less stringent standards. Relevant changes between the Interim and the Final Hospital Rule are noted in the body of the report.

2. "Deadly Restraint Forum: Reader feedback on restraint-related deaths series," Hartford Courant (1999), www.courant.com, cited in Equip for Equality, Use of Physical Restraints on Residents with Mental Illness in Illinois State Hospitals: Findings and Recommendations, Restraint Monitoring and Policy Project Final Report (2000), 6.

3 United States General Accounting Office, Mental Health: Improper Restraint or Seclusion Use Places People at Risk, Report to Congressional Requesters (September 1999), cited in Equip for Equality, Use of Physical Restraints, 7.

4. Various sources as cited in Equip for Equality, Use of Physical Restraints, 16.

5. Ibid.

6. T.R. Harmon, New York Commission on Quality of Care testimony before U.S. Senate Subcommittee on Labor, Health and Human Services, Education, and related agencies (April 13, 1999), cited in Equip for Equality, Use of Physical Restraints, 16.

7. Department of Health and Human Services, Office of Inspector General, The External Quality Review of Psychiatric Hospitals (2000), quoted in Equip for Equality, Use of Physical Restraints, 9.

8. Ibid.

9. Equip for Equality, Use of Physical Restraints on Residents with Mental Illness in Illinois State Hospitals: Findings and Recommendations, Restraint Monitoring and Policy Project Final Report (2000), 4.

10. Ibid.

11. Ibid., 5.

12. Ibid.

13. JCAHO states that seclusion does not include: 1) "a time-out when the individual is

restricted for 30 minutes or less from leaving an unlocked room and when its use is consistent with the individual's treatment plan" or 2) when "an individual is restricted to an unlocked room or area, consistent with a unit's rules…"

14. The Final Hospital Rule defines seclusion as "the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving." It does not, however, incorporate a person's reasonable belief as to whether he or she is prevented from leaving the room. To ensure further clarity, the definition should include those situations in which the person reasonably believes that he or she is prevented from leaving the room or area.

15. Devices to protect a person from falling out of bed are not defined as a restraint in the Final Hospital Rule.

16. The Final Hospital Rule expands the type of practitioner who can examine the individual within one hour of the initiation of the restraint or seclusion.

17. The Final Hospital Rule does not contain any requirement for debriefing following an episode of restraint or seclusion.

18. Aspects of the best practice standards are now incorporated into the Final Hospital Rule. However, the final rule leaves to hospital discretion the frequency of the training, requiring training only at the time of employment and thereafter consistent with hospital policy.

19. The Final Hospital Rule leaves to the discretion of the hospital the frequency at which an individual must be monitored when an individual is restrained for behavioral reasons.