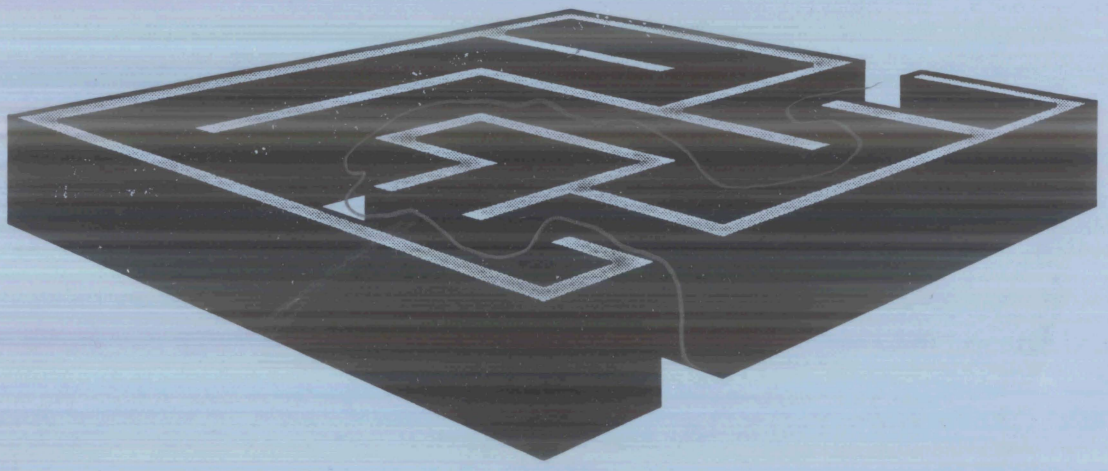
GOVERNANCE OF RESTRAINT & SECLUSION PRACTICES BY NYS LAW, REGULATION, AND POLICY



A REPORT BY THE
NYS COMMISSION ON QUALITY OF CARE FOR THE MENTALLY DISABLED
SEPTEMBER 1995

Governance of Restraint & Seclusion Practices by NYS Law, Regulation, and Policy

Clarence J. Sundram
CHAIRMAN

Elizabeth W. Stack
William P. Benjamin
COMMISSIONERS

SEPTEMBER 1995

NYS COMMISSION
ON QUALITY OF CARE
FOR THE MENTALLY DISABLED

Preface

In Chapter 50 of the Laws of 1992, the State Legislature asked the Commission to conduct a study of restraint and seclusion use in psychiatric facilities. In response to that request, the Commission issued two reports, *Restraint and Seclusion Use in NYS Psychiatric Facilities* and *Voices From the Front Lines: Patients' Perspectives on Restraint and Seclusion Use* (September 1994).

The findings of these reports offered some sobering observations about restraint and seclusion use among New York psychiatric facilities.

- Over the past decade there have been 111 deaths of patients in New York State associated with restraint and seclusion use.
- Rates of use of restraint and seclusion in NYS psychiatric facilities in September 1992 varied from none at all at approximately 18% of the facilities to much higher use of more than 40 orders per month per 100 patients at nearly one-third (30%) of the facilities.
- The variability in restraint and seclusion usage cannot be explained by differences in the hospitals' patient populations. Indeed, the Commission's research verified that hospitals sharing very similar patient populations often had dramatically different restraint and seclusion usage rates.
- Former patients overwhelmingly report that restraint and seclusion are not used in accordance with current state law and regulation, and that undue force, physical injuries and abuse are often associated with restraint and seclusion episodes.
- Commission reviews of 12 psychiatric facilities suggested that low restraint and seclusion use was associated with facilities which offered more rehabilitative programming, more comfortable custodial conditions, including reasonable provisions for telephone calls, visits, and showers.
- Commission research and investigations have consistently indicated both higher rates of restraint and seclusion use and more frequent problems among vulnerable populations, including the elderly, children, and persons with mental retardation.

This third Commission report on restraint and seclusion examines the governance structure provided in current state law, regulation, and NYS Office of Mental Health policy for the use of restraint and seclusion in New York psychiatric facilities. As reflected in this report, although New York once led the nation in its progressive state statute governing restraint use, nearly two decades later, New York's legal protections for patients from unnecessary, abusive and/or neglectful restraint and seclusion practices require substantial revision.

- NYS law does not address the use of seclusion in psychiatric facilities.
- Current NYS law governing restraint and New York's Code of Rules and Regulations governing both restraint and seclusion have not been updated in nearly twenty years, and certain provisions in state regulations conflict with those in state law and vice versa.
- State Office of Mental Health policy governing restraint and seclusion, the most comprehensive governance structure available, extends only to state psychiat-

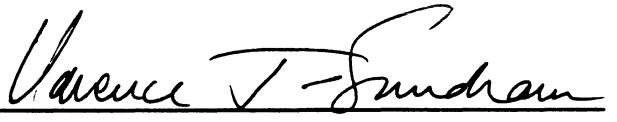
ric centers and does not apply to state-licensed psychiatric facilities, which today serve three of every four individuals hospitalized for psychiatric care in New York.

- Although there are well-recognized problems in the overuse of restraint and seclusion among the elderly, children, and persons with mental retardation in New York, special protections or safeguards are not offered to these vulnerable populations in either New York State law or regulations.
- In the absence of more comprehensive state law and regulation governing restraint and seclusion, individual psychiatric facilities have developed their own restraint and seclusion policies, but these policies do not uniformly incorporate the limited safeguards which are now present in state law and regulations.

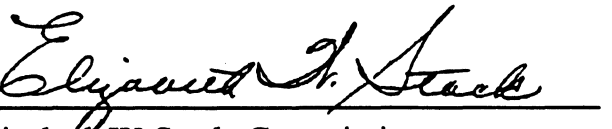
The gaps and contradictory standards in New York's current governance structure for restraint and seclusion, together with the findings of other Commission investigations of inappropriate restraint and seclusion usage, provide strong support for the State Legislature to amend and enhance current statute governing the use of restraint and to extend these safeguards to seclusion use as well. They also indicate a need for added safeguards for the elderly, children and persons with mental retardation in psychiatric facilities who appear to be especially vulnerable to inappropriate and excessive restraint and seclusion.

Therefore, it is recommended that the Legislature consider codifying a single comprehensive statute governing the use of restraint and seclusion in psychiatric facilities to replace four sets of inconsistent, contradictory and duplicative directives contained in state law, regulations, OMH policies and JCAHO standards. In the Appendix of this report, the Commission offers principles which should guide the Legislature in universally ensuring, through statutory reform, that the use of restraint and seclusion in psychiatric facilities* is an option of last resort, carefully carried out and vigorously monitored.

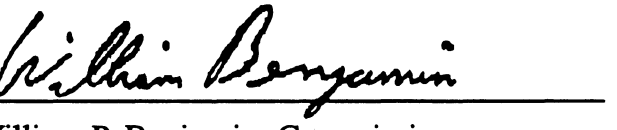
The Commission also recommends that psychiatric facilities in New York consider the principles presented — which reflect best practices at some New York facilities — and, where indicated, revise their existing policies and practices to ensure vital protections for the people they serve.



Clarence J. Sundram, Chairman



Elizabeth W. Stack, Commissioner



William P. Benjamin, Commissioner

* The Commission's recommendation pertains to the use of restraint and seclusion in psychiatric facilities. Current state law covers both mental health and mental retardation facilities. The use of restraint in mental retardation facilities is governed by regulations of the OMRDD. Some of the OMRDD mandates appear inconsistent with state law and warrant closer review and revision. This matter was beyond the scope of the Commission's review.

Research Staff

Project Director

Nancy K. Ray, Ed.D.

Research Coordinator

Cheryl A. Ouimet, C.S.W.

Research Staff

Mindy T. Becker
Jacqueline García, M.S.W.
Patricia W. Johnson, J.D.
Karen J. Myers, M.H.S.A.
Mark E. Rappaport, R.N., M.S.
Natalie J. Russo, R.N., M.A.

Production Staff

Gail P. Fetsko

Table of Contents

List of Figures

Chapter I
Introduction

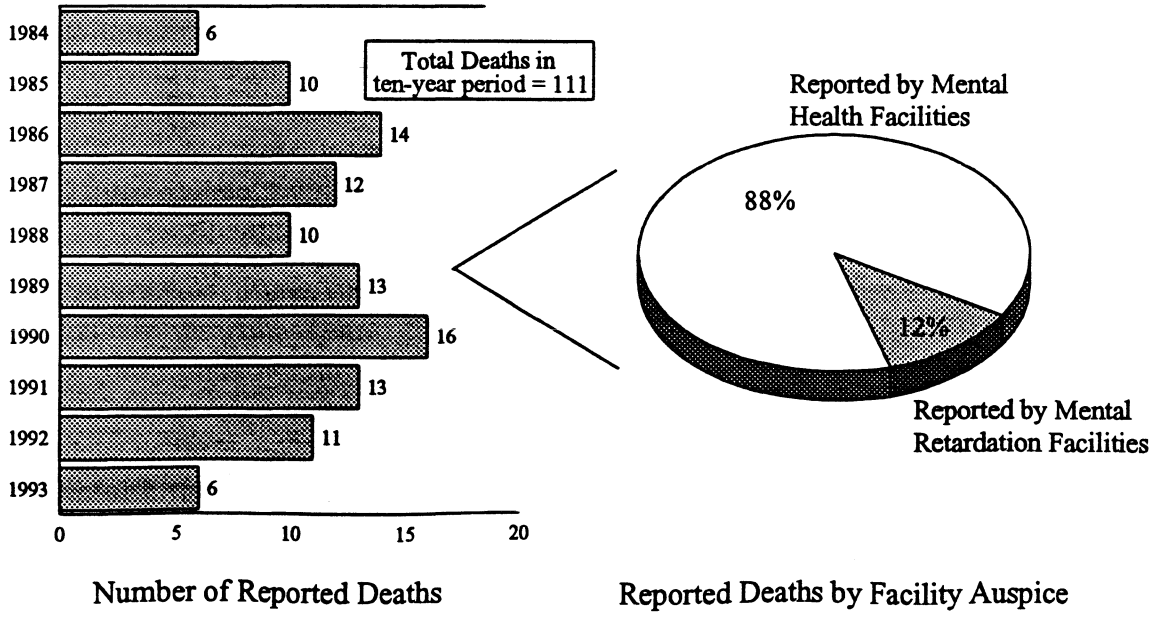
In Chapter 50 of the Laws of 1992, the State Legislature requested that the New York State Commission on Quality of Care conduct a review of the use of restraint and seclusion in the treatment of persons who are mentally disabled.

Investigations of restraint- and seclusion-related deaths have been an ongoing priority of the Commission's Mental Hygiene Medical Review Board, and in total, over the 10–year period 1984–1993, 111 deaths associated with restraint and seclusion use have been reported, investigated, and reviewed by the Board (Figure 1). These individual death reviews, as well as other advocacy complaints and abuse investigations conducted by the Commission, have reinforced the need for all treatment facilities using restraint and seclusion to do so with extreme caution and diligent quality assurance review.

Although serious adverse patient outcomes directly related to restraint and seclusion have been relatively infrequent, there has been a constancy to the number of these recurring preventable injuries and deaths, as well as the problems and deficiencies which have contributed to their occurrence. These problems and deficiencies have included:

- use of restraint and seclusion without adequate efforts to calm the patient or resolve the problem using less restrictive interventions;

Figure 1
Restraint and Seclusion Related Deaths
Reported by Mental Hygiene Facilities
(1984-1993)



- misuse of restraint and seclusion by staff who had not been adequately trained, and who thereby used excessive force or techniques which compromised the safety and well-being of the patient, leading to serious injury or death;
- failure of professional staff to comply substantively with the state's statutory and regulatory monitoring requirements associated with the use of restraint and seclusion, which often left patients' comfort and safety compromised for long periods of time, contributing to the serious harm and sometimes the death of patients;
- use of restraint and seclusion without adequate attention to other environmental hazards, including excessive heat, poorly ventilated rooms, and suicide hazards, which contributed to serious harm to patients and sometimes death; and,
- failure of facilities to recognize medical emergencies sometimes associated with restraint and seclusion use and to ensure that emergency medical equipment was promptly accessible and that staff were well-trained in emergency medical procedures, including cardio-pulmonary resuscitation.

The Review

Based on its experience reviewing the use of restraint and seclusion in psychiatric facilities, the Commission recognized that its response to the Legislature's requested study would require a number of different research activities which incorporated data collection from many sources and perspectives. In accordance with this recognition, the Commission has responded to the Legislature's request with the preparation of three reports.

(1) The first report, *Restraint and Seclusion Practices in NYS Psychiatric Facilities* (September 1994), details the highly variable rates of restraint and seclusion use among NYS psychiatric facilities and provides analyses which indicate that these variations appear to be independent of differences in the patient populations served and of most facility characteristics. The report provides other information, however, which suggests that low restraint and seclusion use by a psychiatric facility tends to be associated with other specific treatment and custodial practices, including greater assurances of patients' personal liberties, including off-ward privileges, better environmental conditions, and more patient participation in programming.

(2) The second report, *Voices From the Front Line: The Psychiatric Patient's Perspective of Restraint and Seclusion Use* (September 1994), reports the findings of the Commission's mail survey to individuals who had been inpatients of New York psychiatric facilities. Summarizing the responses of over 1,000 former service recipients to the mail survey, the report provides both a clear statement of patient concerns regarding restraint and seclusion use and a better understanding of specific restraint and seclusion practices which most substantially influence patients' negative versus positive opinions about their inpatient stays.

(3) This third report, *Governance of Restraint and Seclusion Practices by NYS Law, Regulation, and Policy,* examines the governance of restraint and seclusion practices in New York's psychiatric facilities. The dedication of an entire report

to this issue reflects the Commission's conclusion that existing statutory, regulatory, and state policy mandates governing restraint and seclusion use are inconsistent and inadequate. These limitations in the state's governance of restraint and seclusion have contributed both to the different professional clinical interpretations of existing legal standards regarding restraint and seclusion use and to the widely variable use of these restrictive interventions among the state's psychiatric facilities.

Methods

In conducting its review of the governance of restraint and seclusion practices, the Commission undertook four distinct research steps.

(1) The published literature pertaining to states' laws and regulations and psychiatric facilities' policies and guidelines governing the use of restraint and seclusion with psychiatric patients was reviewed.

(2) Existing New York State law and regulations (which carry the force of law), as well as Office of Mental Health policies, governing restraint and seclusion use in psychiatric facilities were assessed in terms of their comprehensiveness, consistency, and currency with contemporary clinical standards for restraint and seclusion use.

(3) Accreditation standards pertaining to the appropriate use of restraint and seclusion issued by the Joint Commission on Accreditation of Healthcare Organizations, the largest accrediting body of psychiatric hospitals and psychiatric services of general hospitals, were reviewed.

(4) Internal restraint and seclusion policies of state-operated psychiatric centers (N = 24) and psychiatric services of general hospitals (N = 101[1]) were reviewed to assess their compliance with state law and regulations, as well as Office of Mental Health policy governing restraint and seclusion use, and the extent to which these policies provide added patient safeguards.

Through the above research activities, the Commission sought answers to two basic questions.

(1) *Do current New York State laws and regulations, together with the NYS Office of Mental Health's and psychiatric facilities' policies provide adequate direction to ensure the safe and appropriate use of restraint and seclusion in the state's psychiatric treatment facilities?*

(2) And, if not, what specific changes should be made in state law and regulations and/or Office of Mental Health and internal facility policies?

---

[1] Policies were not reviewed for 4 of the 105 psychiatric services of general hospitals, as these hospitals either reported that they did not have policies or these hospitals did not respond to the Commission's request. In addition, policies were not reviewed at one of the 25 state–operated adult psychiatric centers, as this center reported that it did not use either restraint or seclusion.

Chapter II
Review of the Literature

As more comprehensively summarized in the Commission's report, *Restraint and Seclusion Practices in NYS Psychiatric Facilities* (September 1994), there is an enormous body of published literature on restraint and seclusion use in psychiatric facilities. Much of this literature debates the clinical efficacy and necessity of restraint and seclusion use, while another large segment of this literature attempts with little success to identify the key clinical and/or demographic patient characteristics which tend to predict the minority of psychiatric patients who are subjected to these interventions (Binder, 1979; Carpenter, et al., 1988a; Lawson, et al., 1984; Oldham, et al., 1983; Okin, 1985; Plutchik, et al., 1978; Ramachandani, et al., 1981, Shugar and Rehaluk, 1990; Soloff and Turner, 1981; Tardiff, 1981; Thompson, 1986; Way and Banks, 1990).

There are also many studies which have examined the rates of restraint and seclusion use across several inpatient psychiatric facilities. These studies, like the Commission's own research findings, confirm that restraint and seclusion usage rates vary dramatically among psychiatric facilities, and that these variations cannot be consistently linked to differences in the patient populations served by the facilities or to the characteristics of the facilities themselves.

Simultaneously, several researchers have noted dramatic short–term reductions in restraint and seclusion use following the enactment of specific laws or regulations governing the use of these interventions or when strict protocols were instituted to guide the use, monitoring, and documentation related to their use (Swett, et al., 1989 and Kalogjera, et al., 1989). Several researchers have also noted that use of restraint and seclusion, as well as violent patient episodes and injuries, is generally reduced when strict staff adherence to other less restrictive behavioral management plans is assured (Carmel and Hunter, 1990; Colenda and Hamer, 1991; Wong, et al., 1988; VanRybroek, et al., 1987).

Federal Courts Influence Restraint and Seclusion Practices

While there remains considerable debate in clinical circles regarding professional practice guidelines for restraint and seclusion use, over the past two decades federal district courts have increasingly articulated requirements governing the use of these interventions. *Wyatt v. Stickney* (344 F Supp. 373 [M.D. Ala. 1973]) set forth initial requirements regarding the use of these interventions, and these requirements have become the basis of many other decisions (Figure 2).

In *Wyatt*, the court held that patients had the right to be free from restraints and seclusion and that these interventions, except in emergency situations, could only be used consistent with a written order and rationale by a qualified mental health professional. The court order further clarified that restraint and seclusion could only be used in situations where the patient could harm himself or others, that a qualified mental health professional must personally evaluate the patient, that emergency orders may not extend longer than one hour, that written orders may extend for only 24 hours, and that while in restraint or seclusion the patient must be regularly monitored and have bathroom privileges every hour.

Figure 2
Major Provisions of Wyatt v. Stickney Re: Restraint and Seclusion Use

- ❒ States affirmatively patients' right to be free from restraint and physical isolation.
- ❒ Patients may be restrained or secluded only when they may harm themselves or others.
- ❒ Patients may be restrained or secluded only when less restrictive methods are not feasible.
- ❒ Patients may be placed in restraint or seclusion only on a written order of a qualified mental health professional which states a rationale for such action.
- ❒ Qualified mental health professionals may write such orders only after personally seeing and evaluating the patient.
- ❒ Written orders for restraint and seclusion shall be valid for only 24 hours.
- ❒ Emergency imposition of restraints or seclusion without an order by a qualified mental health professional must be limited to one hour.
- ❒ While in restraint and seclusion the patient must be monitored and have bathroom privileges hourly and must have the opportunity to bathe at least every 12 hours.

Subsequently, other federal district court decisions, also emanating from class actions alleging constitutional abuses in public institutions' restraint and seclusion practices, have reaffirmed the *Wyatt* principles governing restraint and seclusion use, and in some instances they have added more stringent requirements. These added requirements have included required 15–minute monitoring checks, review of all restraint and seclusion orders by the administrator or other senior staff persons, required release of patients every two hours, and restrictions against the use of these interventions with persons who are mentally retarded *(New York State Association for Retarded Children, Inc. v. Carey, 393 F. Supp. 715 [E. D. New York 1975]; Youngberg v. Romeo, 457 U.S. 307 [1982]; Eckerhart v. Hensley, 475 F Supp. 908 [W.D. Mo. 1979]; Rogers v. Okin, 478 F. Supp. 1342 [D. Mass. 1979]).*

States' Laws

Often arising from the abuses made public in class action cases over the past two decades, most state legislatures have also passed specific statutes governing the use of restraints and seclusion in the facilities caring for persons who are mentally disabled. As summarized by Brakel et al. (1985), the various state statutes share similar provisions articulating that restraint and seclusion may only be used in situations which may be harmful to the patient or others. In most other respects, however, state statutes governing restraint and seclusion evidence much variability — both in their specific provisions (e.g., length of orders, who can write orders, specific proscriptions against restraint and seclusion use as a punishment or for the convenience of staff) and in their general comprehensiveness. Additionally, specific descriptive language defining dangerousness, risk of harm, imminent harm, etc. is usually not present in states' statutes.

Professional Practice Standards

In the wake of the initiatives of federal courts and state legislatures, some professional organizations and individual clinicians have also published guidelines for the appropriate use of restraint and seclusion (Joint Commission on Accreditation of Healthcare Organizations,

1992; American Psychiatric Association, 1985; Bursten, 1975; Daar and Nelson, 1992; Mitchell and Varley, 1990; Roper, et al, 1985; Tardiff and Mattson, 1984). These various sets of guidelines tend to share some central principles articulated by federal court decisions and state legislatures, including that restraint and seclusion may only be used after other less restrictive interventions have been attempted, that restraint and seclusion must not be used as punishment or for the convenience of staff, and that these interventions must be ordered by a physician, although most concur that they may be initially authorized by nursing staff, with a subsequent physician order.

Most (although not all) professional guidelines also assert that restraint and seclusion are very restrictive interventions which should be used only when there is a "risk of harm" to the patient or others. "Risk of harm," however, is variably defined, with indications varying from imminently dangerous behaviors to property damage to situations where reducing sensory stimulation is judged as an appropriate means of preventing dangerous behavior (Telintelo, et al. 1983; Fassler and Cotton, 1992; Tardiff and Mattson, 1984; Outlaw and Lowery, 1992).

Professional guidelines, like federal court decrees and state statutes, also differ in many other specific areas. Guidelines for the duration of physician orders vary from 1 to 24 hours, and there is considerable disagreement as to the types of mechanical restraints that should be authorized (Joint Commission on Accreditation of Healthcare Organizations, 1992; American Psychiatric Association, 1985; Lion and Soloff, 1984). Published guidelines also offer different advice relative to specific mandates for hands–on physician exams of the patient, the frequency of bathroom and exercise breaks for patients restrained or secluded, the safety design features of seclusion rooms, and required staff training in the use of restraints and seclusion (Tardiff and Mattson, 1984).

Summary

As reflected in this chapter, despite the volume of published clinical research and dialogue on the use of restraint and seclusion in psychiatric facilities, there remains much clinical debate over the efficacy and appropriate use of these interventions. Most research studies confirm markedly variant rates of restraint and seclusion usage across psychiatric facilities which cannot be linked to differences in patients' needs and characteristics. There is also little clinical data which explain the patient behaviors, symptoms, and characteristics which reliably distinguish the minority of psychiatric patients who are restrained and secluded from the majority of psychiatric patients who are not.

Perhaps reflective of these limitations of the clinical research, federal courts and state legislatures, *not clinicians*, have led the way in articulating practice standards governing restraint and seclusion use in psychiatric facilities. Literally dozens of federal class actions — centering on public institutions located across the United States — have closed with specific standards for restraint and seclusion use. And, in the past two decades, almost all state legislatures, often following federal court actions, have passed laws governing restraint and seclusion practices.

Notwithstanding these initiatives, however, the federal courts and state laws have generally treaded lightly in this "clinical arena." At the same time, although some professional organizations, including the Joint Commission on Accreditation of Healthcare Organizations and the American Psychiatric Association have issued practice guidelines related to restraint and seclusion use, as a general rule, these organizations have not gone beyond, and sometimes not as far as, those requirements stated by the courts and state legislatures. Additionally, while published professional guidelines share some common principles, they differ in other key requirements.

As a result, there is limited professional consensus on practice guidelines governing many aspects of restraint and seclusion use.

In this vacuum, there is much room for clinical discretion and variable decision-making. As reported in the Commission's report, *Restraint and Seclusion Practices in NYS Psychiatric Facilities,* this discretion has contributed to dramatic variations among psychiatric facilities in New York in their reliance on restraints and seclusion. Responses from former patients of New York psychiatric facilities, cited in the Commission's report *Voices From the Front Line: The Psychiatric Patient's Perspective of Restraint and Seclusion Use,* further suggest that the actual practices of hospitals in defining situations which warrant restraint and seclusion use, in ensuring attempts to use less restrictive interventions, and in monitoring patients subjected to these interventions are also variable across treatment facilities. Thus, the probability that a patient will be restrained or secluded during the course of a psychiatric hospitalization depends less on the patient's behavior than on the practices of the hospital to which the patient is admitted or committed.

Chapter III
NYS Law, Regulations, and Policies Governing Restraint and Seclusion Use

In the mid–1970s, New York State stood ahead of many other states in its statutory and regulatory governance of restraint and seclusion use by mental hygiene facilities. In 1977, the New York State Legislature passed one of the first state statutes governing restraint use (§33.04 MHL), and two years earlier regulations (14NYCRR §27.7) had been put in place governing the use of both restraint *and* seclusion in mental hygiene facilities, including all state-operated and state–licensed psychiatric facilities.

Other governance standards for restraint and seclusion practices are stated in NYS Office of Mental Health policy ("Patient Care/Management: Restraint and Seclusion," 1986), but these standards apply only to state–operated psychiatric centers. This Office of Mental Health policy does not extend to state–licensed psychiatric facilities, including the state's 105 licensed psychiatric services of general hospitals and its 12 licensed private psychiatric hospitals. Over the past two decades, as state–operated psychiatric centers have been downsized and their role has been narrowed to the provision of intermediate and long–term psychiatric care, these state-licensed facilities have increasingly provided services to the vast majority of New Yorkers seeking inpatient psychiatric admissions (75,000 versus 23,000 admissions).

Other national standards governing the use of restraints and seclusion are stated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the largest accrediting organization for hospitals in the United States. While the Joint Commission has minimal standards for restraint use for general hospitals, its *1993 Mental Health Manual* provides much more detailed standards governing both restraint and seclusion use in psychiatric facilities. In New York, the Office of Mental Health has sought Joint Commission accreditation, in accordance with these more comprehensive standards, for all of its state psychiatric centers. Joint Commission accreditation, based on these more comprehensive standards, is also sought by most private psychiatric hospitals in New York. Most general hospitals with psychiatric services are also accredited by the Joint Commission, but their surveys are based on the Joint Commission's minimal "general hospital" standards for restraint only.

Together, New York's mental hygiene statute and regulations, the Office of Mental Health's policy on restraint and seclusion, and the Joint Commission's *1993 Mental Health Manual* constitute the primary governance infrastructure for restraint and seclusion practices of psychiatric facilities in New York (Figure 3). As discussed below, this infrastructure is neither consistent, nor comprehensive — and in some key areas it offers confusing and conflicting directions to psychiatric facilities. Most critically, only the state's mental hygiene law (which governs restraint only) and the state's mental hygiene regulations apply uniformly to all state–operated and state-licensed psychiatric facilities.

NYS Mental Hygiene Law

In 1977, the New York State Legislature passed the state's first statute (§15.04 MHL) governing the use of mechanical restraints by state mental hygiene facilities. In 1980, this law

Figure 3
New York State Governance Over Restraint and Seclusion Use

NYS Mental Hygiene Law MHL §33.04	▪ Instituted 1977 ▪ Governs *only* restraint use ▪ Applies broadly to facilities operated/licensed by OMH, OMRDD, OASAS
NYS Code of Rules and Regulations Part 14, NYCRR §27.7	▪ Instituted in 1975 ▪ Governs *both* restraint and seclusion use ▪ Applies *only* to facilities operated/licensed by OMH ▪ Omits key standards referenced in mental hygiene law
NYS Office of Mental Health Policy "Patient Care/ Management Restraint & Seclusion"	▪ Instituted in 1986 ▪ Governs *both* restraint and seclusion ▪ Applies *only* to state-operated psychiatric centers ▪ Includes all key standards in state law and regulations, as well as additional guidelines
Joint Commission on Accreditation of Hospital Organizations (Mental Health Manual)	▪ Most recently updated 1993 ▪ Governs both restraint and seclusion ▪ Strictly applies *only* to psychiatric hospitals (*not* general hospitals) ▪ Many standards *less stringent* than provided for in mental hygiene law or Office of Mental Health policy

was recodified in MHL§33.04, but with the exception of a minor language change related to the immediacy of the physician's summons subsequent to the emergency application of restraint, it has not been amended in the past 18 years.

While this initial statute broadly covers all mental hygiene facilities in the state, including settings under the operation or licensure of the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, and the Office of Alcoholism and Substance Abuse Services, it is important to emphasize that this brief statute governs only the use of mechanical restraints; it is silent on the use of seclusion. The statute is also a generic one, with no special provisions for particularly vulnerable populations, including children, persons who are mentally retarded, persons who are elderly, and persons who have a medically-compromised condition.

Notwithstanding its limitations, however, at the time of its writing this statute was among the first legal statements on restraint use with persons with mental disabilities, and to this day, many of the basic principles articulated in the statute are the foundation for hospital restraint and seclusion practices in New York and most of the nation (Figure 4). These principles are summarized below.

- *An important initial section of the law defines the interventions classified as restraints* as "the use of an apparatus on a patient which prevents the free movement of both arms or legs or which totally immobilizes such patient, and which the patient is not able to remove easily." The statute also clearly restricts the various types of "apparatus" which can be used to restrain patients to "the 'camisole' and the 'full or partial restraining sheet,' or other less restrictive restraints as authorized by the commissioner."[2]

[2] The statute also includes specific exclusionary language for medical supports, which the Legislature did not intend to be classified as mechanical restraints. "Nothing in this section shall prevent the use of mechanical supports necessary to keep an infirm or disabled patient in a safe or comfortable position or to provide stability necessary for therapeutic measures such as immobilization of fractures, administration of intravenous or other medically necessary procedures."

Figure 4
Major Provisions of NYS Mental Hygiene Law Governing Restraint (NYS MHL §33.04)

- ❒ Defines restraint as use of an apparatus which prevents free movement of both arms or legs or which totally immobilizes the patient.
- ❒ Allows restraint use only to prevent patients from seriously injuring themselves or others *when less restrictive techniques have been determined to be inappropriate or insufficient.*
- ❒ Requires patient release from restraints when no longer appearing dangerous.
- ❒ Forbids restraint use for punishment, convenience of staff, or as a substitute for programming.
- ❒ Mandates physician personal exams of patients prior to restraint use, except in emergency situations.
- ❒ Requires physician orders and documented rationales for all restraint use.
- ❒ Sets four-hour maximum time limit on restraint orders, except that orders after 9:00 p.m. may be extended to 9:00 a.m. the next day.
- ❒ Requires that restrained patients "be made comfortable," that their safety be monitored at least every 30 minutes, and that they be released every two hours, except when asleep.
- ❒ Requires hospital record-keeping of all restraint episodes.

- ❒ *The statute also lays out clearly the limited circumstances under which restraints may be used.* "Restraint shall be employed only when necessary to prevent a patient from seriously injuring himself or others." The statute further clarifies, "[Restraint] may be applied only if less restrictive techniques have been clinically determined to be inappropriate or insufficient to avoid such injury," and it adds the specific proscription that restraint "may not be employed as punishment, for the convenience of staff, or as a substitute for treatment programs."
- ❒ *The statute adds other provisions governing written orders for restraints,* which must (1) "be effected only by written order of a physician after a personal examination of the patient, except in an emergency situation," (2) "set forth the facts justifying the restraint ... specify the nature of the restraint and any conditions for maintaining the restraint, [including] the time of expiration [of the order]."
- ❒ *Other sections of the statute clarify that emergency orders of restraint may be instituted by staff without a physician's order, but that in these instances a physician must be called immediately,* the patient must be under constant supervision, and if the physician does not arrive within 30 minutes, further detailed documentation of the reason for the delay and the continued need for emergency restraint is required. Physicians arriving more than 30 minutes after an emergency restraint are also mandated to document the reason for their delay.
- ❒ *The statute also places a maximum time limit on restraint orders of four hours, except that orders imposed after 9:00 p.m. may be extended until 9:00 a.m. the next day.*

- *The statute also affirmatively states that while in restraints patients must be made comfortable and their safety regularly monitored.* "During the time that a patient is in restraint, he shall be monitored to see that his physical needs, comfort, and safety are properly cared for." Specific monitoring requirements detailed in statute include: (1) assessing the patient's condition at least every 30 minutes and documenting this assessment, and (2) releasing the patient from restraints at least every two hours, unless he/she is asleep.

- *The state statute also provides for the timely release from restraints of any patient who no longer appears dangerous.* "If at any time a patient upon being released from restraint makes no overt gestures that would threaten serious harm or injury to himself or others, restraints shall not be reimposed and a physician shall be immediately notified. Restraint shall not be reimposed in such situation unless in the physician's professional judgment release would be harmful to the patient or others."

- *Other sections of the statute specify record keeping requirements:* (1) a full record of each restraint episode must be maintained in the patient's record, including the physician's order, and (2) the director of a facility must keep and maintain a record of all restraints.

NYS Mental Hygiene Regulations

The New York Code of Rules and Regulations' primary reference (14 NYCRR, Part 27.1, 27.2, 27.7) to restraint and seclusion predated by two years the state mental hygiene statute pertaining to restraint (1975), and it has not been revised. The most obvious difference between these regulations and state mental hygiene law governing restraint is that the regulations cover *both restraint and seclusion use,* and they accordingly provide the state's first legal definition for seclusion as "the presence of a patient in a room alone with closed door which is not possible for the patient to open from the inside." Mental hygiene regulations also add the restriction against the placement of any person who is mentally retarded in seclusion.

Notwithstanding their broader scope, however, state mental hygiene regulations omit many basic practice standards and requirements specified in mental hygiene law. The regulations provide a more abbreviated definition of restraint than the one established in state mental hygiene law, as "any apparatus that interferes with the free movement of the patient and which the patient is unable to remove easily." This regulatory definition does not make any distinction between medical supports and restraints, suggested in state statute, nor does the regulation specify the forms of authorized restraints, or the need for commissioner approval of other less restrictive forms of restraint.

Like state mental hygiene law, the regulations provide a limited justification for the use of restraint, "only when absolutely necessary to protect the patient from injuring himself or herself or others," and they extend this limited justification to the use of seclusion. State regulations, however, omit any reference to the mandates in mental hygiene law that restraints may be used only if less restrictive interventions have been determined to have been clinically inappropriate or insufficient and that restraint may not be used as punishment, for the convenience of staff, or as a substitute for treatment programs.

In 1975, New York had no separate Office of Mental Health but a single Department of Mental Hygiene which administered all mental health, mental retardation, alcoholism, and substance abuse services. Separate Offices of Mental Health, Mental Retardation and Alcohol and

Substance Abuse Services were established by the State Legislature in 1977.

Other provisions in mental hygiene regulations specify that orders for seclusion and restraint must be written by a physician, with "the facts and reasons for [their] use set forth," and that they must be *rewritten daily.* Of note, the provision for *daily orders* with regard to restraint is in conflict with the four-hour limit for restraint orders (except overnight), as provided in state mental hygiene law. The regulations also specify that all patients shall be released from restraint every two hours (except when asleep) and that all patients shall be released from seclusion every three hours (except when asleep).

Other important provisions governing the care, comfort, and monitoring of patients while in restraint, as specified in mental hygiene law, are not included in state mental hygiene regulations governing restraint and seclusion use in mental hygiene facilities. Additionally, the special safeguards governing the emergency application of restraints without the presence of a physician in state mental hygiene law are also not referenced in mental hygiene regulations.

The only other significant reference to restraint and seclusion in state regulations relates to special review committees of inpatient psychiatric services of general hospitals (14 NYCRR §580.5) and hospitals for the mentally ill (14 NYCRR, §582.5). Both of these parts require facilities to establish special review committees, which include members of the professional clinical staff, for the review of all untoward incidents and *extra risk procedures,* which include (but are not limited to) somatic therapies, experimental treatment modalities, *and restraint and seclusion.* According to the regulations, these committees are to meet as often as necessary, but at least quarterly, and with regard to extra risk procedures to "review ongoing practices and procedures ... and recommend changes in policies, practices, or procedures as may be indicated."

NYS Office of Mental Health Policy

The NYS Office of Mental Health policy ("Patient Care/Management: Restraint and Seclusion," PC–701), issued in 1986, is the most recent and the most comprehensive set of statewide governance guidelines over restraint and seclusion. This policy, however, applies only to state psychiatric centers and does not govern practices by psychiatric units of general hospitals or private psychiatric hospitals, which provide services to over 75,000 individuals annually.

The Office of Mental Health policy does, however, comprehensively cover the provisions in state mental hygiene law governing restraint and universally, as applicable, extends them to seclusion. In addition, it provides a considerably more detailed explanation of certain procedural requirements, like the physician's personal exam of the patient, provisions for emergency restraint and seclusion orders, and the monitoring of patients while in restraints or seclusion. Most important, however, the Office of Mental Health policy adds several *new requirements* (Figure 5).

- The policy explicitly forbids: (1) the use of "undue force" in the application of restraints and seclusion, (2) ankle and wrist restraints which are not secured at all four points, and (3) PRN orders for restraint and seclusion.
- The policy limits restraint and seclusion orders to four hours, except from 9:00 p.m to 9:00 a.m., *provided that the patient is asleep most of this period and is not awake for four continuous hours during this period.*
- The policy also places a definite time-limit of one hour on emergency orders of restraint and seclusion not made by a physician, subject to his/her personal exam of the patient.

Figure 5
Extra Safeguards in NYS Office of Mental Health Policy

- Explicitly forbids:
  - use of undue force
  - PRN orders for restraint or seclusion
  - ankle and wrist restraints not secured at all four points.
  - keeping patients in restraint and seclusion overnight, except when patient is asleep *most* of this period and *not* awake for four continuous hours.
- Restricts emergency orders to one-hour.
- Adds comfort, safety, and observation standards for seclusion rooms.
- Mandates medication reviews of patients placed in restraints or seclusion.
- Mandates staff training in restraint and seclusion techniques, as well as relevant state law, regulations, and policy.
- Clearly differentiates definitions for mechanical supports and mechanical restraints.

- The policy provides that seclusion rooms must accommodate "the patient's physical and environmental needs" ... and that "seclusion shall be utilized only if the rooms or areas allow adequate observation of the patient by staff."
- The policy requires that the physician ordering the restraint or seclusion review the patient's medication prior to each restraint and seclusion order and document this review in the patient's record.
- The policy requires that the head of the clinical staff assure that all clinical and direct care staff receive periodic instruction in the techniques of applying restraints and seclusion and in the laws, regulations, and polices governing the use of the interventions.
- The Office of Mental Health policy also includes considerably more detailed definitions of mechanical supports, as differentiated from mechanical restraints. It defines mechanical supports as both physical safeguards and medical safeguards, and adds the specific provision that they "shall not be used as a substitute for restraint or seclusion." The policy also adds further definitions of both physical and medical safeguards.

Finally, an additional section of the Office of Mental Health's policy significantly expands the state personnel, beyond the Commissioner of Mental Health, who may authorize less restrictive forms of mechanical restraints. The policy designates the Office's Regional Directors, Deputy Commissioner of Research, and the Director of the Bureau of Forensic Services as authorized individuals to approve less restrictive forms of restraint than are specified in the policy for facilities under their responsibility. The provision qualifies that if the incumbent in any of these positions is *not a physician,* a designated physician, not affiliated with the state psychiatric facility, "shall review and authorize the use of less restrictive restraint."[3]

[3] As few individuals in these positions are physicians, this further delegation to other physicians is significant.

Joint Commission Standards

As noted above, the Joint Commission on Accreditation of Healthcare Organizations has also issued guidelines for restraint use in its standards for general hospitals and guidelines for restraint and seclusion use in its *1993 Mental Health Manual.* The standards governing general hospitals — the single largest inpatient psychiatric modality in New York in terms of number of patients served — state only that hospitals must establish procedures governing the use of restraints, including the maximum length of orders, and that the hospital's quality improvement plans must incorporate evaluation of the use of restraints. *These standards do not reference seclusion use.*

In its *1993 Mental Health Manual,* the Joint Commission offers much more detailed standards governing both restraint and seclusion use. These more comprehensive standards are used by the Joint Commission in its accreditation reviews of psychiatric hospitals, including state psychiatric centers and private psychiatric hospitals.

The Joint Commission's *1993 Mental Health Manual* standards echo many (but not all) of the major provisions in New York's mental hygiene law governing restraint — and the Joint Commission also applies all referenced standards uniformly to seclusion. Joint Commission standards also include two quality assurance standards related to restraint and seclusion not mentioned elsewhere in state law and regulation. These standards require that:

- "all uses of seclusion or restraint are reported daily to the head of the professional staff or his designee" and that "the head of the professional staff and/or designee reviews daily all uses of seclusion or restraint and investigates unusual or possibly unwarranted use patterns," and that,
- patients in restraint or seclusion be monitored every 15 minutes, as opposed to every 30 minutes as specified in mental hygiene law, and that attention be given during these monitoring checks in offering patients' regular meals, and opportunities to bathe, and use the toilet.

Several important provisions of New York's mental hygiene law governing restraint or the Office of Mental Health's policy governing restraint and seclusion in state psychiatric centers, however, are either not referenced in the Joint Commission's standards or they are stated less stringently (Figure 6).

Figure 6
Omissions and Less Stringent Provisions of the Joint Commission on Accreditation of Healthcare Organizations

- ✓ Allows restraint or seclusion use to prevent disruption of the environment.
- ✓ Does *not* require a personal exam of the patient by a physician.
- ✓ Allows physicians to confirm emergency orders, with *oral* orders. (Written orders required within 24 hours).
- ✓ Allows seclusion orders to extend for 24 hours.
- ✓ No mandate that patients be released every two hours.
- ✓ No mandate that patients be released when they no longer appear dangerous.
- ✓ No safety standards for seclusion rooms.

- In addition to the justification of dangerousness to self or others, the Joint Commission's standards allow that restraint or seclusion may be used "to prevent serious disruption of the therapeutic environment." There is also no specific proscription in the Joint Commission's standards against using restraint and seclusion as a substitute for programming.
- The Joint Commission's standards require the physician ordering restraint or seclusion to conduct a clinical assessment of the patient; but unlike the provisions in state mental hygiene law and Office of Mental Health policy, there is no requirement for a *personal exam of the patient or any personal contact with the patient.*
- The Joint Commission's standards also allow physicians to confirm emergency orders for restraint or seclusion with *oral orders* which must be made within one hour of the emergency imposition of the restraint or seclusion and must be confirmed in writing *within 24 hours.*
- The Joint Commission's standards allow that seclusion and restraint orders may be written for up to 24 hours, rather than the 4–hour limit (except overnight) stated in mental hygiene law (for restraint only) and Office of Mental Health policy.
- The Joint Commission's standards make no allowance for the mandatory release of patients from restraints and seclusion every two or three hours, as provided for in state mental hygiene law, regulations and NYS Office of Mental Health policy. There is also no specific statement in the Joint Commission's standards that patients must be released from restraint and seclusion promptly when they no longer appear dangerous to themselves or others.
- The Joint Commission's standards also omit any reference to authorized forms of mechanical restraints or any standards for seclusion rooms.

Summary

In summary, New York was ahead of most other states with the State Legislature's passage in 1977 of §15.04 of Mental Hygiene Law governing the use of restraint with persons who are mentally disabled in a wide range of mental health, mental retardation, and alcoholism and substance abuse treatment settings. Over the past 18 years, however, this statutory leadership has not kept pace, and New York's statute governing restraint now appears out–of–date.

This statute is silent on seclusion use, as well as several important provisions for patient monitoring and maximum length of emergency orders. The statute has also not been updated to consider special requirements for restraint or seclusion use with especially vulnerable populations, including people who are mentally retarded, the elderly, children, and people who have serious health conditions.

The state regulations, while affording standards governing both restraint and seclusion, are in other respects inadequate, as they fail to reference many key requirements in the state's mental hygiene law. And, although the NYS Office of Mental Health policy offers the most comprehensive governance structure for restraint and seclusion, it applies to state psychiatric centers, which now serve only a small minority of the persons in New York requiring inpatient psychiatric hospitalization.

Adding to the generally unsatisfactory status of state law, regulation, and policy direction governing restraint and seclusion use in New York's psychiatric facilities are the generally less stringent standards for restraint and seclusion use set forth by the Joint Commission on Accreditation of Healthcare Organizations in its

1993 Mental Health Manual. To the extent that New York hospital administrators turn to the Joint Commission's standards for guidance in establishing their internal restraint and seclusion policies, they may accept standards which are noncompliant with state law or regulations or the policy standards set by the Office of Mental Health for its own state psychiatric centers.

Psychiatric facilities in New York are largely left to fend for themselves as they sort through the inconsistencies and gaps of the state's mental hygiene law, regulations, and NYS Office of Mental Health policy governing restraint and seclusion use. As shown in Figure 7 (pg. 18 & 19), the inconsistencies and gaps in these governance documents could potentially confuse even the most earnest hospital administrator.

Figure 7
Inconsistencies in Restraint and Seclusion Guidelines

Guidelines	*MHL §33.04*	*14NYCRR §27*	*OMH Policy*	*JCAHO MH Manual*
Applicability				
o state psychiatric centers	Y	Y	Y	Y
o private psychiatric hospitals	Y	Y	N	Y
o licensed psychiatric units of general hospitals	Y	Y	N	N
o govern restraint use	Y	Y	Y	Y
o govern seclusion use	N	Y	Y	Y
Definitions				
o defines restraint	Y	N	Y	Y
o defines seclusion	N	Y	Y	Y
o distinguishes medical supports from mechanical restraints	Y	N	Y	N
o distinguishes "time-out" from seclusion	N	N	N	N
o specifies types of mechanical devices which are permitted	Y	N	Y	N
o requires OMH Commissioner approval of restraining devices, not authorized in state law	Y	N	N	N
Restrictions on Restraint & Seclusion Use				
o forbids restraint and seclusion use as punishment, for convenience of staff, or as a substitute for programming	Y	N	Y	N[2]
o explicitly forbids use of undue force in the application of restraint & seclusion	N	N	Y	N
o allows restraint and seclusion use only to prevent patients from *seriously* injuring themselves or others	N[1]	Y	Y	N
o requires that less restrictive techniques be tried and determined to be inappropriate or insufficient prior to restraint or seclusion use	N[1]	N	Y	Y
o forbids "PRN" (as needed), standing orders for restraint & seclusion	N	N	Y	Y
Standards for Orders				
o requires physician orders for all restraint and seclusion use	N[1]	Y	Y	Y
o physicians must *personally* examine the patient	N[1]	N	Y	N
o physicians must document rationale for order	N[1]	Y	Y	Y
o orders must specify the restraining device	N	N[3]	N	N
o emergency orders (no physician authorization) are limited to one hour	N	N	Y	Y
o orders are limited to four hours, except (9:00 p.m. to 9:00 a.m.)	N[1]	N	Y	N
o extension of orders overnight is restricted to patients who are continuously asleep	N	N	Y	N
o orders must specify expiration time	Y	N	Y	N

[1] Provision present, but for restraint only.
[2] JCAHO prescribes all these restrictions on the use of restraint and seclusion, except as a substitute for programming.
[3] Provision present for emergency orders only.

Guidelines	*MHL §33.04*	*14NYCRR §27*	*OMH Policy*	*JCAHO MH Manual*
Release of Restrained/Secluded Patient				
o requires that patients be released every two hours, unless asleep	N[1]	Y[4]	Y	N
o requires physician immediate notification or no reinstatement of restraint or seclusion if upon two-hour release the patient makes no overt gestures threatening serious harm to self or others	N[1]	N	Y	N
o in the above instances, allows restraint & seclusion to be reimposed only if, in the physician's professional judgment, release would be harmful to the patient or others	N[1]	N	Y	N
Safety & Monitoring Requirements				
o patients to be monitored at least every 30 minutes.	N[1]	N	Y	Y
o patients to be monitored at least every 15 minutes.	N	N	Y	Y
o reviews of patients' s medications	N	N	Y	N
o safety standards for seclusion rooms	N	N	Y	N
o patient access to bathroom facilities every two hours	N	N	N	Y
o provision of liquids and regular meals	N	N	N	Y
o vital signs to be checked at least every hour	N	N	N	N
Special Populations				
o prohibits use of seclusion with persons who are mentally retarded	N	Y	N	N
o special precautions for use of restraints & seclusion with children	N	N	N	N
o special precautions for use of restraints & seclusion with the elderly	N	N	N	N
o special precautions for use of restraints & seclusion with persons with specific medical conditions (e.g., cardiac, respiratory, seizure conditions)	N	N	N	N
Record Keeping Requirements				
o records of all restraint & seclusion use	N[1]	Y	Y	Y
o documentation of attempts to use less restrictive alternatives	N	N	N	N
o documentation of physician's *personal* exam of patient	N	N	Y	N
o documentation of regular monitoring checks	N[1]	N	Y	Y
o documentation of any patient injury	N	N	N	N
o documentation of patient release every two hours	N	N	N	N
o documentation of bathroom opportunities	N	N	N	Y
o documentation of regular meals, liquids	N	N	N	Y
Quality Assurance Requirements				
o quality assurance monitoring of restraint & seclusion use	N	N	Y	Y
o clinical review of patients frequently restrained or secluded	N	N	N	N
o staff training in restraint & seclusion standards	N	N	Y	Y
o "hands-on" staff training in application of restraint	N	N	Y	N
o head of professional staff or designee to review *daily* all use of restraint & seclusion	N	N	Y	Y

[1] Provision present, but for restraint only.
[4] Regulation requires patients release from seclusion every three hours.

Chapter IV
Internal Policies of NYS Psychiatric Facilities Governing Restraint and Seclusion

In addition to the provisions in state mental hygiene law and regulations and Office of Mental Health policy, state psychiatric centers and general hospitals with certified inpatient psychiatric services in New York are also required by the NYS Office of Mental Health to develop internal policies governing restraint and seclusion use. The Commission reviewed these internal policies focusing on two basic questions:

(1) To what extent are the internal policies of New York's psychiatric facilities consistent with the specific provisions of state mental hygiene law and regulations governing restraint and seclusion use?

(2) To what extent have psychiatric facilities independently compensated for the inconsistencies and gaps in the mental hygiene law and regulations in formulating comprehensive internal policies governing restraint and seclusion practices?

Methods

The Commission obtained internal policies governing restraint and seclusion practices, as well as related staff training and quality assurance protocols and reports, from 24 of the 25 state psychiatric centers[4] and 101 of the 105 general hospitals in the state. The Commission reviewed these documents relying on a structured content analysis protocol, based on two sets of standards (Figure 8).

One set of standards, labelled "basic standards," included 12 principles for the use of restraint and seclusion, which are reinforced in mental hygiene law and/or regulations. The two literal exceptions to this general rule were basic standards relating to monitoring patient's conditions by taking vital signs and staff training requirements in facility policies governing restraint and seclusion. Although not explicitly stated in state mental hygiene law or regulations, it appeared these provisions were implicit in the intent of these legal standards. Some of the basic standards were also stated in Office of Mental Health policies for state psychiatric centers, as well as the standards of the Joint Commission on Accreditation of Healthcare Organizations.

The second set of standards, labelled "enhanced standards," included 13 guidelines that go beyond what is explicitly required in state mental hygiene law and regulations. Identification of the "enhanced" standards was a subjective process, which reflected the Commission staff's review of many facilities' policies, its site visits over the years to dozens of inpatient

[4] One state psychiatric center, Central Islip Psychiatric Center, which primarily serves elderly patients, was excluded from the analysis as it reported that it used neither restraint nor seclusion. This facility does, however, use mechanical "supports" — or restraining devices which it defines as necessary medical or physical safeguards — with a significant minority of its patients.

Figure 8
Review Standards for Restraint and Seclusion Policies

12 Basic Standards

- ❒ Restraint and seclusion may only be used to prevent harm to self or others.
- ❒ Prior to restraint and seclusion use patient must be examined by a physician.
- ❒ Rationale for restraint/seclusion use must be documented in the record.
- ❒ Less restrictive interventions must be tried prior to use of restraint and seclusion.
- ❒ Restraint orders limited to 4–hours.
- ❒ Seclusion orders limited to 24 hours.
- ❒ While restrained or secluded, patient must be checked every 30 minutes.
- ❒ While restrained or secluded, patient must be released every two hours.
- ❒ While restrained or secluded, vital signs must be taken.
- ❒ While restrained or secluded, patient must be offered fluids.
- ❒ Data reports on restraint and seclusion use.
- ❒ Staff must be trained in restraint and seclusion policies.

13 Enhanced Standards

- ❒ Two–hour limit on restraint orders.
- ❒ Two–hour limit on seclusion orders.
- ❒ Explicit definitions distinguish mechanical restraints from medical/mechanical supports.
- ❒ Mandated staff training in crisis intervention.
- ❒ Mandated staff training in applying restraining devices.
- ❒ Medication review required prior to use of restraint or seclusion.
- ❒ Treatment plan review required after each restraint and seclusion episode.
- ❒ Special authorization of clinical director required for restraint/seclusion episodes longer than 24 hours.
- ❒ Special reviews by clinical team required when an individual experiences "repeat" restraint and seclusion episodes.
- ❒ Physician must meet with patient while he/she is restrained/secluded.
- ❒ Staff must discuss restraint/seclusion episode with the patient.
- ❒ Staff must inform involved family of restraint/seclusion episodes as authorized by patient.
- ❒ Quality assurance process includes patient feedback on use of restraint and seclusion.

psychiatric units, and its interviews with many individuals who had been patients in these settings. Approximately half of the enhanced standards are referenced in the Office of Mental Health's policy governing state–operated psychiatric centers. These 13 standards could be classified into three categories:

(1) *Standards related to enhanced "risk" management* which focused on curtailing the time limits for restraint and seclusion orders (beyond the established 4 hours for restraint and 24 hours for seclusion), a clear definition which distinguishes medical supports from restraints, and added standards for staff training in crisis intervention and hands-on training in applying restraint devices.

(2) *Standards related to treatment enhancements* which required clinical staff to provide treatment plan reviews and medication reviews after each restraint or seclusion episode, or which required "special reviews" by the clinical team when an individual experienced "repeat" restraint and seclusion episodes; and

(3) *Patient empowerment standards* which added specific requirements for psychiatrists (or physicians ordering the intervention) to meet with the patient while he/she was in restraint or seclusion, for ward staff to meet with the patient afterwards to discuss the incident, for hospital staff to inform families involved in a patient's treatment when and why restraint or seclusion was used, and for quality assurance staff to include the feedback of patients who had been restrained and secluded in their oversight of the hospital's use of the interventions.

- Basic Standards

Most facilities' internal policies scored well on the 12 basic standards. Of a possible total score of 12 (with one point for each standard), the 125 reporting facilities had a mean score of 9.8 and a median score of 10. At least 90% of the facilities had incorporated 7 of the 12 basic standards in their policies (Figure 9).

Several key basic standards were not, however, stated in the policies of a significant minority of the psychiatric facilities.

- Eighteen percent (18%) of the facilities' policies failed to state, in accordance with NYS mental hygiene law and regulation, that restraint and seclusion were only to be used to prevent patients from seriously harming themselves or others and that these interventions were only to be used after other less restrictive interventions had been tried and failed.

- More than one–fourth of the facilities' policies failed to reference two important patient care and monitoring guidelines: periodically taking the patient's vital signs (26%) and periodically offering the patient fluids (39%).

- There was also no reference in the policies or other documentation submitted by 40% of the facilities that all staff were required to receive training in the facilities' restraint and seclusion policies.

- Enhanced Standards

The internal policies of the psychiatric facilities were far less likely to incorporate many of the 13 "enhanced" standards (Figure 10). Of a total possible score of 13 (one point for each standard), the mean and median score among the 125 facilities was 3.0. Thirty–nine (39) of the 125 reporting facilities' policies (31%) included 2 or fewer of the 13 enhanced standards.

It appeared that psychiatric facilities, while generally diligent in developing internal policies governing restraint and seclusion, largely restricted their guidelines to those incorporated in state laws and regulations. General hospitals, in particular, were unlikely to take advantage of

Figure 9
Percent of NYS Psychiatric Facilities' Policies Referencing Basic Standards
(N = 125)

- ❒ Seclusion orders limited to 24 hours 99%
- ❒ Rationale for the intervention stated in the record 98%
- ❒ Patient examined by a physician before restraint or seclusion is used 98%
- ❒ Patient is checked every 30 minutes 91%
- ❒ Patient is released every two hours 91%
- ❒ Restraint orders limited to 4 hours 90%
- ❒ Data maintained on restraint and seclusion use 90%
- ❒ Restraint and seclusion may only to be used to prevent patients from harming themselves or others 82%
- ❒ Stated that less restrictive interventions must be proven to have been inadequate or insufficient to prevent injury 82%
- ❒ Monitoring must include periodically taking a patient's vital signs 74%
- ❒ Patient must be offered fluids periodically 61%
- ❒ Staff training in restraint and seclusion policies required 60%

the opportunity of developing internal policies to ensure enhanced safeguards and patient protections in the use of restraint and seclusion.

The psychiatric facilities' policies were most likely to include enhanced standards related to the presence of a clear distinguishing definition for medical supports (versus mechanical restraints) (62%) and added staff training requirements, including requirements for hands–on training in the application of mechanical restraints (49%) and in crisis intervention (43%). The psychiatric facilities were less likely to have incorporated enhanced standards related to special reviews and reconsideration of a patient's treatment based on the need for the use of restraints or seclusion. Only 34% of the facilities' policies mandated medication reviews for patients prior to or after the administration of restraints and seclusion, and only 9% of the facilities' policies required treatment plan reviews for patients after episodes of restraint and seclusion.

Many fewer of the facilities' policies required that staff spend time with patients *while they were in restraint or seclusion,* with policies of only 5 of the 125 facilities (4%) requiring that the physician ordering the restraint or seclusion meet with the patient at some point during the patient's confinement. Additionally, only 16% of the facilities had incorporated in their policies some commentary that involved family members should be notified when and why restraint or seclusion was used. Perhaps most noteworthy, only 3 of the 101 general hospitals' policies and none of the 24 state centers' policies required patient and former patient feedback in quality assurance activities related to restraint and seclusion.

State Psychiatric Centers' versus Community Hospitals' Policies

The analysis also indicated that internal policies of state–operated psychiatric centers, governed by the more stringent and comprehensive

Figure 10
Percent of NYS Psychiatric Facilities' Restraint and Seclusion Policies Referencing "Enhanced" Safeguards
(N = 125)

- ❒ Clearly stated distinguishing definitions for mechanical restraint versus mechanical support — 62%
- ❒ Mandated staff training in applying mechanical restraints — 49%
- ❒ Mandated staff training in crisis intervention — 43%
- ❒ Two–hour time limits on restraint *and* seclusion orders* — 39%
- ❒ Staff must discuss restraint/seclusion episode with patient — 38%
- ❒ Reviews by clinical team required subsequent to repeat restraint/seclusion episodes — 37%
- ❒ Medication reviews required prior to restraint/seclusion — 34%
- ❒ Special authorization required for restraint/seclusion episodes >24 hours — 34%
- ❒ With patient's authority, staff must notify involved family of restraint/seclusion use — 16%
- ❒ Treatment team reviews required after use of restraint/seclusion — 9%
- ❒ Staff must spend some time *with* the patient while he/she is in restraint/seclusion — 4%
- ❒ Quality Assurance process must include patient feedback on restraint/seclusion use — 2%

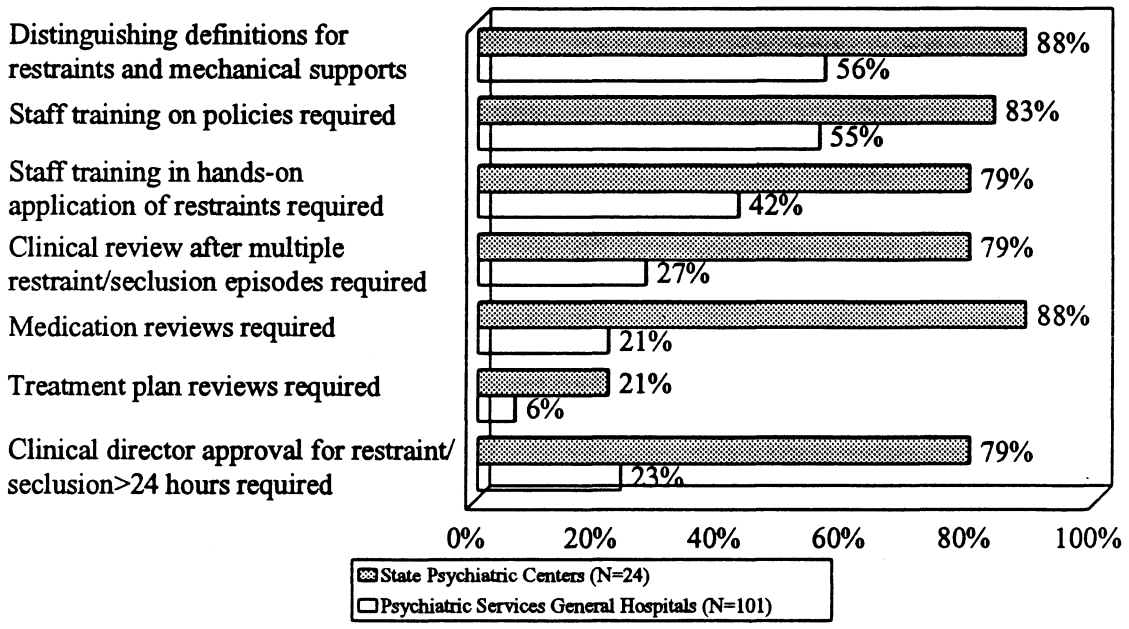
*These were two separate enhanced indicators. Coincidentally, 39% of the facilities' policies referenced each indicator.

NYS Office of Mental Health restraint and seclusion policy, were more comprehensive than the policies of psychiatric services of general hospitals, which are not governed by these Office of Mental Health policies.

The analysis found that state–operated psychiatric centers' policies were significantly more likely than policies of psychiatric services of general hospitals to have mentioned one of the 12 basic standards — mandated staff training in their restraint and seclusion policies (83% versus 55%, $X^2 = 6.74$, df = 1, $p < .01$) — *and 6 of the 13 enhanced standards* (Figure 11). Of these six enhanced standards, the first four listed below are mandated in the NYS Office of Mental Health's restraint and seclusion policy.

- ❒ The clinical director (supervisor) must give written authorization for any restraint or seclusion order for longer than 24 hours (79% versus 23%, $X^2 = 27.64$, df = 1, $p < .01$).
- ❒ The physician must review the patient's medications prior to each episode of restraint (88% versus 21%, $X^2 = 38.68$, df = 1, $p < .01$).
- ❒ All staff who have direct patient contact must complete hands-on training in how to use mechanical restraints (79% versus 42%, $X^2 = 10.96$, df = 1, $p < .01$).
- ❒ The clinical team or clinical director must initiate a review when a patient experiences multiple restraint and seclusion episodes (79% versus 27%, $X^2 = 22.92$, df = 1, $p < .01$).
- ❒ Definitions in the policy clearly distinguish medical supports from mechanical restraints (88% versus 56%, $X^2 = 7.98$, df = 1, $p < .01$).
- ❒ The use of restraint and seclusion must trigger a treatment plan review for the patient (21% versus 6%, $X^2 = 5.36$, df = 1, $p < .05$).

Figure 11
Restraint and Seclusion Policy Standards by Type of Facility



In contrast, general hospitals' policies significantly outperformed state psychiatric centers' policies on none of the basic standards and only one enhanced standard: staff must meet and talk with the patient after the restraint or seclusion episode (43% versus 21%, $X^2 = 3.87$, df = 1, $p < .05$).

Analysis also revealed that state psychiatric centers' policies received significantly higher *total* comprehensiveness scores than those of general hospitals ($t = 6.54$, $df = 123$, $p < .01$). The mean total score for state psychiatric centers of 17.1 (out of a total possible score of 25) was approximately 30% higher than the mean total score of 13.2 for general hospitals.

Policies and Practices

The Commission also took an additional step to examine the crosswalk between psychiatric facilities' restraint and seclusion policies and their practices. We sought to determine whether the comprehensiveness of a facility's policies was associated significantly with its actual use of restraint and seclusion. As more comprehensively discussed in the Commission's report, *Restraint and Seclusion Practices in NYS Psychiatric Facilities*, rates of restraint and seclusion usage vary widely both among New York's state–operated psychiatric centers and its state–certified psychiatric services in general hospitals. The Commission had hypothesized that psychiatric services of general hospitals and state psychiatric centers whose policies more effectively incorporated the assessed basic and enhanced standards may have lower restraint and seclusion use.

This hypothesis, however, was not sustained; no significant relationship was found between the comprehensiveness of facilities' policies and their usage measures for restraint and seclu-

sion. The hypothesis was not sustained when all 125 facilities studied were analyzed as a group or when state psychiatric centers and psychiatric services of general hospitals were analyzed separately. The hypothesis was also not sustained when facilities which were high users of restraint and seclusion were isolated and compared with other facilities. There simply appeared to be no significant relationship (positive or negative) between the comprehensiveness of facilities' internal restraint and seclusion policies and the frequency of the facilities' use of these interventions.

Chapter V
Conclusions and Recommendations

As reflected in this report, New York's governance structure for restraint and seclusion offers both contradictory and incomplete guidance to psychiatric facilities regarding the use of these very restrictive and potentially hazardous interventions. Simultaneously, although psychiatric facilities, in compliance with state regulations and Joint Commission on Accreditation of Healthcare Organization standards, have developed internal policies governing restraint and seclusion, these policies do not compensate for the weaknesses in state law, regulation, and policy. These internal policies, while usually inclusive of the basic principles in state law and regulations governing these interventions, have not, as a general rule, established enhanced clinical quality assurance safeguards.

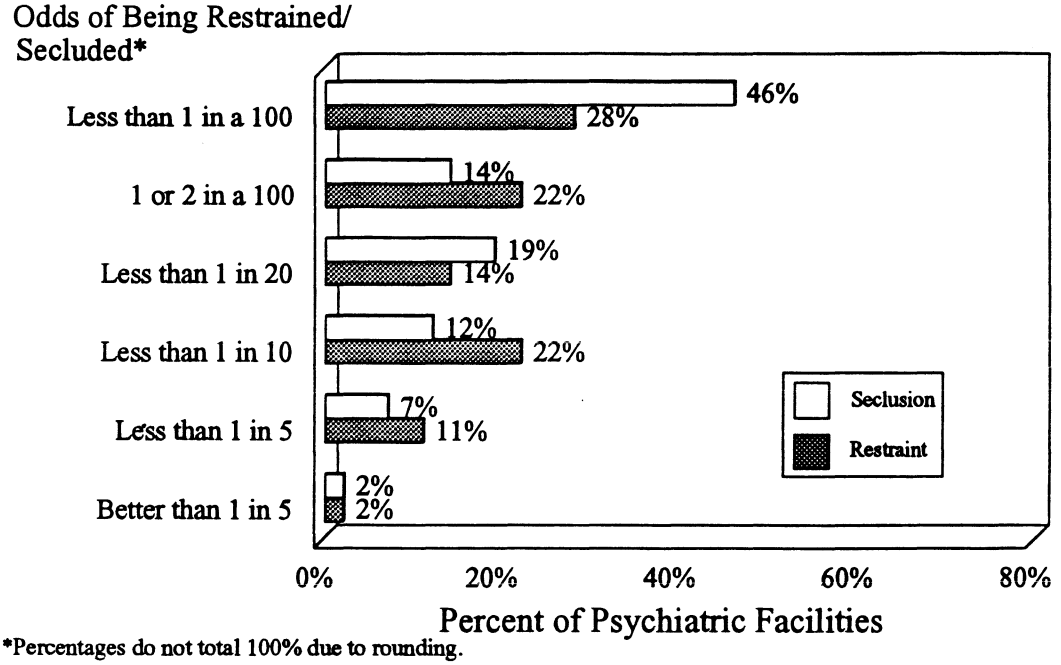
Faced with confusing and contradictory directives, administrators and clinicians in inpatient psychiatric facilities have largely charted their own policy course, with little oversight or correction, for the management of restraint and seclusion use. In a minority of cases, facilities' internal policies have not even addressed the major principles articulated in New York mental hygiene law and regulation and affirmed in federal court decisions and by other state legislatures. There is currently no regular review of the adequacy of these internal policies by the NYS Office of Mental Health, especially for the nonstate–operated facilities.

Recommendation for Statutory and Regulatory Reform

It would be naive of the Commission to suggest that reform of state law and regulations alone would spur more effective and appropriate restraint and seclusion practices by psychiatric facilities. Data collected by the Commission suggest, in fact, that the comprehensiveness of facilities' internal restraint and seclusion policies has little, if any, impact on the actual use of these interventions. Clearly, statutory and regulatory reforms could, however, only set a framework for more appropriate and accountable practices when these interventions are used. The implementation of the new standards by conscientious facility administrators and clinicians, as well as trained direct care staff on inpatient units, will be essential to any real reform in practices.

Just as clearly, real reform in restraint and seclusion practices in New York's psychiatric facilities will require more diligent monitoring of these practices and their compliance with statutory and regulatory standards by psychiatric facilities themselves and the Office of Mental Health. The inclusion of former patients' perspectives of their experiences while being restrained or secluded will be critical in these monitoring activities. Psychiatric facility administrators and clinicians responding to the Commission's earlier reports of its restraint and seclusion research have indicated substantial interest in more enhanced monitoring of the use of these interventions. Recipient advocacy groups have also offered their suggestions and assistance, as facilities move forward in this direction. Thus, it seems to be especially timely for New York to undertake a thorough review and revision of the state's mental hygiene law and regulations governing restraint and seclusion, providing a common point of departure for all psychiatric facilities as they seek to ensure better protection and safety for their patients related to restraint and seclusion use.

Figure 12
Odds of Being Restrained or Secluded in NYS Psychiatric Facilities
(N = 125)



*Percentages do not total 100% due to rounding.

Stronger Governance Required to Address Widely Variant Practices

As noted in the Commission's report, *Restraint and Seclusion Practices in NYS Psychiatric Facilities* (September 1994), there is ample evidence that psychiatric facilities in New York use different operational standards in deciding the appropriate indications for the use of restraint and seclusion — and that use of these variable standards has had a dramatic impact on restraint and seclusion usage among these facilities. At most of New York's psychiatric facilities these interventions are rarely if ever used. At half of these facilities, one's chances as a patient to be subjected to restraints or seclusion during a hospitalization was less than 1 or 2 in 100 (Figure 12).

In contrast, at one–fifth (20%) of the 125 psychiatric facilities studied, one in every ten patients admitted were subjected to restraint or seclusion. And, at nearly one–third (31%) of the facilities, 40 or more orders for restraint and seclusion were written monthly per 100 patients in the average daily census; at 9% of the facilities, 100 or more orders were written monthly per 100 patients in the average daily census (Figure 13).

After substantial examination of these data, the Commission was compelled to conclude — much like other researchers trying to explain wide variations in restraint and seclusion use — that these variations could not be associated with differences in the characteristics and needs of the patients served. Instead, it appeared that most of the variation in restraint and seclusion usage could be traced to varying administrative

expectations and practices on inpatient psychiatric units, as well as differences in clinical "interpretations" of the indications and contraindications for restraint and seclusion use.

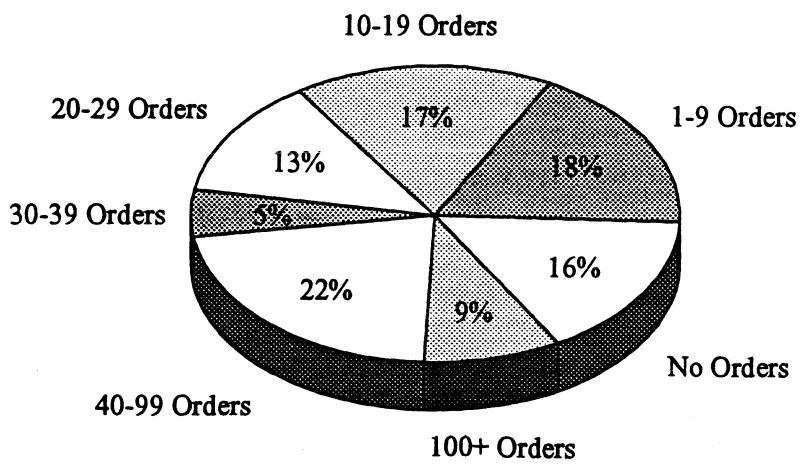
Such variations in practices may be tolerable in other areas of clinical practice. However, there is consistent recognition both in state law and in judicial opinions that the use of restraints and seclusion represent an infringement of an individual's liberty interests and that these interventions, thereby, can be applied only in narrowly defined circumstances which are likely to present serious harm to the individual or others.

Additionally, as amply demonstrated by the Commission's own death investigations and other complaint advocacy work, staff application of restraints or placement of patients in seclusion present very real physical risks of harm to the patient and staff. Each year over the past decade, use of restraints and seclusion has been associated with, at least temporarily, with the death of approximately 10 individuals in mental hygiene facilities. Use of restraint and seclusion is also the most common concurrent circumstance in allegations of institutional child abuse brought to the Commission's attention, and it is also associated with a large percentage of adult patient complaints to the Commission about their hospital stays.

Listening to the Consumer

The Commission report, *Voices From the Front Line: The Psychiatric Patient's Perspective of Restraint and Seclusion Use,* further confirms that almost all individuals subjected to restraints or seclusion in New York's psychiatric facilities have at least one complaint about its use. In this report, the Commission discusses the comments of over 1,000 former patients of psychiatric facilities about their care and treat-

Figure 13
Combined Order Rates for Restraint and Seclusion in NYS Psychiatric Facilities*
(September 1992)



(N = 125 Facilities)

*Combined monthly orders of restraint and seclusion per 100 patients in average daily census.

ment in the hospital and specifically about their experiences with restraint or seclusion. Of the 560 individuals responding to the survey who had been subjected to restraints and seclusion, 94% had at least one complaint about its use.

There was also a strong correlation between the respondents' general dissatisfaction with psychiatric hospitalizations and their "treatment" with restraints and seclusion. It seemed that "treatment" with restraints and seclusion was an experience that most individuals remembered negatively, and that for many individuals the experience also adversely influenced their overall recollections of their hospitalization.

These findings suggest that, aside from the physical dangers of restraint and seclusion use, these interventions may be an additional emotional hardship on patients, leaving them with less positive views overall toward their hospitalization and its benefits. Although difficult to measure, the likely influence of these negative perspectives for individuals' future acceptance of needed inpatient psychiatric care or their receptivity to discharge planning recommendations made by hospital staff is apparent.

Recommendations

In short, the Commission believes that the widely variable restraint and seclusion practices of New York's psychiatric facilities, as well as the perspectives of most individuals who have been subjected to these interventions in New York psychiatric facilities that they have been treated poorly, lend strong support for the Legislature's reconsideration and reform of mental hygiene law governing restraint and seclusion.

In 1977, the New York State Legislature passed one of the first state statutes governing restraint in the nation. In its time this statute set basic standards for statutory governance of restraint use with persons who are mentally disabled. Today, almost 20 years later, it is important for the New York State Legislature to take this step again, upgrading and enhancing the standards and safeguards around restraint and seclusion use.

The Commission, therefore, recommends that the State Legislature revise and augment current mental hygiene law governing restraint and seclusion use in psychiatric facilities.

In this endeavor, there are a number of principles which should guide the Legislature in universally ensuring that the use of these restrictive, and at times dangerous, interventions is an option of last resort, safely carried out, and vigorously monitored. These principles, presented in the Appendix, reflect the best practices of some facilities in New York State and provisions drawn from existing laws, regulations, accreditation standards and policies.

The goal of statutory reform should be to establish a cohesive governance structure over the use of restraint and seclusion which:

- provides uniform protection for patients related to restraint and seclusion use in *all* inpatient psychiatric facilities;
- provides comprehensive safeguards governing the use of *both* restraint and seclusion;
- assures that critical expectations for patient safety, well–being and protection from harm while being restrained or secluded are clarified and consistently monitored;
- assures special protections in restraint and seclusion use with vulnerable populations including the elderly, children, persons who are mentally retarded, and persons with serious medical conditions;
- requires sufficient documentation of the practices followed and their justification to provide an accurate and accountable record of a facility's restraint and seclusion practices; and

- builds in comprehensive quality assurance oversight by inpatient psychiatric facilities themselves and the NYS Office of Mental Health of restraint and seclusion practices.

While the Legislature considers statutory reforms governing the use of restraint and seclusion, it is recommended that psychiatric facilities in the state and the State Office of Mental Health should review the principles set forth in the Appendix with an eye toward determining the degree to which they are embodied in their existing policies and practices, and where necessary, the need to enhance such policies and practices to better protect the people they serve.

Appendix

Guiding Principles for the Use of Restraint and Seclusion

Guiding Principles for the Use of Restraint and Seclusion

- Comprehensive safeguards should govern the use of restraint or seclusion.

  - ☐ Restraint and seclusion should be explicitly defined and definitions should differentiate mechanical restraints from medical supports, and seclusion from time out.
  - ☐ Restraint or seclusion should only be used to prevent patients from seriously harming themselves or others. Restraint and seclusion should not be used as punishment, for the convenience of staff, or as a substitute for programming. Less restrictive interventions must be tried prior to the use of restraint or seclusion.
  - ☐ No patient should be placed in restraint and seclusion simultaneously.
  - ☐ Undue force should not be used in the application of restraint or seclusion.
  - ☐ Prior to restraint or seclusion use, the patient must be personally examined by a physician.
  - ☐ Restraint or seclusion orders should be limited to two hours.
  - ☐ Emergency application of restraint or seclusion should not exceed one hour without a physician's order.
  - ☐ There should be an explicit prohibition against using standing PRN orders for restraint or seclusion.
  - ☐ A physician's order for restraint or seclusion should specify the rationale for the order, the type of restraining device, the initiation and expiration time of the order, and directives to staff on special monitoring activities deemed necessary by the physician in view of the patient's condition.
  - ☐ The extension of orders overnight should be restricted to patients who are continually asleep.
  - ☐ A review of the patient's medication should occur prior to the use of restraint or seclusion.

- The use of restraint or seclusion assures that critical expectations for patient safety, well-being and protection from harm while being restrained or secluded are clarified and consistently monitored.

  - ☐ While in restraint or seclusion patients must be released every two hours and the intervention should not be reimposed unless there is a renewed indication of need.
  - ☐ Patients should be assessed for their general comfort and condition every 15 minutes while in restraint or seclusion.
  - ☐ While in restraint or seclusion, patients' vital signs should be taken every hour, or more frequently as ordered by physician.
  - ☐ Patients should have access to a bathroom at least every two hours while in restraint or seclusion.

- Patients should be offered appropriate meals at regular mealtimes and offered drinking water every hour while in restraint or seclusion.
- Restraining devices should be in good repair and appropriate to the size of the individual.
- Seclusion rooms should meet explicit standards for environmental safety and patients' comfort needs. Emergency medical equipment should be available and staff trained in its use.
- The physician ordering the restraint or seclusion (or his/her designee) should discuss the restraint or seclusion episode with the patient subsequent to his/her release and document this discussion in the patient's record.
- The patient's treatment plan and circumstances leading to an incident of restraint or seclusion should be reviewed after each restraint or seclusion episode to determine whether any modifications in treatment are necessary to provide the patient appropriate and necessary care.

■ The use of restraint or seclusion assures special protections with vulnerable populations including the elderly, children, persons who are mentally retarded, and persons with serious medical conditions.

- Seclusion should be prohibited with persons who are mentally retarded and with children under the age of 13.
- Restraint or seclusion orders for vulnerable populations should be restricted to one hour.
- Physicians should monitor persons with cardio-respiratory problems or other serious medical conditions who are in restraint or seclusion at least every hour.

■ The use of restraint or seclusion requires sufficient documentation of the practices followed and their justification to provide an accurate and accountable record of a facility's restraint or seclusion practices.

- The specific rationale for the use of restraint or seclusion must be documented in the patient's record.
- The nature and findings of the physician's personal examination of the patient for any initial or reorder of restraint or seclusion should be documented in the patient's record.
- Record documentation should be required of the less restrictive interventions which were tried prior to the use of restraint or seclusion and/or the clinical justification that use of less restrictive interventions was not appropriate.
- A description of the 15 minute assessments of the patient's condition and the results of all other monitoring activities ordered while in restraint or seclusion should be documented in the patient's record.

- The use of restraint or seclusion builds in comprehensive quality assurance oversight by inpatient psychiatric facilities themselves and the NYS Office of Mental Health of restraint or seclusion practices.
  - All psychiatric facilities should have a quality assurance monitoring plan related to the use of restraint or seclusion, which includes provisions for at least quarterly senior management team reviews of restraint or seclusion use and patient feedback on the use of restraint or seclusion.
  - Staff training should be mandated in restraint or seclusion policies and regulations, in crisis intervention and in applying restraining devices.
  - Special authorization by the clinical director should be required when a patient's restraint or seclusion episodes exceed 24 hours.
  - A special treatment review should be conducted by the clinical director of those patients who require restraint or seclusion more than once a week.
  - The Office of Mental Health should monitor restraint and/or seclusion use at all state-operated and licensed psychiatric facilities and publish restraint and/or seclusion usage rates of all such facilities at least every two years.

References

American Psychiatric Association (1985). Seclusion and Restraint. *Task Force Report #22*. Washington, DC: Author.

Angold, A. (1989). Seclusion. *British Journal of Psychiatry*, 437–444.

Antoinette, T., Iyengar, S., & Puig-Antich, J. (1990). Is locked seclusion necessary for children under the age of 14? *The American Journal of Psychiatry*, 147(10), 1283–1289.

Binder, R. L. (1979). The use of seclusion and restraint on an inpatient crisis intervention unit. *Hospital and Community Psychiatry*, 30, 266–69.

Blakeslee, J., Goldman, B., & Papougenis, D. (1990). Untying the elderly: Kendal's restraint-free program at Longwood and Crosslands. *Generations*, 14(Suppl.), 79–80.

Bond, C. F., DiCandia, C. G., & MacKinnon, J. R. (1988). Responses to violence in a psychiatric setting: The role of a patient's race. *Personality and Social Psychology Bulletin*, 14(3), 448–458.

Brakel, S. J., Parry, J., & Weiner, B. A. (1985). *The mentally disabled and the law*. Chicago: American Bar Association.

Burger, S. (1993). Avoiding physical restraint use. National Citizens' Coalition for Nursing Home Reform.

Bursten, B. (1975). Using mechanical restraints for acutely disturbed psychiatric patients. *Hospital and Community Psychiatry*, 26, 757–759.

Carmel, H., & Hunter, M. (1990). Compliance with training in managing assaultive behavior and injuries from inpatient violence. *Hospital and Community Psychiatry*, 41(5), 558–560.

Carpenter, M. D., Hannon, V. R., McCleery, G., & Wanderling, J. A. (1988a). Ethnic differences in seclusion and restraint. *Journal of Nervous and Mental Disease*, 176(12), 726–731.

Carpenter, M. D., Hannon, V. R., McCleery, G., & Wanderling J. A. (1988b). Variations in seclusion and restraint practices by hospital location. *Hospital and Community Psychiatry*, 39(4), 418–423.

Chamberlin, J. (1985). An ex-patient's response to Soliday. *Journal of Nervous and Mental Disease, 173*(5), 288–289.

Chu, C., & Ryan, S. J. (1987). The role of seclusion in psychiatric hospital practice. *Psychiatric Hospital*, 18(3), 121–125.

Colenda, C. C., & Hamer, R. M. (1991). Antecedents and interventions for aggressive behavior of patients in geropsychiatric state hospitals. *Hospital and Community Psychiatry*, 42(3), 287–292.

Cotton, N. S. (1989). The developmental-clinical rationale for the use of seclusion in the psychiatric treatment of children. *The American Journal of Orthopsychiatry*, 59(3), 442–450.

Covert, A.B., Rodrigues, T., & Soloman, K. (1977). The use of mechanical and chemical restraints in nursing homes. *Journal of the American Geriatrics Society,* 25(2), 85–89.

Craig, C., Ray, F., & Hix, C. (1989). Seclusion and restraint: Decreasing the discomfort. *The Journal of Psychosocial Nursing*, 27(7), 17–19.

Crespi, T. D. (1990). Restraint and seclusion with institutionalized adolescents. *Adolescence.* 25(100), 825–829.

Daar, M., & Nelson, T. (1992). Reforming seclusion and restraint practices: An advocacy manual.

Danford, R., San Diego County seclusion and restraint project: A comparison of practices and a formula for change. Patient Advocacy Program and the University of San Diego Law School.

Davidson, N., Hemingway, M. J., & Wysocki, T. (1984). Reducing the use of restrictive procedures in a residential facility. *Hospital and Community Psychiatry*, 35(2), 164–167.

Dietz, P. E., & Rada, R. T. (1983). Seclusion rates and census in a maximum security hospital. *Behavioral Sciences and the Law*, 1(4), 89–93.

Erickson, W. D., & Realmuto, G. (1983). Frequency of seclusion in an adolescent psychiatric unit. *Journal of Clinical Psychiatry*, 44(7), 238–241.

Evans, L. K., Strumpf, N. E., & Williams, C. (1991). Redefining a standard of care for frail older people: Alternatives to routine physical restraint. In Paul R. Katz, Robert L. Kane, & Mathy D. Mezey (Eds.), *Advances in Long-Term Care* (Vol. 1). New York: Springer.

Fassler, D., & Cotton, N. (1992). A national survey on the use of seclusion in the psychiatric treatment of children. *Hospital Community and Psychiatry*, 43, 370–374.

Fitzgerald, R. G., & Long, I. (1973). Seclusion in the management of severely disturbed manic and depressed patients. *Perspectives in Psychiatric Care*, 11(2), 59–64.

Flaherty, J. A., & Meagher (1980). Measuring racial bias in inpatient treatment. *American Journal of Psychiatry*, 137(6), 679–682.

Garrison, W. T., Ecker, B., Friedman, M., Davidoff, R., Haeberle, K., & Wagner, M. (1990). Aggression and counteraggression during child psychiatric hospitalization. *Journal of the American Academy of Child Adolescent Psychiatry*, 29(2), 242–250.

Gerlock, A., & Solomons, H. C. (1983). Factors associated with the seclusion of psychiatric patients. *Perspectives in Psychiatric Care*, 21(2), 47–53.

Guirguis, E. F. (1978). Management of disturbed patients: An alternative to the use of mechanical restraints. *Journal of Clinical Psychiatry*, 39, 295–300.

Gutheil, T. G. (1978). Observations on the theoretical basis for seclusion of the psychiatric inpatient. *American Journal of Psychiatry*, 135, 325–328.

Gutheil, T. G. (1984). Indications and contraindications for seclusion and restraint. In K. Tardiff (Ed.), *The psychiatric uses of restraint and seclusion* (pp. 11–17). Washington, DC: American Psychiatric Press.

Gutheil, T. G. (1984). Review of individual quantitative studies. In K. Tardiff (Ed.), *The psychiatric uses of restraint and seclusion* (pp. 125–140). Washington, DC: American Psychiatric Press.

Gutheil, T. G., Applebaum, P. S., & Wexler, D.B. (1983). The appropriateness of "least restrictive alternative" analysis for involuntary procedures with institutionalized mentally ill. *Journal of Psychiatry and Law*, 11(1), 7–17.

Halleck, S. L. (1974). Legal and ethical aspects of behavior control. *American Journal of Psychiatry*, 131(4), 381–385, 1974.

Hammill, K., McEvoy, J. P., Koral, H., & Schneider, N. (1989). Hospitalized schizophrenic patient views about seclusion. *Journal of Clinical Psychiatry*, 50(5), 174–177.

Irwin, M. (1987). Are seclusion rooms needed on children's psychiatric units? *American Journal of Orthopsychiatry*, 57, 125–126.

Kalogjera, I. J., Bedi, A., Watson, W. N., & Meyer, A. D. (1989). Impact of therapeutic management on use of seclusion and restraint with disruptive adolescent inpatients. *Hospital and Community Psychiatry*, 40(3), 280–285.

Lawson, W. B., Yesavage, J. A., & Werner, P. D. (1984). Race, violence and psychopathology. *Journal of Clinical Psychiatry*, 45, 294–297.

Liberman, R. P., & Wong, S. E. (1984). Behavior analysis and therapy procedures related to restraint and seclusion. In K. Tardiff (Ed.), *The psychiatric uses of restraint and seclusion* (pp. 35–67). Washington, DC: American Psychiatric Press.

Lion, J. R., & Soloff, P. H. (1984). Implementation of seclusion and restraint. In K. Tardiff (Ed.), *The psychiatric uses of restraint and seclusion* (pp. 19–34). Washington, DC: American Psychiatric Press.

Joint Commission on Accreditation of HealthcareOrganizations (1993). Accreditation manual for mental health, chemical dependency, and mental retardation and developmental disabilities. Oakbrook Terrace, Illinois: Author.

MacDonald, A. (1988). Reducing seclusion in a psychiatric hospital. *Senior Nurse*, 8(11), 4–7.

Mattson, M. R., & Sacks, M. H. (1978). Seclusion: Uses and complications. *American Journal of Psychiatry*, 135, 1210.

Miller, D., Walker, M. C., & Friedman, D. (1989). Use of a holding technique to control the violent behavior of seriously disturbed adolescents. *Hospital and Community Psychiatry*, 40(5), 520–524.

Millstein, K. H., & Cotton, N. S. (1990). Predictors of the use of seclusion on an inpatient child psychiatric unit. *Journal of the American Academy of Child Adolescent Psychiatry*, 29(2), 256–264.

Mitchell, J., & Varley, C. (1990). Isolation and restraint in juvenile correctional facilities. *Journal of the American Academy of Child and Adolescent Psychiatry*, 29(2), 251–255.

Monroe, C. M., VanRybroek, G. J., & Maier, G. J. (1988). Decompressing aggressive inpatients: Breaking the aggression cycle to enhance positive outcome. *Behavioral Sciences and the Law*, 6(4), 543–557.

Morrision, P. (1991). Use of environmental seclusion monitored. *Nursing Times*, 87(37), 54.

Moss, R. J., & LaPuma, J. (1991). The ethics of mechanical restraints. *Hastings Center Report*, 22–25.

Naumann, C. E., Maus, M., & Thomas, D. R. (1983). An analysis of guidelines for the use of locked room time-out. *Behavioral Engineering*, 8(2), 77–89.

New York State Office of Mental Health Report (July 1994). Report of the task force on restraint and seclusion. Albany, NY: Author.

Okin, R. L. (1985). Variation among state hospitals in use of seclusion and restraint. *Hospital Community Psychiatry*, 36, 648–652.

Oldham, J. M., Russakoff, L. M., & Prusnofsky, L. (1983). Seclusion: Patterns and milieu. *Journal of Nervous and Mental Disease*, 171, 645–650.

Outlaw, F., & Lowery, B. (1992). Seclusion: The nursing challenge. *Journal of Psychosocial Nursing*, 30(4), 13–17.

Phillips, P., & Nasr, S. J. (1983). Seclusion and restraint and prediction of violence. *American Journal of Psychiatry*, 140, 229–232.

Pilette, P. C. (1978). The tyranny of seclusion: A brief essay. *Journal of Psychosocial Nursing and Mental Health Services*, 16(10), 19–21.

Plutchik, R., Karasu, T. B., Conte, H. R., Siegel, B., & Jerrett, I. (1978). Toward a rationale for the seclusion process. *Journal of Nervous and Mental Disease*, 166, 571–579.

Ramachandani, D., Akhtar, S., & Helfrich, J. (1981). Seclusion of psychiatric inpatients: A General Hospital Perspective. *International Journal of Social Psychiatry*, 27, 309–315.

Roper, J. M., Coutts, A., Sather, J., & Taylor, R. (1985). Restraint and seclusion: A standard and standard care plan. *Journal of Psychosocial Nursing and Mental Health*, 23, 18–23.

Rosen, H., & DiGiacomo, J. N. (1978). The role of physical restraint in the treatment of psychiatric illness. *Journal of Clinical Psychiatry*, 39, 228–232.

Sheridan, M., Henrion, R., Robinson, L., & Baxter, V. (1990). Precipitants of violence in a psychiatric inpatient setting. *Hospital and Community Psychiatry*, 4(7), 776–780.

Shugar, G., & Rehaluk, R. (1990). Continuous observation for psychiatric inpatients: A critical evaluation. *Comprehensive Psychiatry*, 30(1), 48–55.

Sloane, P. D., Matthew, L. J., Scarborough, M., Desai, J. R., Koch, G. G., & Tangen, C. (1991). Physical and pharmacological restraint of nursing home patients with dementia—impact of specialized units, *JAMA*, 265(10), 1278–1282.

Soloff, P. H. (1978). Behavioral precipitants of restraint in the modern milieu. *Comprehensive Psychiatry*, 19, 179–184.

Soloff, P. H. (1984). Historical notes on seclusion and restraint. *The psychiatric uses of restraint and seclusion* (pp. 1–9). Washington, DC: American Psychiatric Press.

Soloff, P. H., & Turner, S. M. (1981). Patterns of seclusion: A prospective study. *Journal of Nervous and Mental Disease*, 169, 37–44.

Soloff, P. H., Gutheil, T. G., & Wexler, D. B. (1985). Seclusion and restraint in 1985: A review and update. *Hospital and Community Psychiatry,* 36(6), 652–665.

Stewart, J. T., Myers, W. C., Burket, R. C., & Lyles, W. B. (1990). A review of the pharmacotherapy of aggression in children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 29(2), 269–277.

Susselman, S. (1973). The use of physical restraint: Its relation to other forms of psychotherapeutic intervention. In S. A. Szurek and I. N. Berlin (Eds.), *Clinical Studies in Childhood Psychoses* (pp. 522–528). New York: Bruner/Mazel.

Swett, C., Michaels, A. S., & Cole, J. O. (1989). Effects of a state law on rates of restraint on a child and adolescent unit. *Bulletin of the American Academy of Psychiatry and the Law,* 17(2), 165–169.

Tardiff, K. (1981). Emergency control measures for psychiatric inpatients. Journal of Nervous and Mental Disease, 169, 614–618.

Tardiff, K. (1992). The current state of psychiatry in the treatment of violent patients. *Archives of General Psychiatry*, 49, 439–499.

Tardiff, K., & Mattson, M. R. (1984). A survey of state mental health directors concerning guidelines for seclusion and restraint. In K. Tardiff (Ed.), *The psychiatric uses of restraint and seclusion*, (pp. 141–150). Washington, DC: American Psychiatric Press.

Telintelo, S., Kuhlman, T. L., & Winger, C. (1983). A study of the use of restraint in a psychiatric emergency room. *Hospital and Community Psychiatry*, 34, 164–165.

Thompson, P. (1986). The use of seclusion in psychiatric hospitals in the Newcastle area. *British Journal of Psychiatry*, 149, 471–474.

Tsemberis, S., & Sullivan, C. (1988). Seclusion in context: Introducing a seclusion room into a children's unit of a municipal hospital. *American Journal of Orthopsychiatry*, 462–465.

VanRybroek, G., Kuhlman, T., Maier, G., & Kaye, M. (1987). Preventive aggression devices (PADS): Ambulatory restraints as an alternative to seclusion. *Journal of Clinical Psychiatry*, 48(10), 401–405.

Vitiello, B., Ricciuti, A. J., & Behar, D. (1987). PRN medications in child state hospital inpatients. *Journal of Clinical Psychiatry*, 48(9), 351–354.

Wadeson, H., & Carpenter, W. T. (1976). Impact of seclusion room experience. *Journal of Nervous and Mental Disease*, 163, 318.

Way, B. B. (1986). The use of restraint and seclusion in New York State psychiatric centers. *International Journal of Law and Psychiatry*, 8, 383–393.

Way, B. B., & Banks S. M. (1990). Use of seclusion and restraint in public psychiatric hospitals: Patient characteristics and facility effects. *Hospital and Community Psychiatry*, 41(1), 75–81.

Whaley, M. S., & Ramirez, L. F. (1980). The use of seclusion rooms and physical restraints in the treatment of psychiatric patients. *Journal of Psychosocial Nursing and Mental Health Services*, 18(1):13–16.

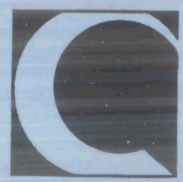
Wong, S. E., Woolsey, J. E., Innocent, J., & Liberman, R. P. (1988). Behavioral treatment of violent psychiatric patients. *Psychiatric Clinics of North America*, 11(4), 569–579.

Copies of this report are available in large print, braille, or voice tape. Please call the Commission for assistance in obtaining such copies at 518-473-7538.

The Commission on Quality of Care for the Mentally Disabled is an independent agency responsible for oversight in New York State's mental hygiene system. The Commission also investigates complaints and responds to requests concerning patient/resident care and treatment which cannot be resolved with mental hygiene facilities.

The Commission's statewide toll-free number is for calls from patients/residents of mental hygiene facilities and programs, their families, and other concerned advocates.

Toll-free Number: 1-800-624-4143 (Voice/TDD)



In an effort to reduce the costs of printing, please notify the Commission if you wish your name to be deleted from our mailing list or if your address has changed. Contact:

Commission Publications
NYS Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, NY 12210-2895

Tel. (518) 473-7538