New York State Documents

Restraint & Seclusion Practices in New York State Psychiatric Facilities

The second report assesses the perspectives of former patients on the use of restraint and seclusion, as well as the apparent adverse influence of these interventions on individuals' overall assessment of their inpatient experience. Survey respondents overwhelmingly report that restraint and seclusion were used contrary to state law and policy, and that they were often poorly treated, abused or injured when restrained or secluded. In an era of increasing demands for consumer satisfaction in governmental services, the Commission recommended psychiatric facilities listen to the views and concerns expressed by over 1,000 "customers" of psychiatric services and ensure psychiatric facilities become more accountable and responsive to the needs of persons with serious mental illness.

Based on our first report's findings that patient clinical characteristics do not explain the wide variations in usage of these interventions, the Commission concluded that, despite Mental Hygiene Law and regulatory restrictions, there is a risk that restraint and seclusion are being used as punishment or for staff convenience at some facilities. Therefore, the Commission believes there is a need to re-examine the laws, regulations and policy which have allowed facilities such broad discretion in the use of restraint and seclusion and will issue a third report in the fall, entitled "***Governance of Restraint and Seclusion Practices***", which will evaluate the adequacy of existing protections governing use of these interventions and recommend appropriate changes.

The Office of Mental Health has similarly identified a need to reduce restraint and seclusion use, and some initiatives are reportedly underway at state psychiatric centers. OMH, however, did not agree with the Commission's recommendation that more careful monitoring be extended to psychiatric services of general hospitals, which now provide approximately three-fourths of the psychiatric inpatient admissions in New York, stating that OMH does not have sufficient resources. The Commission and OMH also disagree on other matters related to restraint and seclusion use. OMH seeks to authorize seclusion of persons with mental retardation, explicitly forbidden in the Willowbrook Consent Decree and state regulations dating back to 1975, and to authorize two new forms of restraint--the calming blanket restraint and five-point restraint. The Commission has expressed its disagreement with these steps, noting that authorizing the use of seclusion with persons with mental retardation is a giant step backwards for New York, and OMH has provided no empirical research to demonstrate the safety of the other new forms of restraining devices.

The findings, conclusions and recommendations of the Commission report reflect the unanimous opinion of the members of the Commission. A draft of this report was reviewed by OMH. Their response is appended to the report.

This report is being filed in accordance with Article 6 of the Public Officers Law and is considered a public document.

ENCLOSURES

STATE OF NEW YORK
COMMISSION ON QUALITY OF CARE
FOR THE MENTALLY DISABLED

MEMORANDUM

FROM: Clarence J. Sundram

DATE: September 15, 1994

Enclosed are two reports of the Commission based on our study of the use of restraint and seclusion in New York State psychiatric facilities, which was requested by the Legislature.

The first report, ***"Restraint and Seclusion Practices in New York State Psychiatric Facilities"***, reports on widely variable usage rates among the state's 125 state-operated psychiatric centers and state-licensed psychiatric services in general hospitals. The use of restraints and seclusion has increased dramatically over the past decade and has been associated with over 100 patient deaths over that period of time.

The Commission found the variation in usage could not be explained based on facility demographic or patient clinical characteristics. Rather, the Commission determined that the treatment preferences and practices of administrators and clinical staff are the predictors of low rates of restraint and seclusion. Typically, "low user" facilities shared a strong patient-centered treatment orientation. The Commission found such facilities share several key factors: their directors clearly advocate a treatment philosophy and staff practices encouraging minimal use of restraint and seclusion; low user wards are more likely to give patients other liberties, and to offer better living conditions; and less restraint and seclusion is found on wards with more activities for patients.

The Commission's first report recommends OMH increase its oversight of psychiatric facilities' use of these potentially dangerous interventions, and suggests that adopting the management philosophy and practices of low-user facilities may help high-users change the "culture" of their facilities and thereby reduce reliance on restraint and seclusion.778 The Commission's second report, ***"Voices From the Frontline: Patients' Perspectives of Restraint and Seclusion Use"***, reports on the findings of the Commission's survey of individuals who had been inpatients of psychiatric facilities in the state. With responses from over 1,000 former patients, this represents one of the largest surveys of consumer opinion of inpatient psychiatric care generally--and restraint and seclusion in particular--reported in professional literature.

(Over)

Restraint and Seclusion Practices in New York State Psychiatric Facilities

Clarence J. Sundram
CHAIRMAN

Elizabeth W. Stack
William P. Benjamin
COMMISSIONERS

September 1994

New York State Commission on Quality of Care
for the Mentally Disabled

Preface

In Chapter 50 of the Laws of 1992, the State Legislature requested that the Commission examine restraint and seclusion practices in NYS psychiatric facilities. The Legislature was troubled by a newspaper account, drawing on reports of Commission investigations, which had detailed more than 100 patient deaths attributed to restraint and seclusion use in New York psychiatric facilities over the previous decade. Concern was also expressed that New York's psychiatric facilities relied more heavily on these interventions, and especially the camisole (or the straightjacket) than other states.

In undertaking this review, the Commission examined restraint and seclusion practices from a number of different perspectives. This report details the Commission's examination of restraint and seclusion usage patterns across adult psychiatric facilities in New York State and explores the factors which may be associated with psychiatric facilities' varying usage rates of these interventions. A second report, *Voices From the Front Lines: the Patients' Perspective of Restraint and Seclusion Use*, relates the data from a large mail survey to individuals (N = 1,040) who had received inpatient psychiatric services.

Some psychiatric facilities (16%) in New York State make no use of restraint or seclusion

As related in this report, the Commission found that some psychiatric facilities (16%) in New York State make no use of restraint or seclusion and that the majority (51%) had *combined* monthly usage rates of fewer than 20 orders of restraint *and* seclusion per 100 patients in their average daily census [See Report pp. 11 - 20]. Simultaneously, a minority of New York's psychiatric facilities use these interventions relatively often. These facilities included 39 of the 125 facilities studied (31%) which had combined monthly order rates for restraint and seclusion of 40 or more orders per 100 patients in their average daily census [See Report p.19]. Even among the three forensic state psychiatric centers, which tended to have the highest rates of restraint and seclusion use, there was 500% variation in usage rates for these interventions [See Report p. 17].

Facilities located downstate, designated as teaching hospitals, and having lower average patient acuity levels, were more likely than other facilities to have higher restraint and seclusion usage rates.

Study of the psychiatric facilities, the characteristics of their patient populations, and their restraint and seclusion usage rates generally found that variations in the use of these interventions could not be significantly linked to differences in their patient populations or to most facility characteristics. Facilities located downstate, designated as teaching hospitals, and having lower average patient acuity

levels, were more likely than other facilities to have higher usage rates of these interventions [See Report p. 23]. Other variables that the Commission studied, including the percentage of patients with concomitant drug/alcohol abuse disorders; the percentage of patients classified as seriously mentally ill; urban/rural location of the facility; age, sex, race, or socio-economic status of the patient population; or size of the facility were generally found to be not significantly associated with the variations in restraint and seclusion usage measures [See Report p. 22].

Treatment practices at psychiatric facilities making low use of restraint and seclusion shared several characteristics, associated with a strong patient–centered treatment orientation.

In contrast with these findings, however, the Commission's more indepth study of 12 psychiatric facilities (seven state psychiatric centers and five psychiatric services of general hospitals) indicated that *treatment philosophy and practices*, as opposed to patient characteristics, may be more determinant of low restraint and seclusion use. These reviews indicated that treatment practices at psychiatric facilities making low use of restraint and seclusion shared several characteristics, associated with a strong patient–centered treatment orientation.

- These low-use facilities were more likely to have administrators who believed strongly that restraint and seclusion use should be minimized and who had instituted a number of specific practices — ranging from increased clinical scrutiny of restraint and seclusion use to more crisis intervention training for their staff to more emphasis on patient–staff interactions — in a direct effort to keep restraint and seclusion use low [See Report p. 28].
- These facilities were more attentive to various practices which afforded patients more personal liberties while they were in the facility — including greater provisions for escorted and unescorted off–unit privileges, privacy when making telephone calls, privacy in visiting, access to a telephone in times of crisis, ability to attend weekly church services, freedom to take showers at unscheduled times [See Report p. 32].
- These facilities were more likely to have ensured at least 50% of their patients at least 20 hours of active therapeutic programming weekly [See Report p. 34].

The low restraint and seclusion use facilities demonstrate a culture oriented towards patient-centered values communicated from the top down, not a random assortment of "reformed" facility practices.

- These facilities were more likely to ensure better patient living conditions — especially in dayrooms and patient bedrooms [See Report p. 33].

Together, these findings indicate that low use of restraint and seclusion appears to be less associated with differences in the needs of the patients served than with differences in

the overall treatment philosophies and practices promoted by the managers and senior clinical staff of psychiatric facilities. The findings further suggest that adoption of key features of the management philosophy, leadership, and daily treatment practices of low use facilities may assist high use psychiatric facilities in lowering their usage of these potentially dangerous interventions.

It is also clear, however, that making these changes is not a simple matter. The low restraint and seclusion use facilities demonstrate a culture oriented towards patient-centered values communicated from the top down, not a random assortment of "reformed" facility practices. These changes cannot be accomplished overnight; nor are they likely to be instituted easily by fiat. They require a reorientation of all facility staff, diligent attention by senior management and clinical staff, and ongoing assistance, training, and support to frontline staff.

Letting psychiatric facilities know where they stand regarding the use of these interventions intended to protect patients from harm, but which can also be potentially and lethally dangerous, is critical to any sound quality assurance program,

This report also reinforces the importance of efforts by the NYS Office of Mental Health in collecting and disseminating restraint and seclusion usage data from its state–operated and – licensed inpatient psychiatric facilities. Letting psychiatric facilities know where they stand regarding the use of these interventions intended to protect patients from harm, but which can also be potentially and lethally dangerous, is critical to any sound quality assurance program. In the past year, the Commission has published these facility usage rates in its newsletter, and it is apparent that facilities have generally been attentive to these reports. Notably, three of the highest user facilities have recently attempted reforms to reduce their restraint and seclusion use.

But if patients' clinical characteristics don't explain the wide variations in practice, it seems reasonable to conclude that, despite the legal prohibitions, factors unrelated to patients' needs are driving the use of restraint and seclusion in many cases.

The wide variations in practice in using these highly restrictive forms of intervention, which expose both patients and staff to the risk of injury, also call into question the broad latitude of judgment entrusted to psychiatric facilities. The Mental Hygiene Law and OMH regulation and policies state that these interventions should not be used as punishment, for the convenience of staff, or as a substitute for programs. But if patients' clinical characteristics don't explain the wide variations in practice, it seems reasonable to conclude that, despite the legal prohibitions, factors unrelated to patients' needs are driving the use of restraint and seclusion in many cases.

Thus, while there is ample room for self-improvement in psychiatric facilities in reducing the unnecessary use of restraint and seclusion, there is also a need to reexamine the framework of laws, regulations and poli-

cies that have permitted such broad discretion. The Commission plans to assist in that process of reexamination in a third report, *Governance of Restraint and Seclusion Practices*, to be issued in the fall of 1994, which will examine the adequacy of New York State law, regulation, and policy in governing the use of these interventions in psychiatric facilities.

The Office of Mental Health reviewed a draft of this report, and it responded that the agency would be taking steps to reduce the use of restraints and seclusion at state psychiatric centers with high usage rates (Appendix B). The Office noted, however, that its monitoring of state-licensed psychiatric facilities' restraint and seclusion use would be limited due to resource constraints. In its response the Office of Mental Health also shared with the Commission its own recommendations related to restraint and seclusion use.

The Commission responded to the Office of Mental Health (August 10, 1994) restating its recommendation for systemic, on-going monitoring of restraint and seclusion use at state-licensed psychiatric facilities', emphasizing the significant role of these facilities in providing approximately 75% of all inpatient psychiatric care in the state. While supporting many of the recommendations in the Office of Mental Health's Task Force report, the Commission also raised objections to three recommendations, including the reversal of New York's long-standing prohibition of the use of seclusion with individuals who are mentally retarded and the introduction of two new restraining devices (the blanket restraint and PADS, arm to wrist restraints). The Commission's letter to the Office of Mental Health is included in Appendix C.

Clarence J. Sundram, Chairman

Elizabeth W. Stack, Commissioner

William P. Benjamin, Commissioner

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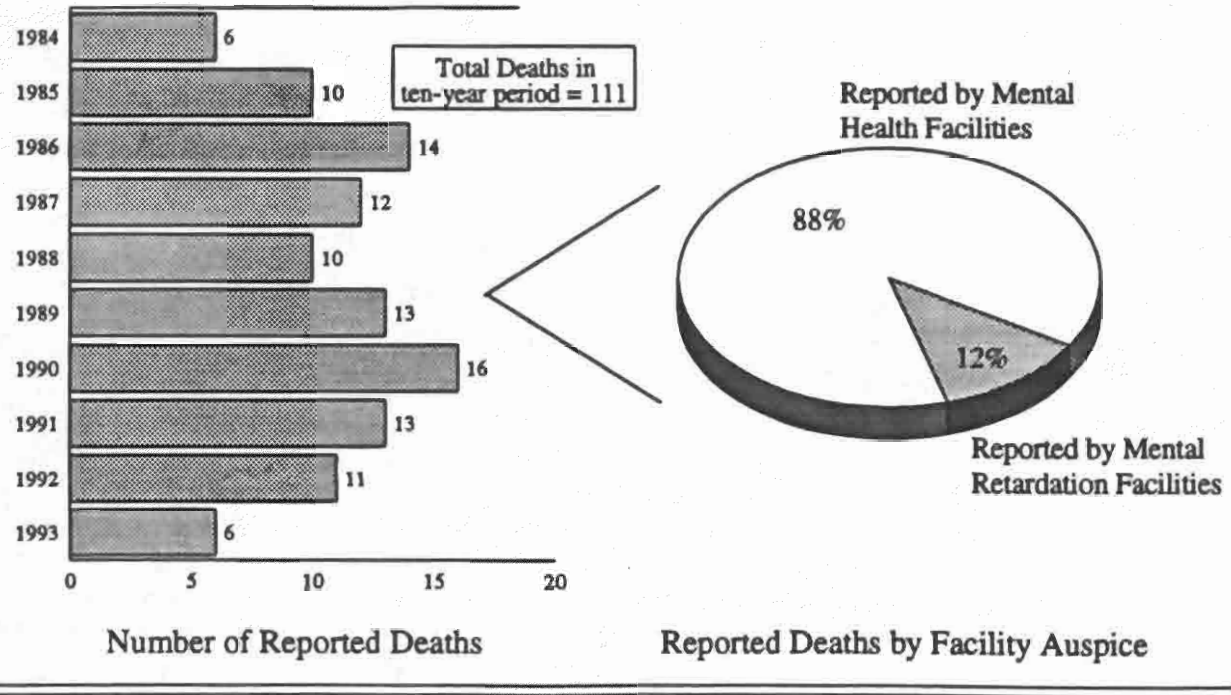
Chapter I
Introduction

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 psychiatric facilities.

Investigation of restraint- and seclusion-related deaths has been an ongoing priority of the Commission's Mental Hygiene Medical Review Board, and in total, over the ten-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 investigations conducted by the Commission into complaints from patients and allegations of abuse, have reinforced the need for all treatment facilities using restraint and seclusion to do so with extreme caution and diligent quality assurance review.

Although patient deaths directly related to restraint and seclusion have been relatively infrequent, each year the Commission has investigated cases involving preventable injuries and deaths, and has identified problems and defi-

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



ciencies which have contributed to their occurrence.[1] These problems and deficiencies have included:

- the unnecessary use and misuse of restraint and seclusion without adequate efforts to calm the patient or resolve the problem using less restrictive interventions;
- use of restraint and seclusion by staff who had not been adequately trained, and who thereby misused techniques and sometimes used excessive force, 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 requirements governing the use of restraint and seclusion, which often left patients' comfort and safety seriously 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 that are 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 cardiopulmonary resuscitation.

Figure 2
Review Methods

- ✓ Review of the restraint and seclusion literature.
- ✓ Analysis of NYS law, regulations, and policies governing restraint and seclusion.
- ✓ Restraint and seclusion usage rates of NYS psychiatric facilities were calculated and analyzed.
- ✓ Review of NYS psychiatric facilities' internal restraint and seclusion policies.
- ✓ On-site visits to 12 NYS psychiatric facilities.
- ✓ Survey of individuals restrained or secluded in NYS psychiatric facilities.

Methods of the Review

Based on its experience reviewing the use of restraint and seclusion in psychiatric treatment 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 (Figure 2).

Five research activities were designed:

(1) The professional literature on restraint and seclusion use was reviewed.

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[1] NYS Commission on Quality of Care, *Christopher Dugan - A Patient at South Beach Psychiatric Center,* January 1985; *Mia Martine - A Patient at Mid-Hudson Psychiatric Center,* December 1982; *Pedro Montez - A Patient at Manhattan Psychiatric Center,* December 1982; *Alex Zolla - A Patient at South Beach Psychiatric Center,* May 1982; *Janice Sherman - A Patient at South Beach Psychiatric Center,* February 1982; *Fred Zimmer - A Patient at Kingsboro Psychiatric Center,* June 1981; *Alphonse Rio - A Patient at South Beach Psychiatric Center,* March 1981; *Peter Breen - A Patient at St. Lawrence Psychiatric Center,* February 1981; *Allen S. - A Patient at Manhattan Psychiatric Center,* November 1979.

(2) State law and regulations governing restraint and seclusion use, as well as the formal written policies related to restraint and seclusion of state-operated adult psychiatric centers and all general hospitals with certified inpatient psychiatric units were reviewed.

(3) Via a mail survey, restraint and seclusion usage data from state-operated adult psychiatric centers and general hospitals with certified inpatient psychiatric units in New York State were collected and analyzed.

(4) Formal site visits were conducted at 12 inpatient psychiatric facilities, including 5 facilities classified as low users of restraint and seclusion and 7 facilities classified as moderate/high users of restraint and seclusion.

(5) A mail survey of individuals who had formerly received inpatient psychiatric treatment in New York was conducted to obtain a patient perspective on the use of restraint and seclusion, as well as their overall inpatient psychiatric treatment.

Major Policy Questions

Through the above research activities, the Commission sought answers to several basic questions regarding the use of restraint and seclusion in inpatient psychiatric settings:

(1) *What advice does the literature and research on the use of restraint and seclusion offer regarding the appropriate and therapeutic use of these interventions among adults in inpatient psychiatric treatment facilities?*

(2) What is current practice among New York's state-operated and -licensed inpatient psychiatric settings related to the frequency of restraint and seclusion use?

(3) Are there readily identifiable factors pertaining to facility characteristics, formal policies, the patient populations served, or other treatment practices, which are associated with variations in psychiatric treatment settings' use of restraint and seclusion?

(4) Do current laws, regulations, and policies adequately protect patients in psychiatric facilities by ensuring the safe and appropriate use of restraint and seclusion? And, if not, what specific changes should be made?

(5) What do individuals who have been treated in inpatient psychiatric treatment settings in New York have to say regarding the use of restraints and seclusion? How do patients' perspectives appear similar to or different from the perspectives of clinicians on the use of restraint and seclusion?

Organization of the Report

This initial report, *Restraint and Seclusion Practices in NYS Psychiatric Facilities* (September 1994), summarizes the Commission's findings related to the first three of the above research activities. This report describes the restraint and seclusion usage rates of New York's 25 state-operated psychiatric centers and its state-licensed psychiatric services in 103 general hospitals. Casting these findings against the backdrop of prior published research and also against the Commission's own analyses, this report also seeks explanations for the widely variant usage rates which were found.

Two other reports complete the Commission's reporting on its examination of restraint and seclusion practices in New York's psychiatric facilities. *Voices From the Front Line: Patients' Perspectives 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.

A third report, *Governance of Restraint and Seclusion Practices by NYS Law, Regulations, and Policy,* which will examine the governance of restraint and seclusion practices in New York's psychiatric facilities, will be issued later this year. The dedication of an entire report to this issue reflects the Commission's belief that existing statutory, regulatory, and state policy mandates governing restraint and seclusion use are inconsistent and inadequate and that 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.

Chapter II
Review of the Literature

Published works on the use of restraint and seclusion in psychiatric treatment settings are plentiful. This research, summarized in a recent report by the NYS Office of Mental Health (*Report on the Task Force on Restraint and Seclusion*, NYS Office of Mental Health, Appendixes III, IV, V, March 1993), has examined the use of these interventions from multiple perspectives.

Therapeutic Benefits

Much research has focused on the therapeutic benefits of the use of restraint and seclusion, with authors asserting various points of view ranging from strongly advocating the benefits of the interventions in preventing injury, reducing sensory stimulation, maintaining the ward milieu, and conserving staff resources (Gutheil, 1978; Fitzgerald and Long, 1973; Cotton, 1989) to advising cautious use of the interventions, noting that they have few therapeutic benefits and that they may, in fact, contribute to psychiatric problems of the patients (Pilette, 1978; Guirguis, 1978; Chamberlin, 1985; Hammill, et al., 1989; Monroe, et al. 1988; Outlaw and Lowery, 1992) (Figure 3).

At least three divergent points of view emerge on the therapeutic benefits/disadvantages of restraint and seclusion. One school of thought, represented in the works of Telintelo and his colleagues (1983), advocates for the use of restraint and seclusion as an "early intervention," suggesting that these interventions have a calming effect upon some patients, help to teach "internal controls," and generally provide a positive adjunct to a therapeutic treatment regime. Consistent with this permissive perspective on the use of restraint and seclusion, others have suggested that protection of the ward atmosphere and/or patient request are legitimate reasons for employing restraint and seclusion (Fassler and Cotton, 1992; Rosen, 1978; Tardiff and Mattson, 1984; Whaley and Ramirez, 1980, Liberman and Wong, 1984).

Figure 3
Three Schools of Thought on Restraint and Seclusion

- As early intervention strategies to:
  - reduce sensory stimulation
  - teach internal controls
  - protect property & treatment milieu
  - conserve staff resources
  - respond to patient requests
- As a "last resort" intervention to:
  - prevent patients from harming themselves or others
  - prevent patients from destroying property
- As intrinsically harmful to patients and nontherapeutic interventions:
  - advisable only in the most dangerous situations
  - signal "treatment failure"
  - require diligent clinical review

The second more popularly expressed point of view is that restraint and seclusion are necessary, last resort interventions in an inpatient psychiatric treatment setting to prevent patients from harming themselves or others or from destroying property. Advocates of this point of view (Outlaw and Lowery, 1992), while not suggesting that restraint and seclusion have intrinsic positive benefits, acknowledge that their use is sometimes imperative to prevent negative consequences of the patients' behavior that cannot be treated with other means. This is also the perspective which has been adopted by New York State and which has been codified in New York law and regulations governing the use of restraint and seclusion by state-operated and -licensed psychiatric facilities (NYS Mental Hygiene Law §33.04 and 14 NYCRR 27.1, 27.2, 27.7).

A third perspective is that the use of restraint and seclusion may be intrinsically *harmful* to patients, that these interventions should be considered *nontherapeutic*, and that their use should be avoided in all but the most threatening and dangerous situations. Proponents of this school of thought (Irwin, 1987; Pilette, 1978; Guirguis, 1978) usually advocate that psychiatric treatment units not be constructed with the availability of seclusion rooms and that every incident of restraint use be carefully reviewed, with specific attention to the patient's treatment plan, as the use of restraint is viewed as *indicative of treatment failure.*

An emerging body of literature has also focused on the therapeutic contraindications of restraint and seclusion use for certain vulnerable populations, including persons with compromised physical health (American Psychiatric Association, 1985; Tardiff, 1992), children (Kalogjera, 1989; Antoinette, et al., 1990; Susselman, 1973), and the elderly (Burger, 1993; Covert, et al., 1977; Blakeslee, et al., 1990; Evans, et al., 1991). These authors make various arguments that use of restraint and seclusion can be especially dangerous to the physical and/or emotional well-being of these patient groups. They advocate that the use of these interventions with these vulnerable populations be very restricted, diligently monitored and reviewed, and governed by strict practice guidelines.

Usage Rates for Restraint and Seclusion

Several researchers have also targeted their examinations to measuring the frequency of use of restraint and seclusion across different treatment settings (Angold, 1989; Okin, 1985; Phillips and Nasr, 1983; Soloff, et al., 1985; Way, 1986; Way and Banks, 1990). Without exception, these researchers have found that usage rates have varied widely and unpredictably across treatment facilities and often among treatment units within the same facility (Figure 4). The NYS Office of Mental Health's (1994) recently prepared summary of the literature identifies rates of restraint and seclusion use from .4% to 66% of the patients served across the various studies reviewed.

The Way and Banks study (1990) is particularly relevant to this report as the authors reported on February 1984 restraint and seclusion usage among 24 New York State psychiatric centers, including 22 nonforensic centers and 2 forensic centers.[2] The study found widely variant monthly rates among the nonforensic centers studied (3 to 213 "occurrences" per 100 patients), and an average usage rate of 9.5 occurrences per 100 patients. Subsequent follow-up data collected by the NYS Office of Mental Health in June 1992 revealed that although the census at the centers had decreased by approximately 43% in the interim eight years, the number of orders for restraint and seclusion had

[2] At the time the Way and Banks study was conducted (1984), New York had only 24 state psychiatric centers, as the state's third forensic center (Kirby Psychiatric Center) had not yet opened.

Figure 4
General Observations of Studies of Restraint and Seclusion Use

- Restraint and seclusion use varies dramatically among psychiatric facilities.
- ***Variations in restraint and seclusion use among psychiatric facilities cannot be readily explained.***
- Patients' characteristics are not reliable predictors of restraint and seclusion use.
- Facility characteristics are not reliable predictors of restraint and seclusion use.
- Time of day and day of week are not reliable predictors of restraint and seclusion use.
- No or low seclusion use is not a reliable predictor of restraint use (or vice versa).
- Low restraint or seclusion use is not consistently associated with greater use of medications.

remained virtually unchanged, resulting in an 80% increase in usage rates of the interventions. (*Report of the Task Force for Restraint and Seclusion*, NYS Office of Mental Health, 1994).

In general, however, comparative review of research studies on usage rates of restraint and seclusion is compromised by methodological issues, including the small samples of hospitals/units that are being studied and the different approaches in calculating usage rates (Gutheil, 1984; NYS Office of Mental Health, 1993).[3] Whereas the small sample sizes in all but a handful of studies (Carpenter, et al., 1988(b); Guirguis and Durost, 1978; Okin, 1985; Tardiff, 1981; Thompson, 1986; Way, 1986; Way and Banks, 1990) limit the validity of comparing usage rates within studies, the different methods employed by researchers in calculating restraint and seclusion rates yield very different usage rates, and comparing rates across studies based on different calculations is much like comparing apples and oranges.

It is significant, however, that most published studies which have examined usage rates of restraint and seclusion across more than five treatment settings or facilities have generally concluded that usage cannot be clearly associated with specific patient characteristics or needs (Okin, 1985; Way and Banks, 1990). The mixed findings of other studies, limited to a smaller number of treatment settings, also suggest that usage of restraint and seclusion may be largely independent of the treatment needs and characteristics of the patients.

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[3] Researchers in the field have calculated rates using various numerators (e.g., patients involved, episodes of the intervention, physician orders) and denominators (e.g., average census, patients served, patient days, etc.). The choice of numerator is particularly significant as alternate choices measure fundamentally different aspects of usage. Use of "patients involved," for example, relates the prevalence of use among the patient population served, while use of episodes and orders measures the frequency and duration of use of the interventions in the particular treatment setting. Similarly, various denominators can alter rates significantly, especially in studies over a relatively long period of time, which include treatment settings with varying average lengths of stay. Conversely, when study intervals are kept short (less than 30 days), choice of denominator makes less of a difference.

Who is Restrained and Secluded?

Many researchers have also studied patients who have been restrained or secluded attempting to discern demographic and clinical characteristics which distinguish these patients from the majority of patients who are not restrained or secluded. Despite their number, however, these studies have yielded few consistent findings suggesting that any particular demographic or clinical patient characteristic is significantly associated with either restraint or seclusion use.

In studies, race, age, sex, socioeconomic class, diagnoses, length of stay, and different aspects of a patient's psychiatric or behavioral history have been shown to be both significantly and nonsignificantly associated with restraint and seclusion use (Binder, 1979; Bond, et al., 1988; Carpenter, et al., 1988(a); Flaherty and Meagher, 1980; Lawson, et al., 1984; Oldham, et al., 1983; Okin, 1985; Plutchik and Karasu, 1978; Philips and Nasr, 1983; Ramachandani, et al., 1988; Shuger and Rehaluk, 1990; Soloff and Turner, 1981; Tardiff, 1981; Thompson, 1986; Way and Banks, 1990). Similarly, the relatively fewer published studies which have examined the impact of certain characteristics of inpatient unit or the time of the incident, including average length of stay, size of the unit, high or low census, shift, and day of the week, have not demonstrated consistent findings (Binder, 1979; Gerlock and Solomons, 1983; Tardiff, 1981; Thompson, 1986; Way, 1986; Way and Banks, 1990).

Influence of Statutory, Regulatory, and Policy Mandates

Another smaller body of literature has sought to examine what happens to hospital practices when restraint or seclusion use is prohibited and, specifically, whether the prohibition of one intervention encourages increased use of the other intervention or of chemical restraints (Antoinette, et al., 1990; Miller, et al., 1989; Sloane, et al., 1991; Tsemberis and Sullivan, 1988). Again, the research findings are inconclusive, and it appears that the impact of such prohibitions are largely idiosyncratic to the hospital affected and other policy and value orientations that have transpired in the same interval.

At the same time, however, 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; Kalogjera, et al., 1989; Davidson, et al., 1984; Erickson and Realmuto, 1983). 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., 1988).

Clinical Practice Guidelines

There is also an emerging body of literature, especially in the past two decades, which focuses on guidelines for the appropriate use of restraint and seclusion (American Psychiatric Association, 1985; Bursten, 1975; Daar and Nelson, 1992; Halleck, 1974; Chu and Ryan, 1987; Mitchell and Varley, 1990; Roper, et al., 1985; Tardiff and Mattson, 1984). These various sets of guidelines tend to share some central principles, including 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 (Figure 5).

Most published guidelines also assert that restraint and seclusion are very restrictive inter-

Figure 5
Clinical Standards for Restraint and Seclusion Use

Commonly Accepted	*Debated*
✓ May be used only when there is a risk of harm to the patient or others.	? Length of restraint/seclusion orders.
✓ May **not** be used as punishment or for staff convenience.	? Types of mechanical restraints to be used.
✓ May be used only after less restrictive interventions have been tried and failed.	? Timeliness of physician exams.
✓ Orders must be signed by a physician.	? Safety features of seclusion rooms.
	? Frequency of patient breaks for bathroom use or exercise.
	? Required staff training.

ventions that should be used only when there is a risk of harm to the patient or others and only after other less restrictive interventions have been attempted. Notably, principles for the limited use of restraint and seclusion, only after less restrictive interventions have been attempted, have also been articulated and reaffirmed by federal and state courts in various court orders and consent decrees in class actions on behalf of institutionalized persons. (Wyatt v. Stickney, 344 F. Supp. 387 [(M. D. Ala. 1972)]; New York State Association for Retarded Children, Inc. v. Carey, 393 F. Supp. 715 [(E. D. N.Y. 1975)]; Youngberg v. Romeo, 457 U. S. 307 [(1982)]. Most states now also have state laws governing at a minimum the limited justifications for the use of restraint and/or seclusion (Brakel, et al., 1985).

Despite the consistency of federal and state guidelines on these basic principles guiding the use of restraint and seclusion, various states' regulations and policies, as well as clinical experts' suggestions for policy mandates, differ in many other respects (Naumann, et al., 1983). 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 (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

In short, despite its volume, the published literature on the use of restraint and seclusion leaves many unanswered questions and even more equivocally answered questions. Even on the most fundamental issues, including the "indications" for restraint and seclusion use, the patient populations which are most likely to benefit from the interventions, and the appropriate safeguards which facilities should ensure to protect patients from the inappropriate, punitive use of the interventions, there remains considerable debate among clinical experts.

Additionally, largely absent from the published research are reports which have posited reliable explanations for the dramatic variations in reported restraint and seclusion usage rates across hospitals or reports which have examined how more or less frequent restraint and/or seclusion use affects patient outcomes (Moss and LaPuma, 1991; Crespi, 1990). Simultaneously, the implication of much of the research that has been done is that: (1) hospital usage rates tend to be unrelated to their patient population characteristics; and (2) these rates can be easily influenced by specific administrative and programmatic changes affecting a hospital.

Reflective of the inconclusive clinical research, civil rights and mental health advocates have looked chiefly to federal and state courts, state legislatures, and executive state agencies to take the lead in developing guidelines for the use of restraint and seclusion in psychiatric treatment facilities. Yet, these government agents have generally been cautious in treading in this arena, and have continued to allow broad discretion to hospital staff regarding the use of these interventions. As a result, there continues to be wide and unexplained variations in the use of restraint and seclusion.

Chapter III
Restraint and Seclusion Usage Rates

A research priority of the Commission's study was to provide a profile of restraint and seclusion use across New York State's two main classes of inpatient psychiatric settings, state-operated psychiatric centers and inpatient psychiatric services of general hospitals. Although the NYS Office of Mental Health had conducted periodic reviews of restraint and seclusion usage among state psychiatric centers, and since mid-1992 has begun to collect these data monthly from state centers, no similar surveys had ever been compiled for psychiatric services of general hospitals. Thus, although general hospitals in recent years have far surpassed state psychiatric centers in the number of psychiatric patients served annually (approximately 75,000 versus 23,000 patients), prior to the Commission's study, little was known about restraint and seclusion usage on their inpatient psychiatric services.

Data Collection

Mail surveys were sent to directors of all 25 adult state psychiatric centers (including the three forensic state psychiatric centers) and all 105 general hospitals with certified psychiatric units in New York State. The surveys requested self-reported data on restraint and seclusion use among adult psychiatric inpatients by the number of restraint and seclusion orders and the number of unique individuals restrained or secluded for September 1992. Facilities were also asked to report other data on the total number of psychiatric patients served during the month, average psychiatric patient census for the month, and number of certified adult psychiatric beds.

All facilities responded to the Commission's mail survey. One community hospital, however, reported in its response that it did not maintain data on restraint and seclusion usage, and one other community hospital submitted data which had apparent internal inconsistencies which it could not correct. Thus, restraint and seclusion data were obtained from all 25 state-operated adult psychiatric centers and 103 of the 105 general hospitals with licensed inpatient psychiatric units.

Throughout the reporting of restraint and seclusion usage rates, data for nonforensic state psychiatric centers, forensic state psychiatric centers, and psychiatric services of general hospitals are treated separately to reflect their distinct roles in New York's psychiatric service system. Psychiatric services of general hospitals, in accordance with state policy, are responsible largely for the provision of short-term (less than 60 days) acute psychiatric care, while state psychiatric centers are responsible for intermediate and long-term psychiatric care for individuals who, after an acute care stay in a general hospital continue to need ongoing inpatient psychiatric care.

State-operated *forensic* psychiatric centers, in contrast, may provide both acute, intermediate, and long-term psychiatric care for individuals who have been charged or convicted of a crime and determined to need psychiatric treatment. One of the state's three forensic centers, Mid-Hudson Psychiatric Center, also serves some patients who are transferred to the forensic setting from other state psychiatric centers due to their especially dangerous and assaultive behaviors.

Restraint and Seclusion Usage Measures

Four usage measures, two related to restraint use and two related to seclusion use, were calculated for each facility:

(1) the percentage of patients served in September 1992 who were restrained;

(2) the rate of restraint use, as defined by total restraint orders to average patient census in September 1992;

(3) the percentage of patients served in September 1992 who were secluded; and

(4) the rate of seclusion use, as defined by total seclusion orders to average patient census in September 1992.[4]

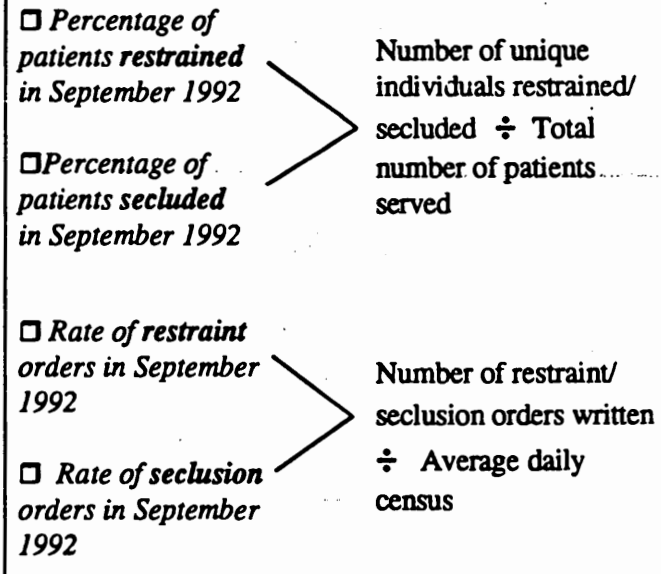
Each of the usage measures presented a different perspective on restraint and seclusion use (Figure 6). The two measures representing the percentage of patients served who were restrained or secluded provided patient-centered measures which reflected the chances that patients served by a hospital or center would be subjected to either one of the interventions. The two rate measures relating the total orders for restraint and seclusion to the facility average monthly census provided an indication of the frequency of use of the interventions by the facility, irrespective of the number of unique patients who actually experienced them.

Limitations of the Data Analysis

When surveys were returned, they were reviewed, and follow-up requests were made to facilities to clarify omissions and apparent errors in the data. In the course of this review, data yielding outlier usage measures were especially carefully checked with the reporting facilities. Notwithstanding these efforts, however, it should be emphasized that restraint and seclusion usage data were self-reported by the facilities, and the Commission did not authenticate the data through a review of primary records.

Also of importance, facilities were asked *not to report* in their restraint data incidents involving medical supports (as defined by the Joint Commission on the Accreditation of Hospitals) as differentiated from mechanical restraints (*1993 Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services*, JCAHO,

Figure 6
Restraint and Seclusion Usage Measures



[4] Consideration was also given to other rate measures, as defined by total number of restraint or seclusion orders to total patients served and total certified beds, but further analysis of these rates indicated that they were so significantly and highly correlated ($r = .9984, -.9348, p < .001$) to the other rate measures (orders to average patient census) that they would add little to the interpretation of the raw data.

p.173). Although most general hospitals and state centers were familiar with this definition of medical supports, some hospitals and state centers had apparently used a more liberal definition of medical supports for some time, and may not, therefore, have fully included all incidents of mechanical restraints with the elderly in their data. In particular, one state psychiatric center with a large elderly population (Central Islip Psychiatric Center) reported using medical supports with approximately 33% of its patients, but no use of mechanical restraints.

Seclusion Usage Rates

The most outstanding data finding across all four calculated usage measures for seclusion and restraint was the dramatic variation in these measures among both the general hospitals and the state psychiatric centers studied (Figure 7). The most dramatic variation was seen in seclusion use measures. Many of the facilities surveyed reported no use of this intervention in September 1992, while a small minority reported high use.

☐ Percentage of Patients Secluded

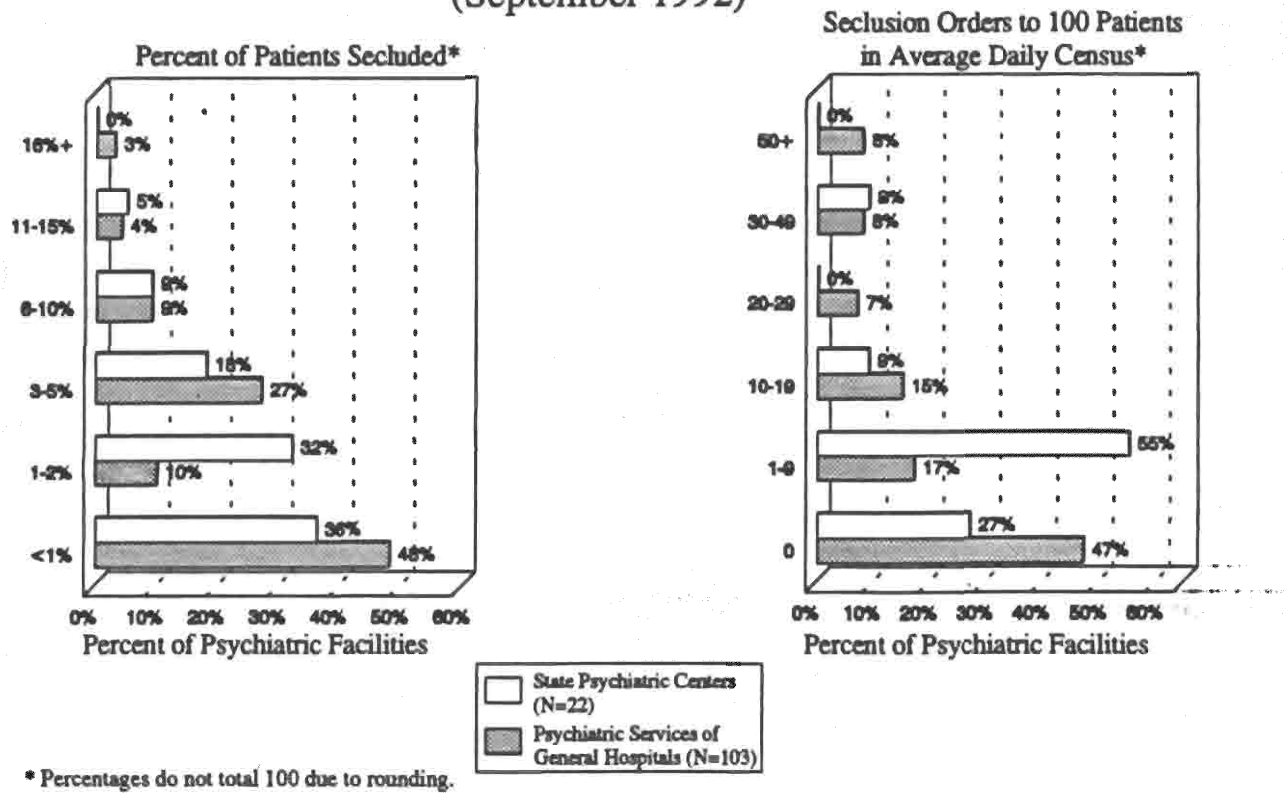
As shown in Figure 8, at 48% of the general hospitals and 36% of the state psychiatric centers, fewer than 1% of the patients served were secluded in September 1992. At another 37% of the general hospitals and 50% of the nonforensic state psychiatric centers, between 1% and 5% of

Figure 7
Distribution of Restraint and Seclusion Usage Measures for New York Psychiatric Facilities
(September 1992)

Nonforensic State Psychiatric Centers (N = 22)	Mean	Median	Standard Deviation	Range
Percent Patients Secluded	3%	1%	3%	0-13%
Seclusion Orders Per 100 Patients in Average Daily Census	6	2	10	0-35
Percent Patients Restrained	4%	2%	5%	0-24%
Restraint Orders Per 100 Patients in Average Daily Census	10	8.5	9	0-36

Psychiatric Services of General Hospitals (N = 103)	Mean	Median	Standard Deviation	Range
Percent Patients Secluded	3%	1%	5%	0-23%
Seclusion Orders Per 100 Patients in Average Daily Census	12	4	19	0-88
Percent Patients Restrained	5%	3%	6%	0-40%
Restraint Orders Per 100 Patients in Average Daily Census	30	10	57	0-336

Figure 8: Seclusion Usage by New York Psychiatric Facilities (September 1992)



* Percentages do not total 100 due to rounding.

the psychiatric patients served in September 1992 were secluded.

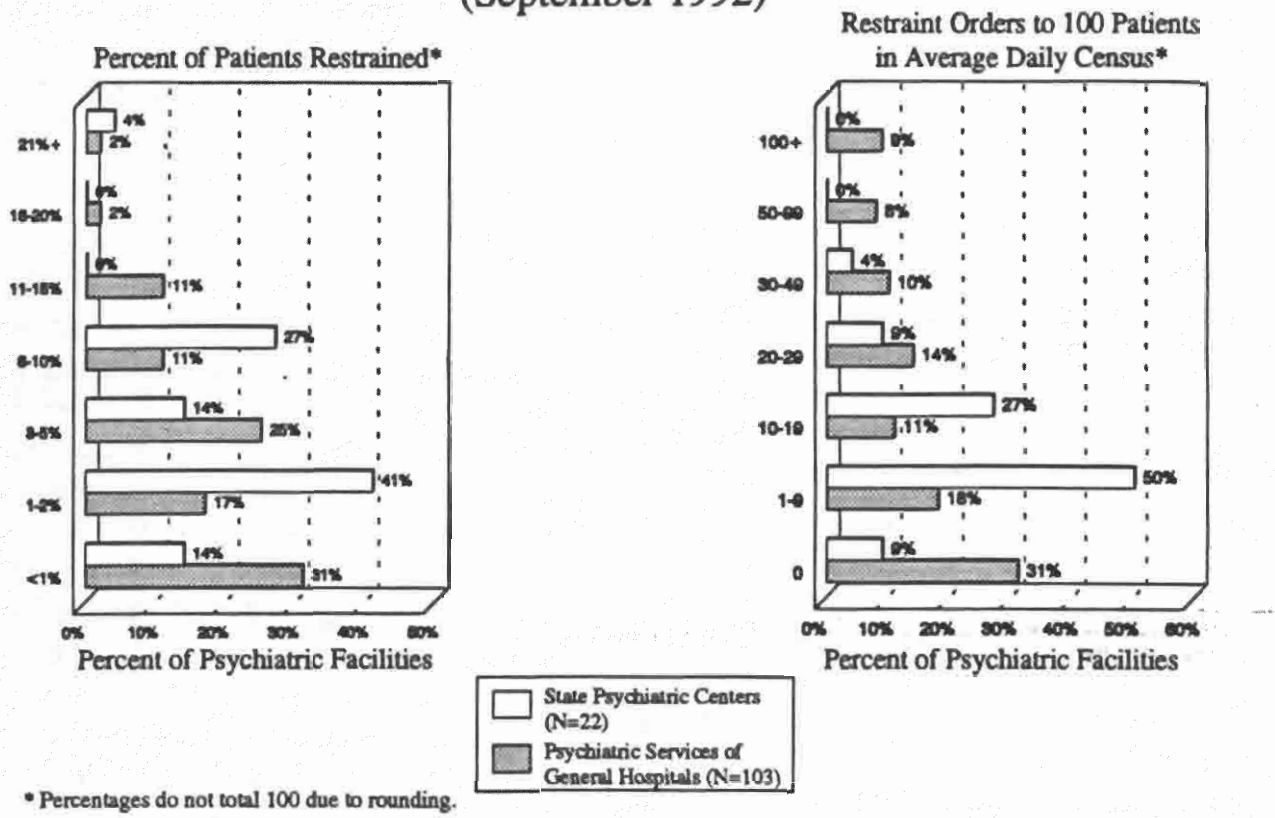
Eight reporting facilities, including one nonforensic state psychiatric center (5%) and seven general hospitals (7%), were outliers in their more common use of seclusion. At each of these facilities more than 10% of the patients served in September 1992 were secluded.

☐ Seclusion Order Rates

Similarly, the data indicated that 47% of the general hospitals and 27% of the nonforensic state psychiatric centers had ***no orders*** for seclusion for September 1992. An additional 17% of the general hospitals and 55% of the nonforensic state psychiatric centers reported fewer than 10 seclusion orders per 100 patients in their average daily census for September 1992.

Relatively higher rates of seclusion use of 20 or more orders per 100 patients in the average daily census were limited to approximately one-fifth of the general hospitals (22%) and 9% of the nonforensic state psychiatric centers. Within this subgroup of facilities, 16 general hospitals (16%) and 2 nonforensic state psychiatric centers (9%) had seclusion use rates of 30 or more orders per 100 patients in the average daily census for September 1992. Of note, 8 general hospitals had seclusion rates of 50 or more orders per 100 patients in the average daily census for September 1992.

Figure 9: Restraint Usage by New York Psychiatric Facilities
(September 1992)



* Percentages do not total 100 due to rounding.

☐ Seclusion Use by Forensic Psychiatric Centers

Seclusion usage by the forensic state psychiatric centers was variable (See Figure 10, pg. 17). One of these three centers, Central New York Psychiatric Center, made no use of seclusion in September 1992, and as a matter of policy, this facility reported that it does not use seclusion. One of the other two centers, Kirby Psychiatric Center, on the other hand, reported the highest usage of seclusion among all the state psychiatric centers (18% of patients served in the one-month study period secluded and 57 seclusion orders per 100 patients in the average census). The third center, Mid-Hudson Psychiatric Center, also had a relatively high rate of seclusion orders of 25 per 100 patients in the average census, but it reported a relatively low percentage (3%) of patients subjected to seclusion in the one-month study period.

Restraint Usage

The data suggested that a psychiatric patient's chances of being mechanically restrained during his or her inpatient stay at either a community hospital or state psychiatric center were considerably greater than his or her chances of being secluded.

☐ Percentage of Patients Restrained

Statewide, only 31% of the general hospitals and only 14% of the nonforensic state psychiatric centers reported that fewer than 1% of their patients were restrained during September 1992 (Figure 9).

Forty-four (44) percent of the general hospitals and 55% of the nonforensic state psychiatric centers reported that they had restrained between 1% and 5% of their patients in September 1992. A much smaller percentage of the general hospitals surveyed (15%) and nonforensic state psychiatric centers (5%) reported that they had restrained more than 10% of the patients served in September 1992.

On the highest end, two general hospitals and one state psychiatric center, however, reported that over 20% of the patients served in September 1992 had been restrained. At each of these three facilities, use of posey/waist restraints (not reported as medical supports) with elderly psychiatric patients accounted for at least 50% of the patients restrained.

☐ Restraint Order Rates

One-third of the general hospitals (31%) and nine (9) percent of nonforensic state psychiatric centers reported no orders of restraint for September 1992.[5] Further analysis clarified that, general hospitals which did use restraint were likely to use it more often than nonforensic state psychiatric centers. Fifty-five percent of the nonforensic state centers which used restraints reported low order rates of fewer than 10 restraint orders per 100 patients in their average census. In contrast, only 27% of the general hospitals which used restraints reported fewer than 10 restraint orders per 100 patients in their average census. Many more general hospitals also had relatively high restraint order rates. Forty (40%) percent of the general hospitals versus only 14% of the nonforensic state psychiatric centers reported 20 or more restraint orders per 100 patients in their average census. Additionally, while there were no nonforensic state psychiatric centers with rates of 40 or more orders per 100 patients in their average census, but 20% of the general hospitals met or exceeded this benchmark. Nine general hospitals (9%) reported 100 or more restraint orders per 100 patients in their average census for September 1992.

☐ Restraint Use by Forensic Psychiatric Centers

All three forensic state psychiatric centers were frequent users of restraint. The percentage of patients served who were restrained during the one-month study period at these centers ranged from 17% at Kirby Psychiatric Center, to 19% at Mid-Hudson Psychiatric Center, to 28% at Central New York Psychiatric Center. Rates of restraint orders were especially high at these three centers, ranging from 74 orders per 100 patients in the average census at Central New York, to 313 orders per 100 patients in the average census at Kirby, to 349 orders per 100 patients in the average census at Mid-Hudson. (The highest restraint order rate among the 22 nonforensic psychiatric centers was 36 orders to 100 patients.)

It was also interesting that while Central New York Psychiatric Center, the one forensic center which made no use of seclusion, did tend to restrain a greater percentage of its patients, its restraint order rate was more than four times *lower* than the restraint order rates of the other two forensic centers which also used seclusion (Figure 10). It appeared that while the policy mandate forbidding seclusion use at this facility may have influenced the use of restraint with more of its patients, it may have also simulta-

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[5] One of the two state psychiatric centers reporting no restraint orders for September 1992 did, however, report an unusually high order rate (35 per 100 patients in the average census) for posey/waist and geri-chair "medical supports" used with its predominantly elderly psychiatric population.

Figure 10
Restraint and Seclusion Usage by Forensic State Psychiatric Centers (September 1992)

Center	Percentage of Patients Restrained	Percentage of Patients Secluded	Rate of Restraint Orders*	Rate of Seclusion Orders*
Central NY Psychiatric Center	28%	0%	74	0
Mid-Hudson Psychiatric Center	19%	3%	349	25
Kirby Forensic Psychiatric	17%	18%	313	57
Average for nonforensic state centers	4%	3%	10	6

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

neously encouraged generally more conservative decision-making by physicians in writing restraint orders.

Relationship Among the Usage Measures

Further analysis indicated that facilities with lower order rates for restraint and seclusion also tended to use these interventions with fewer of their patients. Conversely, facilities with higher order rates for restraint or seclusion tended to use these interventions with more of their patients (Figure 11). This finding was contrary to early reports from many "high user" facility administrators who attributed their facility's higher use of restraint and seclusion to a small number of very difficult patients.

Analyses also showed that use of restraints was not significantly correlated with the use of seclusion. The percentage of patients secluded was neither positively nor negatively associated with the percent of patients restrained. Nor were the order rates for seclusion associated with the order rates for restraint

Further analysis revealed that despite their unique service system roles in providing acute versus intermediate and long-term care, psychiatric services of general hospitals did not differ significantly from state nonforensic psychiatric centers in the average percentage of the patients served who were restrained ($\bar{X}$ = 5% versus 4%) or in the average percentage of patients served who were secluded ($\bar{X}$ = 3% at both types of facilities) (Figure 12). On the other hand, general hospitals did *differ significantly* from nonforensic state psychiatric centers in their higher rates of restraint orders and seclusion orders.[6] The analyses found that the mean rate of restraint orders and the mean rate of seclusion

[6] Rate of restraint: $t = 3.36$, $df = 120.39$, $p < .01$; Rate of seclusion: $t = 2.11$, $df = 59.83$, $p < .05$.

orders of general hospitals ($\bar{X}$ = .30 and .12, respectively) were at least twice the mean rates of nonforensic state psychiatric centers ($\bar{X}$ =.10 and .06, respectively).

Summary

In summary, the Commission found dramatic variations in restraint and seclusion use among NYS psychiatric facilities (Figure 13). Twenty (20) of the 125 facilities (16%) reported no use of restraint or seclusion during the one-month study period. In contrast, 39 of the 125 facilities reported combined monthly restraint and seclusion order rates of 40 or more orders per every 100 patients in their average daily census, including 11 facilities with combined order rates of 100 or more orders per every 100 patients.

Similarly, at nonforensic state psychiatric centers, the percentage of patients served monthly subjected to restraint and to seclusion ranged from 0% to 24% restrained, and from 0% to 13% secluded. For psychiatric services of general hospitals, the range in the percentage of patients served subjected to restraint and to seclusion was even greater: 0% to 40% restrained, and 0% to 23% secluded.

Forensic state psychiatric centers had the highest usage rates for these interventions among

Figure 11
Correlations Among Restraint and Seclusion Usage Measures for NYS Psychiatric Facilities
(September 1992)

Psychiatric Services of General Hospitals (N = 103)	Percent Patients Secluded	Rate Seclusion Orders	Percent Patients Restrained	Rate Restraint Orders
Percent Patients Secluded	1.00	.62**	.06	.04
Rate Seclusion Orders	.62**	1.00	-.06	.11
Percent Patients Restrained	.06	-.06	1.00	.49**
Rate Restraint Orders	.04	.11	.49**	1.00

Nonforensic State Psychiatric Centers (N = 22)	Percent Patients Secluded	Rate Seclusion Orders	Percent Patients Restrained	Rate Restraint Orders
Percent Patients Secluded	1.00	.88**	.11	-.06
Rate Seclusion Orders	.88**	1.00	-.13	-.03
Percent Patients Restrained	.11	-.13	1.00	.83**
Rate Restraint Orders	.06	-.03	.83**	1.00

*p < .01, **p < .001

Figure 12
Restraint and Seclusion Use: Psychiatric Services of General Hospitals Versus State Psychiatric Centers
(September 1992)

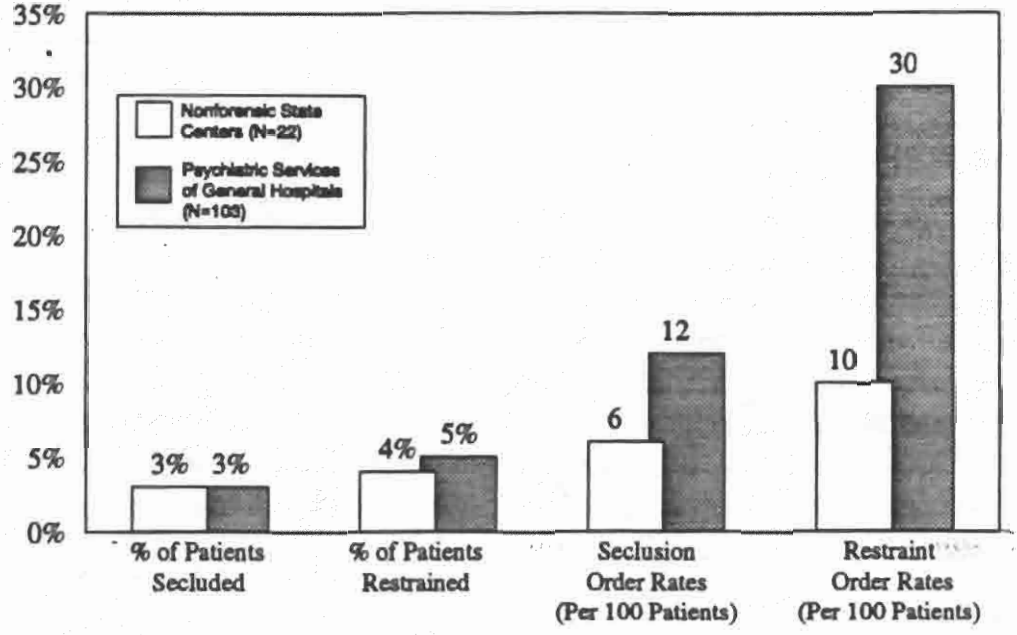
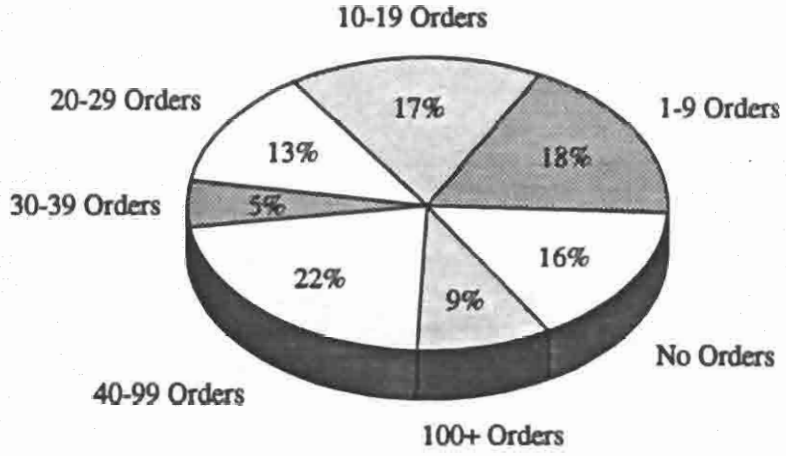


Figure 13
Combined Order Rates for Restraint and Seclusion in NYS Psychiatric Facilities*
(September 1992)



(N = 125 Facilities)

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

state psychiatric centers and most psychiatric services of general hospitals. Yet, even among forensic state centers, combined rates for restraint and seclusion varied by more than 500% (from 74 to 375 monthly orders per 100 patients in the average daily census). It was also noteworthy that psychiatric services of 16 general hospitals had higher combined order rates for restraint and seclusion (> 74 orders per 100 patients) than one of New York's three forensic state psychiatric centers (Central New York Psychiatric Center).

Relationships among the usage measures for restraint and seclusion provided little additional explanation of facilities' variation in the use of the interventions. On the one hand, no relationship was found between a facility's use of restraint and its use of seclusion. High use of one intervention did not predict low use of the other. Nor did high use of one intervention predict high use of the other.

On the other hand, we did find that higher use facilities of either restraint or seclusion tended to be characterized both by their high frequency of *orders* for the intervention *and* their use of the intervention with *more of their patients*. This finding tended to undercut the explanation offered by many administrators of high restraint and/or seclusion user facilities that their relatively higher usage rate was due to frequent use of the intervention(s) with only a small percentage of their patients.

Finally, the Commission had anticipated that restraint and seclusion use would differ markedly between psychiatric services of general hospitals and nonforensic state psychiatric centers, given their contrasting service system roles in acute versus intermediate and long-term psychiatric care. We found, however, that the two subclasses of facilities were remarkably similar in the percentage of patients served who were restrained and who were secluded, although psychiatric services of general hospitals did write significantly more orders for these interventions than nonforensic state psychiatric centers.

Chapter IV
Few Predictors of Restraint and Seclusion Usage

Relying on data reported by the psychiatric facilities and maintained by the NYS Office of Mental Health, further analyses were conducted to determine if the dramatic variation in the use of restraint and seclusion by general hospitals or nonforensic state psychiatric centers was significantly associated with various facility and patient characteristics. In general, these analyses revealed few significant associations, and it was difficult to discern any clear relationship between restraint and seclusion usage and most specific facility and patient population characteristics.

Few Significant Relationships

These analyses examined the relationships between the restraint and seclusion usage measures and six variables assessing facility characteristics and eight variables assessing patient characteristics. In total, these analyses looked at 112 possible relationships with the four restraint and seclusion usage measures. Only 11 of these tested relationships proved to be significant (Figure 14).

Only one significant association between restraint and seclusion usage measures and the tested facility and patient characteristics was found for nonforensic state psychiatric centers. Nonforensic state centers whose patient populations included a greater percentage of individuals under 35 had higher seclusion rates than other centers ($r = .62$, $p < .01$).

Significant Relationships

The few significant relationships between facility and patient characteristics and restraint and seclusion usage measures were restricted, with the exception of the one cited above, to psychiatric services of general hospitals and usually to only one of the four usage measures — *the percentage of patients secluded* (Figure 15). The analyses found that a greater percentage of patients tended to be secluded at psychiatric services of general hospitals:

- located in urban ($t = 4.09$, $df = 56.6$, $p < .001$), downstate communities ($t = -2.06$, $df = 84.71$, $p < .05$);
- with a larger average daily psychiatric patient census ($r = .26$, $p < .01$);
- affiliated with medical schools or designated as teaching hospitals ($t = 2.34$, $df = 91$, $p < .05$);
- serving more nonwhite patients ($r = -.49$, $p < .001$); and
- serving more indigent patients ($r = .28$, $p < .01$).

In most cases, these significant relationships were restricted to the one usage measure of the percentage of patients secluded. Stronger relationships were noted, however, with two variables — medical school affiliation and hospital location downstate.

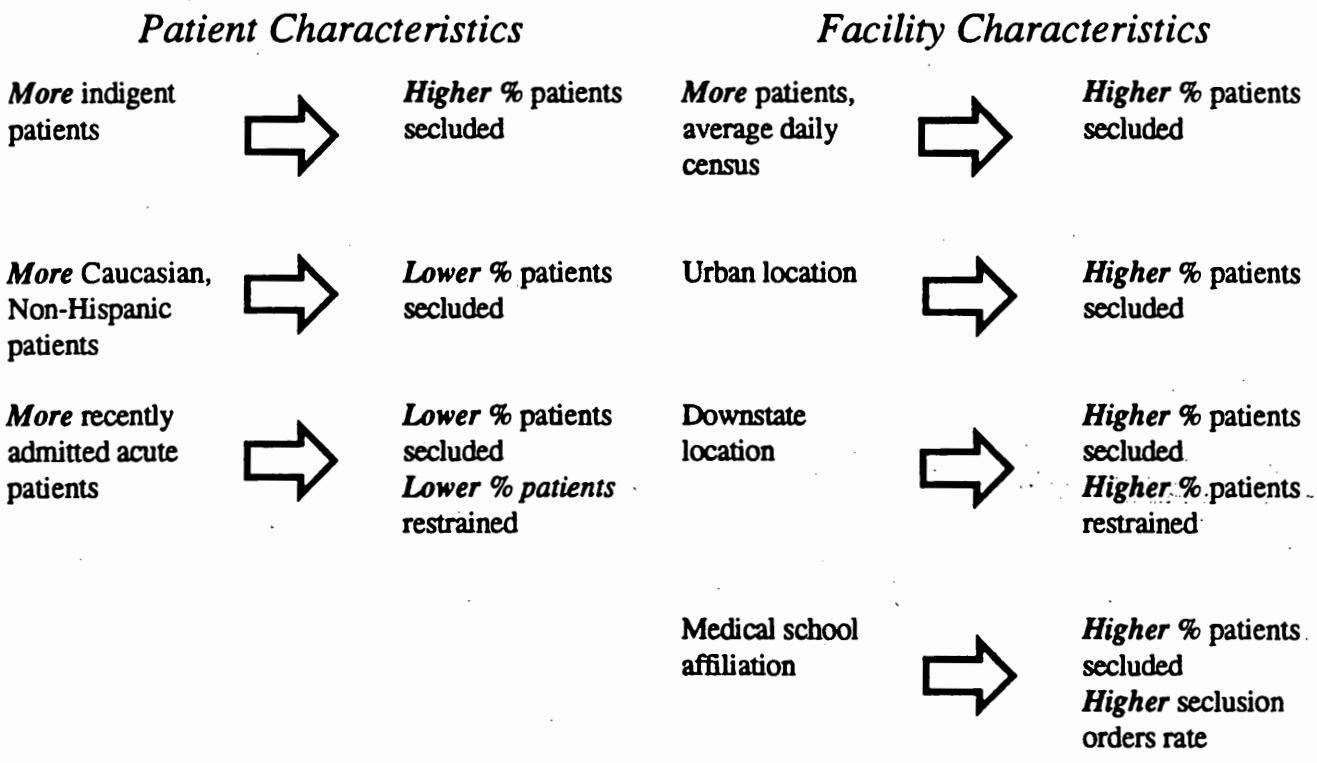
- General hospitals affiliated with medical schools or designated as teaching hospitals were significantly *more* likely than other general hospitals not only to seclude a greater percentage of their patients, but also to have a higher seclusion order rate ($t = 2.42$, $df = 91$, $p < .05$). These hospitals were also more likely to

Figure 14
Relationship Between Restraint & Seclusion Usage Measures for NYS Psychiatric Facilities and Various Facility and Patient Characteristics
(September 1992)

	Nonforensic State Psychiatric Centers (N = 22)				Psychiatric Services of General Hospitals (N = 103)			
Variable	**Percent Patients Secluded**	**Rate Seclusion Orders**	**Percent Patients Restrained**	**Rate Restraint Orders**	**Percent Patients Secluded**	**Rate Seclusion Orders**	**Percent Patients Restrained**	**Rate Restraint Orders**
Certified Capacity	--	--	--	--	--	--	--	--
Patients served	--	--	--	--	--	--	--	--
Average daily census	--	--	--	--	**(+)	--	--	--
Occupancy Rate	--	--	--	--	--	--	--	--
Acuity index	--	--	--	--	***(-)	--	**(-)	--
Medical School Affiliated	(not applicable)				*(+)	*(+)	--	--
Urban location	--	--	--	--	***(+)	--	--	--
Downstate location	--	--	--	--	*(+)	--	*(+)	--
% patients indigent	(data not available)				**(+)	--	--	--
% patients > 65 years	--	--	--	--	--	--	--	--
% patients < 35 years	--	***(+)	--	--	--	--	--	--
% patients male	--	--	--	--	--	--	--	--
% patients Caucasian, non-Hispanic	--	--	--	--	***(-)	--	--	--
% patients classified SPMI	--	--	--	--	--	--	--	--
% patients concomitant drug/alcohol abuse	--	--	--	--	--	--	--	--

-- = Nonsignificant; * p<.05; ** p<.01; *** p<.001.

Figure 15
Isolated Predictors of Restraint and Seclusion Use By Psychiatric Services of General Hospitals
(N = 103)



be classified as "high users" of restraint and seclusion, as defined by having one or more restraint or seclusion usage measure which was at least one standard deviation above the mean.

- General hospitals located downstate (NYC/Long Island) were significantly *more* likely than other general hospitals not only to seclude a greater percentage of their patients, but also to restrain a greater percentage of their patients ($t = -2.38$, $df = 81.74$, $p < .05$).

Explanations for these stronger relationships are not clear. It may be that the inexperience and/or frequent rotations of psychiatric residents in medical school-affiliated/teaching general hospitals influence the tendency of these hospitals to use restraint and seclusion more often. Or perhaps the availability of more physicians in medical school-affiliated and teaching hospitals, the only authorized personnel to write restraint and seclusion orders in New York, may contribute to these hospitals' greater use of the interventions.

Correspondingly, one could hypothesize that the tendency of general hospitals in upstate areas to use restraint and seclusion with a smaller percentage of their patients may be influenced by the greater likelihood that attending psychia-

trists in these settings have prior knowledge of the patients served on their inpatient units. This familiarity may decrease the likelihood that patient behaviors or statements are misinterpreted or that psychiatric staff resort to the use of restraint and seclusion as a "safety measure" in cases where they have little knowledge of the patient.

Treatment Acuity and Restraint and Seclusion Use

The Commission was especially interested in determining whether the acuteness of patient symptomatology was related to the variation in restraint and seclusion use among psychiatric facilities. Unfortunately, neither the Office of Mental Health nor the reporting facilities had reliable measures of the symptom acuity of the patient populations of individual hospitals. In the absence of these measures, the Commission constructed a surrogate treatment acuity measure linked to psychiatric patient turnover (the ratio of total patients served to the average daily census) during the one-month period studied (September 1992).

Psychiatric facilities with higher patient bed turnover ratios were presumed to have a higher treatment acuity index, as a greater percentage of their patient bed days were devoted to recently admitted patients. Conversely, psychiatric facilities with lower patient bed turnover ratios were presumed to have a lower treatment acuity index, as a greater percentage of their patient bed days were devoted to patients who had not been recently admitted.

The range in calculated patient acuity index measures for psychiatric services of general hospitals was .91[7] – 4.48, with a mean of 2.4. Reflective of the generally longer lengths of patient stays in nonforensic state psychiatric centers, designated by state policy to provide intermediate and long-term psychiatric care, their range in acuity index measures was considerably narrower, 1.01 – 1.62, with a mean of 1.2.

When patient acuity index measures were correlated with the four restraint and seclusion measures, *no significant relationships* were noted for nonforensic state psychiatric centers. Acuity index measures were also not significantly associated with restraint or seclusion orders rates for psychiatric services of general hospitals. The analyses did find, however, that psychiatric services of general hospitals with *lower* patient acuity index measures tended to both seclude and restrain a *greater* percentage of the patients they served.[8]

This inverse relationship was contrary to the expectation that higher (rather than lower) patient acuity would be associated with increased restraint and seclusion use. Yet, from another point of view, these findings suggest that the more days patients stay on an inpatient psychiatric unit, the greater their likelihood of being secluded or restrained, which also has certain intuitive validity.

Additionally, in New York (as in most other states) longer lengths of psychiatric stays in general hospitals tend to be associated with discharge planning problems, rather than acute symptomatology. Hospitals with lower treatment acuity measures may rely more on restraint and seclusion as they find themselves more often

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[7] Acuity index measures of less than 1.00 are unlikely, as the total number of patients served would usually always be greater than the average daily census. The two general hospitals with acuity indexes of less than 1.00 indicated (upon Commission follow-up) that they had an average length of stay of greater than 30 days and that readmissions of a small number of individuals in September 1992 resulted in the hospital serving fewer unique individuals that month than their average daily census.

[8] (Percentage secluded: $r = -.42$, $p < .001$; Percentage restrained $r = -.31$, $p < .01$.

"managing" significant numbers of patients who are no longer in the acute phase of their illness on treatment units which typically have few therapeutic or recreational activities and many hours of unstructured time, when boredom and frustration from long confinement can contribute to patient fights and aggression.

Summary

As reflected in this chapter, the Commission generally found that differences in patient and facility profiles could not explain the dramatic variation in restraint and seclusion usage rates among New York State psychiatric facilities. With one exception (i.e., the percentage of patients under 35), none of the tested patient or facility characteristics were found to have a significant relationship with the variable restraint and seclusion usage rates of nonforensic state psychiatric centers.

Although a small number of the tested patient and facility characteristics were significantly associated with the variable restraint or seclusion use among psychiatric services of general hospitals, very few of these relationships proved to be significant for more than one of the four calculated basic restraint and seclusion usage measures. Explanations for these few more supported relationships can only be hypothesized. It may be that clinical staff's greater familiarity with the patients served in rural and upstate hospitals and not affiliated with medical schools (which are not subject to frequent resident psychiatrist staff rotations), contributes to the generally lower seclusion and restraint use by these hospitals' psychiatric services.

The inverse relationship between a psychiatric services' treatment acuity may reflect the greater level of patient frustration and difficult behaviors as patients are kept on psychiatric services beyond their optimal length of stay awaiting discharge plans. Alternately, the more obvious suggestion may simply be that the longer patients are maintained on psychiatric services, the more likely they are to be subjected to restraints or seclusion.

Notwithstanding these few significant associations and their possible explanations, however, the overwhelming statistical evidence suggests that most variance in restraint and seclusion usage rates among NYS psychiatric facilities is independent of corresponding differences in their patients' needs or characteristics. These findings leave one with a critical unanswered question: *How are some psychiatric facilities able to treat and manage comparable psychiatric patients with no or very limited use of restraint or seclusion, while others were required to rely on these interventions frequently*?

Chapter V
Perspectives From the Front Lines

In the course of its review, the Commission also made on-site visits to 12 inpatient psychiatric facilities to examine restraint and seclusion practices on the front lines. The Commission expected that observations on psychiatric units, reviews of current patients' records, and interviews with staff and patients would shed light on the actual restraint and seclusion practices in New York. Most critically, the Commission sought to determine if front-line practices of psychiatric facilities would help explain the unanswered question of how some psychiatric facilities appeared to be able to treat patients effectively with little or no restraint or seclusion use. If patient and facility characteristics could not readily explain the variation in practice, the Commission wondered if treatment philosophies, treatment methods, or other aspects of these hospitals' treatment settings may offer better explanations.

Visited Facilities

Visits were made to six nonforensic state adult psychiatric centers, one forensic state psychiatric center, and five general hospitals with certified inpatient psychiatric units. By design, the sample of 12 facilities included facilities with variable usage of restraint and seclusion (Figure 16). Combined restraint and seclusion order rates across the six nonforensic state psychiatric centers ranged from 2 to 48 orders per 100 patients, while combined order rates among the five general hospitals ranged from 3 to 188 orders per 100 patients. The one forensic state center in the sample, which served a unique patient population, had a combined restraint and seclusion order rate of 375 orders per 100 patients. Three of the state psychiatric centers visited, Hutchings, Manhattan, and Buffalo Psychiatric Centers, and two of the general hospitals, Columbia Presbyterian and Ellis Hospitals, with combined order rates for both restraint and seclusion of less than 15 orders per 100 patients in the average census for September 1992, were classified as *low users.*

Figure 16
Restraint and Seclusion Usage Rates of Facilities Visited (September 1992)

Facility	Restraint and Seclusion Orders Rate*	Designated as "Low User"
Hutchings PC**	2	Yes
Manhattan PC	3	Yes
Ellis Hospital	3	Yes
Columbia Presbyterian Hospital	7	Yes
Buffalo PC	12	Yes
Woodhull Hospital	26	No
Bronx State PC	27	No
South Beach PC	28	No
Capital District PC	48	No
NY Univ Medical Ctr	159	No
Niagara Falls Hospital	188	No
Mid-Hudson Forensic PC	375	No

* Rates = total restraint and seclusion orders to 100 patients in average daily census.

** PC = State-operated Psychiatric Center

Facility Review Protocols

Two to four Commission staff spent three to four days on site at each sample facility, interviewing senior administrators and clinical staff, reviewing treatment and custodial care practices, assessing the general environment on the psychiatric unit(s), reviewing selected patient records, collecting data on the unscheduled use of psychotropic medications, and interviewing patients currently on the units (Figure 17). Based on these observations, record reviews, and interviews, Commission staff completed detailed survey instruments related to PRN and STAT medication administrations, environmental conditions, the provisions of personal liberties to patients, and the availability of therapeutic and recreational programming.

In total, 30 inpatient psychiatric units were reviewed across the 12 facilities, 21 at the seven state psychiatric centers and 9 at the five general hospitals. At each state psychiatric center, three inpatient units were reviewed. Two inpatient psychiatric units were reviewed at four of the five general hospitals, and at the remaining community hospital, the one (and only) inpatient psychiatric unit was reviewed.[9]

Figure 17
On-Site Facility Review Protocols

- ☐ Interviews with senior administrative and clinical staff
- ☐ Review of ward conditions, programing, and patient liberty issues
- ☐ Review of as needed (PRN) and emergency (STAT) psychotropic medication orders
- ☐ Record reviews of and/interviews with patients recently restrained and/or secluded
- ☐ Informal on-unit observations of patient activities and patient/staff interactions

Treatment Philosophies

Of special interest to the Commission was whether administrative and clinical leadership at treatment facilities with low use of restraint and seclusion espoused distinctive treatment philosophies or protocols surrounding restraint and seclusion use. At *all* of the 12 facilities, Commission staff were told that restraint and seclusion use was monitored and that these interventions were only to be used as a last resort, when other interventions had not been successful in managing a patient's dangerous behaviors. Yet, notwithstanding this commonality in responses, there were apparent distinguishing features in the responses of the five low-user facilities which appeared relevant to their low restraint and seclusion use (Figure 18).

Manhattan Psychiatric Center

Leadership staff at Manhattan Psychiatric Center, for example, stated that they viewed the use of restraint and seclusion as "evidence of therapeutic failure" and that all such orders were reviewed daily by the senior clinical team, with a focus on reevaluating of planned treatment for the patient(s) and making needed changes to eliminate restraint and seclusion use. These

[9] At three of the general hospitals, the Commission's unit sample represented all of the inpatient psychiatric units at the hospital; at the fourth hospital two of the hospitals' three units were reviewed; and at the fifth hospital two of the hospital's five psychiatric units were reviewed.

staff also stressed that it was not enough for management staff to articulate these views in policy statements. They emphasized that it was critical that leadership staff both "talked the talk and walked the walk," ensuring that their interactions with other staff and patients reinforced the center's treatment philosophy and the expectation that it will be reflected in unit practices. Of note, Commission staff were impressed that on all three units of the center visited, center staff from therapy aides to nurses to other members of the clinical team expressed the same core philosophy for restraint and seclusion use, often even using the same language.

Hutchings Psychiatric Center

Senior staff at Hutchings Psychiatric Center, another low-user facility, also stressed their belief that restraint and seclusion are not frequently needed when inpatient treatment is well-managed. They emphasized that their staff's familiarity with individual patients and the center's philosophy that any infringement of a patient's personal liberties was a very serious matter were central to the center's low use of restraint and seclusion. They elaborated that the center's low use of restraint and seclusion could be directly attributed to staff's earnest efforts at early intervention and less restrictive alternatives, the administration's conscientious efforts to train staff in crisis intervention techniques, and the center's attention in ensuring that the ward environment itself was humane, normalizing, and allowed patients some time to be alone.

Buffalo Psychiatric Center

Senior staff at a third low-user state psychiatric center, Buffalo Psychiatric Center, raised many of the same points noted above, but emphasized their procedural practices in reviewing restraint and seclusion incidents daily at morning report, as well as trend data reported monthly. This center also has a special procedure mandating a clinical conference regarding any patient who is restrained or secluded three or more times in 30 days. This special review requires, among other things, the completion of a special quality assurance form reviewing the patient's treatment and care. Administrators and clinicians at the center emphasized that all of these monitoring activities focused on a critical questioning of whether the use of restraint or seclusion could have been prevented with better crisis management. Other factors which this center's leadership attributed to their low use of restraint and seclusion included the closure of the center's secure unit and the redesign of the unit environments with open nursing stations, which compelled staff to come out from behind walls and windows and to interact more frequently and to intervene more promptly in difficult situations.

Figure 18
Administrative Practices Associated with Low Restraint and Seclusion Use

- ✓ Clear policy statement that restraint and seclusion are extreme, exceptional interventions.
- ✓ Emphasize staff training.
- ✓ Encourage use of less restrictive interventions.
- ✓ Emphasize early crisis intervention by staff.
- ✓ Consider any increase in restraint/seclusion use a "red flag" quality assurance indicator.

Ellis and Columbia Presbyterian Hospitals

At the two low-user general hospitals, Ellis and Columbia Presbyterian Hospitals, it was

apparent that administrative and clinical staff on the psychiatric service shared a firm belief that restraint and seclusion simply were not interventions required by most psychiatric patients. Although clinicians at both hospitals recognized the need for the exceptional use of these interventions, there was common acknowledgment that they should not be common components of inpatient psychiatric treatment. One of these hospitals (Ellis) had no seclusion rooms, and the staff employed frequent one-to-one staff coverage for patients to avoid the use of restraints. Senior staff at Ellis Hospital also attributed their low use of restraint and seclusion to the ambiance of the psychiatric units, which were spacious, nicely accommodated, and afforded most patients single rooms. This hospital also reported providing crisis intervention training to all staff, which focused on using verbal and other interventions in lieu of restraints.

The other community hospital, Columbia Presbyterian Hospital, which was also a medical school-affiliated institution, emphasized the importance of clinical staff presence and interaction with patients in de-escalating situations which may contribute to restraint and seclusion use. During the Commission's on-site visits to this hospital, the frequency of psychiatrists' presence on the psychiatric units and their frequent interactions with patients during the day were significant observations of the review team. Patients on the psychiatric units also had many personal liberties in how they spent their days. Off-grounds privileges, especially in the company of family members or friends, were granted with some regularity, and basic schedules for such activities as showers, naps, and recreation were left largely to the patients' discretion.

In summary, although senior administrators and clinicians at the low-user facilities expressed differing explanations and rationales for their low use of restraint and seclusion, several common themes emerged. All started with a strong and consistent value statement on the use of the interventions as an extreme and exceptional practice; they emphasized the value of staff training in the facility's treatment philosophy, as well as in crisis intervention; they repeated the importance of regular and predictable staff interaction with patients on the units; and they affirmed the importance of a unit environment that was humane, comfortable, and as nonrestrictive of patients' liberties as possible.

Perhaps most importantly, at each of these facilities, leadership appeared to view the use of restraint and seclusion as an indicator that something was amiss, either with the individual patient's treatment or the unit itself. Thus, restraint and seclusion use was employed as a quality assurance indicator which was carefully scrutinized. In contrast, administrators and senior clinical staff at three of the facilities which had markedly higher use of restraint and seclusion expressed considerably more equivocal views toward the frequent use of restraints and seclusion, asserting that high use could not necessarily be associated with better or worse clinical practices.

Unscheduled Use of Psychotropic Medications

The Commission also assessed the use of PRN and STAT administrations[10] of psychotropic medications across the facilities visited. Two conflicting hypotheses had been proposed. One suggested that psychiatric treatment facilities which were low users of restraint and seclusion would be high users of unscheduled admin-

[10] PRN and STAT are acronyms for unscheduled medication administrations. PRN medication orders are written by physicians prescribing medications on an as needed basis for a specific condition (e.g., "for fever," "for pain," "for severe anxiety," etc.). PRN orders usually cover a period of time (7-30 days), and they may authorize one or more as needed administrations of the medication. STAT medication orders, in contrast, are emergency orders written proximate to the time the medication is given and usually restricted to a single medication dosage.

Figure 19
Relationship Between Restraint and Seclusion Use and the Use of Psychotropic Medications

Low Use of Restraint and Seclusion	High Use of PRN & STAT Medication Administrations
Low Use of Restraint and Seclusion	Low Use of PRN & STAT Medication Administrations
High Use of Restraint and Seclusion	High Use of PRN & STAT Medication Administrations
Restraint and Seclusion Use	PRN & STAT Medication Use

istrations of psychotropic medications, either PRNs or STATs, as these interventions would be used in the place of restraint and seclusion in managing patients' dangerous behaviors. A second hypothesis proposed the opposite trend, whereby facilities which infrequently used restraint and seclusion would also infrequently use PRN or STAT administrations of psychotropic medications, which they would view as "chemical" restraints and also contrary to their "least restrictive" treatment philosophy.

For this examination, the Commission calculated two measures of PRN/STAT psychotropic medication use: (1) the percentage of patients on each unit who received at least one such administration in the 30 days prior to the Commission's review, and (2) the ratio of the total number of PRN/STAT administrations to each unit's average census for the 30 days prior to the Commission's review. Additionally, the Commission also calculated current usage measures for restraint and seclusion on each unit visited, measuring the unit's usage of these interventions (by percentage of patients and by total orders to average census) in the same 30-day period.

The analyses revealed wide variations among the 30 units in their use of PRN and STAT administrations of psychotropic medications, but neither of the proposed hypotheses linking the use of these interventions to restraint and seclusion use were supported (Figure 19).[11] Although there was a tendency for units at low restraint/seclusion user facilities to have a lower rate of PRN/STAT orders to average census ($\bar{X}$ = 2.96) than units from other facilities ($\bar{X}$= 3.79), this difference did not approach significance (t = .85, df = 28, p = .402).

[11] The percentage of patients who had received a PRN or STAT administration of a psychotropic medication ranged from less than 25% to more than 75% on the 30 units visited. Similarly, total PRN/STAT administrations to average census rates varied from less than 50 administrations to every 100 patients to over 600 administrations to every100 patients on the 30 units visited.

Personal Liberties

Based on staff and patient interviews, Commission staff also assessed the provision of personal liberties for patients on the 30 units of the 12 facilities visited. Our hypothesis was that low use of restraint and seclusion would be associated with greater allowance for patients' personal liberties.

Each unit received an aggregate "personal liberties score," which had a potential range of 0 - 10. The score was based on the unit's performance on ten standards, including the provision of privacy for patients visiting with families and friends, opportunities for patients to participate in religious worship, and allowances for patients to take showers at unscheduled times. Although initial surveys included the assessment of other items related to personal liberties, all items where 90% or more of the units received a positive score were deleted as they did not add to the normative scale.

Across the 30 units visited at the 12 facilities, personal liberty scores varied from high scores of 9-10 received by 11 of the units visited to low scores of 6 or less received by 3 of the units visited. Notably, 16 of the 30 units reviewed (53%) had personal liberty scores of 7-8 in the middle range.

Analysis revealed that units at low restraint and seclusion facilities were significantly more likely to have higher personal liberty scores than units at other facilities visited (X^2 = 11.13, df = 5, p<.05) (Figure 20). High scores of 9-10 on the personal liberty scale were awarded to 70% of the units at low-user facilities versus only 12% of the units at the other facilities in the sample. Additionally, there was a consistent trend of better performance across many of the specific personal liberty standards by units from low-user facilities.

- Whereas 100% of the units at low-user facilities allowed patients reasonable privacy when making and receiving telephone calls, this was true at only 35% of the units at other facilities (X^2 = 6.54, df = 1, p <.01).
- Whereas 77% of the units at low-user facilities afforded patients private rooms for visiting, this was true for only 47% of the units at other facilities (nonsignificant).
- Whereas 100% of the units at low-user facilities allowed patients to use the telephone in times of crisis, this was assured at only 79% of the units at other facilities (nonsignificant).
- Whereas 100% of the units at low-user facilities allowed patients to attend weekly religious services, this was assured at only 77% of the units at other facilities (nonsignificant).

Figure 20
Personal Liberties on Low Versus Other Restraint and Seclusion-User Psychiatric Units

	Low User Units (n=13)	Other Units (n=17)
Overall scores 90%+	70%	12%
Privacy using telephone	100%	35%
Privacy for visitors	77%	47%
Telephone access in times of crisis	100%	79%
Weekly religious services	100%	77%
Shower at unscheduled times	92%	76%

Figure 21
Off-Unit Privileges on Low Versus Other Restraint and Seclusion-User Psychiatric Units

	Low User Units (n=13)	Other Units (n=17)
Some patients with privileges	77%	29%
At least 20% of patients with privileges	46%	5%

- Whereas 92% of the units at low-user facilities allowed their patients to shower at an unscheduled time, this was true at only 76% of the units from other facilities (nonsignificant).

Perhaps even more central to personal liberties, the units visited at low-user facilities were significantly more likely than units at other facilities to grant at least some of their patients *escorted or unescorted off-unit privileges* (Figure 21). The analyses showed that while 77% of the units at low-user facilities had granted at least some of their patients such privileges at the time of the Commission's review, this was true for only 29% of the units at other facilities. (X^2 = 4.89, df = 1, p <.05). Other analyses showed that at least one-fifth of the patients on nearly half (46%) of the units visited at low-user facilities had escorted or unescorted ground privileges at the time of the Commission's visit. This was true for only one of the 21 units visited at the other facilities (X^2 = 8.59, df = 2, p <.05).

Environmental Conditions

Overall environmental conditions were also assessed on each of the 30 units visited. A unit's environmental score (0-12) was based on the quality of its environmental conditions measured on a 3-point scale in each of six areas: (1) common living areas, (2) dining rooms, (3) bedrooms, (4) bathrooms, (5) seclusion rooms, and (6) "other" areas. If no cleanliness, maintenance, furnishings, safety or other problems were identified in the area, the unit received two points for that area; some identified problems resulted in a score of one point; and serious identified problems resulted in a score of zero.

Similar to the personal liberty scores of the units, environmental condition scores ranged from a low score of 4 awarded to one unit, to perfect scores of 12 awarded to nine units. In total, 21 of the 30 units had high scores of 10-12, whereas five units had low scores of 4-8 (less than 70%).

When this variation in environmental scores was studied further, no significant difference in the overall environmental scores between units from low restraint and seclusion-user facilities and units from other facilities was noted. Despite this absence of a significant difference in overall environmental scores, there was a trend toward better environmental conditions on units at low restraint and seclusion user facilities (Figure 22).

- Seventy-eight percent (78%) of the units at low-user facilities received overall high environmental condition scores of 10-12, compared to only 66% of the units at the other facilities.
- Psychiatric units of low restraint- and seclusion-user facilities were also *significantly* more likely than units visited at the other facilities to have no environmental problems (i.e., some or serious)

in primary unit living areas, including common living areas (92% versus 65%, $X^2 = 6.63$, df = 2, $p < .05$) and bedrooms (69% versus 41%, $X^2 = 8.54$, df = 2, $p < .05$).

Programming

In assessing the availability of programming on the units visited, Commission staff looked at five programming indicators. These indicators included: (1) the provision of at least three hours of *scheduled* activities daily (Monday-Friday), (2) the provision of at least four hours of *scheduled* activities on Saturday and Sunday, (3) the availability of recreational materials and equipment, (4) the scheduling of at least 20 hours of therapeutic or recreational activities weekly, and (5) attendance by at least half of its patients at scheduled therapeutic or recreational activities at least 20 hours weekly.[12] Overall programming scores across the 30 units varied markedly from 0 (one unit) to the perfect score of 5. In total, 8 of the 30 units had scores of 3 or lower; 9 units had scores of 4; and 13 units had a perfect score of 5. Although there was no significant difference in total programming scores between units at low restraint- and seclusion-user facilities and units of other facilities, units from low restraint and seclusion-user facilities were significantly more likely than other units to have ensured that at least 50% of their patients were currently participating in at least 20 hours of scheduled therapeutic or recreational activities weekly (92% versus 47%, $X^2 = 4.90$, df = 1, $p < .05$).

Figure 22
Environmental Conditions on Low Versus Other Restraint and Seclusion-User Psychiatric Units

	Low User Units (n=13)	Other Units (n=17)
Overall high environmental scores (10+)	78%	66%
No problems in dayrooms	92%	65%
No problems in bedrooms	69%	41%

Summary

As reflected in the above findings, there are distinct characteristics of the treatment philosophies and protocols governing the use of restraint and seclusion at low-user psychiatric facilities (Figure 23). The findings also suggested that these articulated philosophies and protocols were a part of a broader picture of generally better performance across a range of other indicators. The common thread that ran through all of these facilities appeared to be stronger and more consistent patient-centered values and clinical leadership that persistently reinforced these values with all staff.

(1) Senior administrators/clinicians at low-user facilities appear to think differently and apparently more cautiously about the use of restraint and seclusion.

[12] Of note, NYS Mental Hygiene Law §33.03, requires the Office of Mental Health to establish programming standards for state psychiatric centers. By policy, the Office of Mental Health has established this standard at 20 hours of programming for individual patients weekly.

Figure 23
Characteristics of Psychiatric Units of Low Restraint and Seclusion-User Facilities

- ✓ Their patients have more personal liberties.
- ✓ More of their patients have off-unit privileges.
- ✓ Dayrooms and bedrooms are better maintained and more comfortable, and attractively furnished.
- ✓ More of their patients are engaged in 20 hours of programming weekly.

Most clearly, they tend to view anything but very low use of these interventions as "a red flag," signaling that something may be wrong. Administrators and clinicians at these facilities also believe that use of restraint and seclusion must be evaluated within a broader context of the patient's overall treatment plan, other restrictions on patient liberties, staff skills in other less restrictive crisis intervention responses, and the overall comfort and safety of the unit environment.

(2) *On-site assessments of the facilities further suggested that psychiatric facilities characterized by low use of restraint/seclusion appeared to also share some other important distinguishing characteristics in their practices related to protecting patients' personal liberties, living unit conditions, and patient programming opportunities.*

- These facilities were significantly more likely than units visited at other facilities to afford their patients more personal liberties in the normal activities of daily living.
- These facilities were significantly more likely than units of other hospitals to afford patients off-unit escorted or unescorted privileges.
- Environmental conditions in primary living areas of these facilities were significantly more likely than those of units at other facilities visited to evidence no problems.
- These facilities were significantly more likely than units at other facilities visited to afford at least 50% of their patients (at the time of the Commission's review) at least 20 hours of therapeutic or recreational programming weekly.

(3) *Contrary to expectations, variations in restraint and seclusion use appeared largely independent of the equally great variations found among facilities in their use of PRN/STAT administrations of psychotropic medications.*

Units of low-user facilities did not appear to substitute the unscheduled administrations of psychotropic medications for restraint and seclusion use. There was also no evidence that units of low-user facilities made less use of unscheduled administrations of psychotropic medications than units of other facilities.

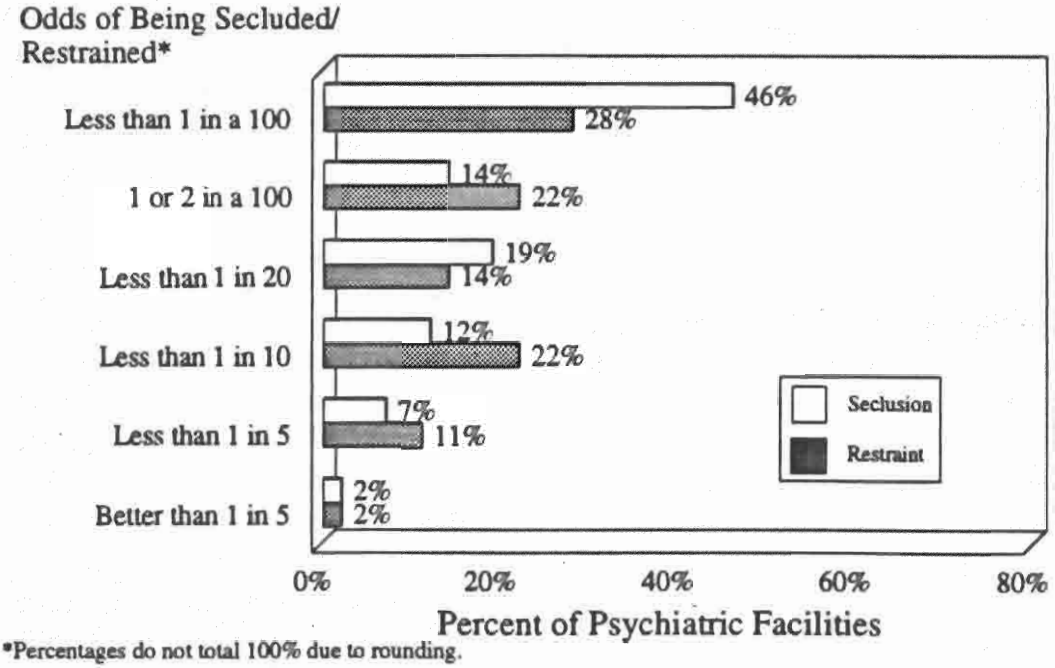
Chapter VI
Conclusions and Recommendations

When a patient is admitted to a psychiatric facility, he may have many questions and concerns. One of them will likely be how he will be treated if he becomes dangerous to himself or others or if he simply becomes angry and loses control. As reported in this review, the likelihood that patients will be subjected to restraints or seclusion at these times varies dramatically among New York's psychiatric facilities. At most of New York's psychiatric facilities, restraint and seclusion are infrequently, if ever, used; at more than one-fifth (21%) of these facilities, however, at least one in every ten patients admitted will be restrained or secluded (Figure 24). At nearly one-third (31%) of these facilities there were 40 or more orders for restraint and seclusion per every 100 patients in the average census will be written monthly.

Few Explanations for Variable Usage Rates

With the exception of the generally higher restraint and seclusion use by forensic state psychiatric centers, this dramatic variation in restraint and seclusion use among New York's psychiatric facilities could not be readily predicted either by patient or facility characteristics. The analyses also showed that a psychiatric facility's use of restraint was independent of its use of

Figure 24
Odds of Being Restrained or Secluded
in NYS Psychiatric Facilities
(N = 125)



*Percentages do not total 100% due to rounding.

seclusion. High use of restraint was not associated with low use of seclusion or vice versa. Nor was high use of restraint significantly associated with high use of seclusion. Low use of one of the interventions also did not predict low use of the other.

It appeared that the variable use of restraint and seclusion across New York's psychiatric facilities was largely a by-product of the discretion of the clinical staff. There was also some evidence that clinical staff's familiarity with individual patients may be an important factor at psychiatric facilities making limited use of these interventions. This familiarity may have influenced the smaller percentage of patients restrained or secluded in upstate hospitals where clinical staff are more likely to know the patients served, based on previous admissions and outpatient services, than in hospitals located in downstate (New York City and Long Island) communities where the facilities are generally larger and both patient and staff turnover rates are likely to be higher.

Similarly, higher rates of seclusion use by psychiatric services of hospitals affiliated with medical schools may have been influenced by frequent rotations of resident psychiatrists, which limit their familiarity with the patients served. Alternately higher rates of seclusion use by medical school-affiliated hospitals may be attributed simply to the generally greater availability and presence on these psychiatric services of physician staff, the only personnel authorized to write seclusion orders in New York.

The data analysis further suggested that psychiatric facilities which maintained patients on units for longer stays — awaiting appropriate discharge arrangements — tend to use restraint and seclusion with a greater percentage of the patients served. It seemed that psychiatric services of general hospitals which were able to achieve briefer lengths of stay were also able to limit the use of restraint and seclusion to fewer of their patients.

Findings Consistent With Other Research

In general, however, the findings of this study were consistent with other published studies which have concluded that variations in restraint and seclusion use among psychiatric facilities appears to be independent of the characteristics or needs of the patient populations served or the facilities themselves. Age, sex, and race of the patients served by psychiatric facilities, the percentage of patients they served who were classified as seriously mentally ill, who had a concomitant substance abuse diagnosis, or who were indigent, generally were not significant predictors of the variation in restraint and seclusion use among New York's psychiatric facilities. Likewise, the size of psychiatric facilities and their occupancy rates were not significantly associated with the variable restraint and seclusion use.

The Commission's study also reinforced that the variability in restraint and seclusion use among New York's psychiatric facilities reflects the divergent clinical opinions regarding the "appropriate" use of these restrictive interventions in psychiatric treatment. Even on the most fundamental issues, including the indications and contraindications for restraint and seclusion use, the patient populations which are most likely to benefit from the interventions, and the appropriate safeguards which facilities should have in place to govern the use of restraint and seclusion, there remains considerable debate among clinicians writing in the professional journals.

Reflective of the inconclusive clinical research and the divided clinical opinions on the use of restraints and seclusion, civil rights and mental health advocates have looked to federal and state courts, state legislatures, and executive state agencies to take the lead in developing guidelines for the use of restraint and seclusion.

Yet, as in New York, these government agents have been cautious in treading in this clinical arena, and individual hospitals and practitioners continue to exercise much discretion in the use of both restraints and seclusion. The dramatic variability in New York's psychiatric facilities' usage of restraint and seclusion is powerful testimony to the wide latitude of this clinical discretion and the limited influence of state laws, regulations, and policies in identifying and regulating the minority of psychiatric facilities whose usage of restraint and seclusion is significantly higher than most facilities.

Treatment Philosophies May Be the Difference

Notwithstanding the Commission's findings that there is little objective basis for the dramatic variation in restraint and seclusion use among New York's 125 psychiatric facilities, on-site reviews of psychiatric facilities did offer some insights in explaining how some psychiatric facilities were able to treat patients and manage difficult and dangerous behaviors with no or very limited use of restraint and seclusion. First and foremost, administrators and senior clinicians of low restraint and seclusion use facilities spoke forcefully and clearly of their beliefs that use of restraint and seclusion had little, if any, therapeutic benefit for patients. Some even viewed these interventions as "counter-therapeutic," and all emphasized the need to reserve the use of these interventions as an absolute last resort. These administrators had strong convictions that anything but very low use of these interventions was "a red flag" signaling that something may be wrong in the patient's treatment plan or the overall treatment setting. They detailed ongoing efforts to ensure that their values regarding restraint and seclusion use were communicated down to line staff, they reinforced the importance of clinical staff's frequent presence on the treatment units, and they spoke of the importance of humane and comfortable treatment environments which respected the personal liberties of patients.

Senior administrators and clinicians at low-user facilities were also clearly proud of their low use of restraint and seclusion, and all could quickly list steps that they had taken to keep the use of these interventions to a minimum. They spoke plainly of the close linkage between restraint and seclusion use and other treatment interventions used with the patient, and the staff's capability and confidence in using other less restrictive crisis intervention approaches with patients having special difficulties.

The Commission also found different and better treatment and daily living conditions at the facilities classified as low users of restraint and seclusion. These facilities scored significantly better in the provision of personal liberties to patients; they tended to provide better environmental conditions, especially in primary living areas of common dayrooms and patient bedrooms; these facilities were significantly more likely to have ensured that at least 50% of the patients present at the time of the Commission's review were participating in at least 20 hours of therapeutic or recreational programming weekly.

Notably, the Commission also found no relationship between the unscheduled use of psychotropic medications (PRNs and STAT administrations) and restraint and seclusion usage at the 12 facilities visited. In particular, it did not appear that reduced use of restraint and seclusion at low-user facilities signaled higher unscheduled use of psychotropic medications. Indeed, like the wide variation in restraint and seclusion usage, the wide variation in the unscheduled use of psychotropic medications among the 12 facilities was not readily explained.

Weak Monitoring of Restraint & Seclusion Use

The Commission also found that although almost all of facilities (90%) reported that they maintained monthly or quarterly data on restraint and seclusion use, most made limited use of these reports to reduce restraint and seclusion use. Few facilities reported conducting on-unit observations and record reviews to further examine patients who were subject to frequent restraint or seclusion orders or units with higher restraint and seclusion rates. In particular, largely because these data had not been made available to them, most facilities have not evaluated the appropriateness of their usage rates by measuring them against those of other facilities. At best, facilities tended to measure the appropriateness of their restraint and seclusion usage against their own past performance. This tendency had the inevitable outcome of reinforcing rather than questioning ongoing restraint and seclusion practices, unless they deviated far from the norm for the facility.

The Office of Mental Health has also not facilitated comparative reviews of restraint and seclusion use among facilities. Since June 1992, the Office has been collecting restraint and seclusion data for state psychiatric centers, but it has avoided publishing these rates with the names of the facilities. Additionally, Office of Mental Health certification reviews of licensed psychiatric units of general hospitals have not focused on the frequency of restraint and seclusion use or the units' compliance with state law and regulations or the hospital's own policies governing the use of these interventions. The Office of Mental Health also does no routine data review of restraint and seclusion use by these hospitals' psychiatric services.

Recommendations

Based on these findings and conclusions, the Commission offers the following recommendations to the NYS Office of Mental Health. The recommendations focus on guaranteeing better monitoring and oversight of restraint and seclusion practices in New York's psychiatric facilities, and they share a common goal of ensuring that these interventions are used only in situations which may present a danger to the patient or others and when all other reasonable, less restrictive interventions have been tried and failed. The expectation is that implementation of these recommendations will reduce the use of restraints and seclusion at high-user psychiatric facilities and also encourage all psychiatric facilities to review how effectively they communicate patient-centered values, attitudes, and practices which appear to be the common attributes of psychiatric facilities which make little or no use of these interventions.

(1) The NYS Office of Mental Health should periodically (but at least semi-annually) collect and analyze restraint and seclusion usage data of state psychiatric centers and other state-licensed inpatient psychiatric facilities. Reports identifying the restraint and seclusion usage rates of the state's psychiatric facilities should be shared with all state-operated and state-licensed psychiatric facilities at least annually.

(2) The NYS Office of Mental Health should require state-operated and state-licensed psychiatric facilities to examine their restraint and seclusion use periodically, measuring their performance both against their own past performance and the performance of other psychiatric facilities in their community and the state. The objective of these activities should be to ensure the facility has taken all reasonable steps to minimize its use of these interventions, and these facility monitoring activities and their outcomes should be consistently reviewed by Office of Mental Health officials in their regular reviews of care and treatment in psychiatric facilities.

(3) The NYS Office of Mental Health should facilitate the sharing of best practices of state psychiatric centers, licensed psychiatric services of general hospitals, and private psychiatric hospitals which have consistently demonstrated very low or no usage of restraint and seclusion. Administrators and clinical staff of these facilities should be encouraged to share their perspectives of the explanations of their facilities' low use of restraint and seclusion in Office of Mental Health newsletters and other publications and in training sessions and seminars with administrators and clinicians of other psychiatric facilities.

(4) The NYS Office of Mental Health should identify those state psychiatric centers and state-licensed psychiatric facilities which make unusually high use of restraint and seclusion, ensure a diligent examination and monitoring of the restraint and seclusion practices of these facilities, and take whatever steps that appear to be warranted to reduce the use of these interventions at these facilities.

Review of restraint and seclusion practices at these facilities should also constitute a distinct focus of the Office of Mental Health's certification reviews of these licensed facilities.

- In this context, it will be especially important for the Office of Mental Health to make a careful study of restraint and seclusion use at its forensic state psychiatric centers, where rates of restraint and seclusion were substantially higher than at other state psychiatric centers, and especially at Mid-Hudson and Kirby Psychiatric Centers which had combined monthly restraint and seclusion rates of well over 300 orders per 100 patients.

- Similarly, the Office of Mental Health should direct priority attention to the 16 psychiatric services of general hospitals which had combined monthly restraint and seclusion rates of over 75 orders per 100 patients.

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Appendix A

Restraint and Seclusion Rates at Psychiatric Services of General Hospitals and State Psychiatric Centers

Community Hospitals by Percent of Psychiatric Patients Served Who Were Secluded
(September 1992)

< 1% of patients were secluded

A.O. Fox Memorial Hosp.
Arden Hill Hosp.
Auburn Memorial Hosp.
Bayley Seton Hosp.
Benedictine Hosp.
Booth Memorial Medical Center
Clifton Springs Hosp. & Clinic
Commun. General Hosp.-Sullivan
Commun. General Hosp.-Syracuse
Coney Island Hosp.
Cortland Memorial Hosp.
CVPH Medical Center
Eastern Long Island Hosp.
Ellis Hosp.
Franklin Hosp. Medical Center
Glens Falls Hosp. Commun. MH
Good Samaritan Hosp.
Harlem Hosp. Center
House of Good Samaritan/Mercy
Interfaith Medical Center
John T. Mather Memorial Hosp.
Kings County Hosp. Center
Maimonides Medical Center
Mary Imogene Bassett Hosp.
Methodist Hosp.
Nassau County Medical Center
Niagara Falls Memorial Med. Ctr.
North General Hosp.
No. Shore Univ. Hosp.-Glen Cove
Northern Westchester Hosp. Ctr.
Olean General Hosp.
Oswego Hosp. MH Ctr. Division
Phelps Memorial Hosp. Center
Samaritan Hosp.
Saratoga Hosp. MH Unit
South Nassau Commun. Hosp.
St. Clare's Hosp. and Health Ctr.
St. Elizabeth Hosp.
St. Francis Hosp.
St. James Mercy Hosp.
St. John's Episcopal Hosp.-LI
St. Joseph's Hosp.-Elmira
St. Mary's Hosp. CCMHC
St. Vincent's Med. Ctr.-Richmond
Summit Park Hosp.
University Hosp.-Brooklyn
White Plains Hosp. Center
Winthrop University Hosp.
Woodhull Medical and MH Center

1 - 5% of patients were secluded

A. Barton Hepburn Hosp.
Albany Medical Center Hosp.
Bellevue Hosp. Center
Buffalo General Hosp.
Central General Hosp.
Cornwall Hosp.
Erie County Medical Center
Elmhurst Hosp. Center
Hempstead General Hosp.
Hillside Hosp. LIJMC
Huntington Hosp.
Lenox Hill Hosp.
Lincoln Medical and MH Center
Long Beach Memorial Hosp.
Mercy Medical Center
Mount Sinai Medical Center
New York Hosp.-Westchester
Newark/Wayne Commun. Hosp.
North Shore University-Cornell
Our Lady of Mercy Medical Center
Payne Whitney Psychiatric Clinic
Presbyterian Hosp. (Columbia)
Putnam Hosp. Center
Rochester General Hosp.
Soldiers and Sailors Mem. Hosp.
Southside Hosp.
St. Barnabas Hosp.
St. John's Episcopal Hosp.-So. Shore
St. Joseph's Medical Center
St. Luke's-Roosevelt Hosp. Center
St. Vincent's Hosp.-Westchester
Stony Brook University Hosp.
Staten Island University Hosp.
SUNY HSC Univ. Hosp.-Syracuse
Syosset Commun. Hosp.
Tompkins Commun. Hosp.
United Health Srvs.-Binghamton
Women's Christian Hosp.-Jones

6 - 10% of patients were secluded

Beth Israel Medical Center
Bronx Municipal Hosp. Center
Genesee Hosp.
New York Univ. Medical Center
Queens Hosp. Center
St. Joseph's HHC Syracuse
St. Vincent's Hosp.-NYC
United Hosp. Medical Center
University Rochester/Strong Mem.

11% + of patients were secluded

Bronx-Lebanon Hosp. Center
Cabrini Medical Center
Metropolitan Hosp. Center
Montifiore Medical Center
North Central Bronx Hosp.
Park Ridge Hosp.
Westchester County Medical Center

Community Hospitals by Percent of Psychiatric Patients Served Who Were Restrained
(September 1992)

< 1% of patients were restrained

A.O. Fox Memorial Hosp.
Albany Medical Center Hosp.
Booth Memorial Medical Center
Clifton Springs Hosp. & Clinic
Commun. General Hosp.-Sullivan
Commun. General Hosp.-Syracuse
Cortland Memorial Hosp.
Eastern Long Island Hosp.
Erie County Medical Center
Genesee Hosp.
House of Good Samaritan/Mercy
Huntington Hosp.
Interfaith Medical Center
John T. Mather Memorial Hosp.
Mary Imogene Bassett Hosp.
Metropolitan Hosp. Center
Montifiore Medical Center
Newark/Wayne Commun. Hosp.
Olean General Hosp.
Our Lady of Mercy Medical Center
Park Ridge Hosp.
Phelps Memorial Hosp. Center
Presbyterian Hosp. (Columbia)
Saratoga Hosp. MH Unit
St. Clare's Hosp. and Health Ctr.
St. James Mercy Hosp.
St. John's Episcopal Hosp.-LI
SUNY HSC Univ. Hosp.-Syracuse
Syosset Commun. Hosp.
White Plains Hosp. Center
Winthrop University Hosp.
Women's Christian Hosp.-Jones

1 - 5% of patients were restrained

A. Barton Hepburn Hosp.
Arden Hill Hosp.
Bayley Seton Hosp.
Benedictine Hosp.
Beth Israel Medical Center
Bronx-Lebanon Hosp. Center
Bronx Municipal Hosp. Center
Buffalo General Hospital
Coney Island Hosp.
CVPH Medical Center
Ellis Hosp.
Elmhurst Hosp. Center
Glens Falls Hosp. Commun. MH
Good Samaritan Hosp.
Hempstead General Hosp.
Hillside Hosp. LIJMC
Lenox Hill Hosp.
Lincoln Medical and MH Center
Mercy Medical Center
Methodist Hosp.
Nassau County Medical Center
New York Hosp.-Westchester
New York Univ. Medical Center
Niagara Falls Memorial Med. Ctr.
North Central Bronx Hosp.
North Shore Univsity-Cornell
No. Shore Univ. Hosp.-Glen Cove
Northern Westchester Hosp. Ctr.
Oswego Hosp. MH Ctr. Division
Payne Whitney Psychiatric Clinic
Soldiers and Sailors Mem. Hosp.
Southside Hosp.
St. Barnabas Hosp.
St. Elizabeth Hosp.
St. Francis Hosp.
St. Joseph's Hosp.-Elmira
St. Joseph's Medical Center
St. Joseph's HHC Syracuse
St. Mary's Hosp. CCMHC
St. Vincent's Hosp.-Westchester
St. Vincent's Hosp.-NYC
Summit Park Hosp.
Tompkins Commun. Hosp.
University Rochester/Strong Mem.
Woodhull Medical and MH Center

6 - 10% of patients were restrained

Auburn Memorial Hosp.
Bellevue Hosp. Center
Cornwall Hosp.
Kings County Hosp. Center
Mount Sinai Medical Center
Queens Hosp. Center
Samaritan Hosp.
Stony Brook University Hosp.
United Health Srvs.-Binghamton
United Hosp. Medical Center
University Hosp.-Brooklyn

11 - 15% of patients were restrained

Cabrini Medical Center
Central General Hosp.
Franklin Hosp. Medical Center
Harlem Hosp. Center
Long Beach Memorial Hosp.
Maimonides Medical Center
North General Hosp.
South Nassau Commun. Hosp.
St. Lukes-Roosevelt Hosp. Center
St. Vincent's Med. Ctr.-Richmond
Westchester County Medical Center

16% + of patients were restrained

Putnam Hosp. Center
Rochester General Hosp.
St. John's Episcopal Hosp.-So. Shore
Staten Island University Hosp.

State Psychiatric Centers by Percent of Patients Served Who Were Secluded (September 1992)

< 1% of patients were secluded

Binghamton PC
Central Islip PC
Central New York PC
Elmira PC
Hutchings PC
Kings Park PC
Kingsboro PC
Pilgrim PC
Willard PC

1 - 5% of patients were secluded

Creedmoor PC
Harlem Valley PC
Hudson River PC
Manhattan PC
Mid-Hudson PC
Middletown PC
Mohawk Valley PC
NYS Psychiatric Institute
Rochester PC
Rockland PC
South Beach PC
St. Lawrence PC

6% - 10% of patients were secluded

Bronx PC
Buffalo PC

11% + of patients were secluded

Capital District PC
Kirby Forensic PC

State Psychiatric Centers by Percent of Patients Served Who Were Restrained (September 1992)

< 1% of patients were restrained

Bronx PC
Buffalo PC
Central Islip PC

1 - 5% of patients were restrained

Binghamton PC
Creedmoor PC
Harlem Valley PC
Hudson River PC
Hutchings PC
Kingsboro PC
Manhattan PC
Middletown PC
Mohawk Valley PC
NYS Psychiatric Institute
Pilgram PC
Rockland PC

6 - 10% of patients were restrained

Capital District PC
Elmira PC
Kings Park PC
South Beach PC
St. Lawrence PC
Willard PC

15% + of patients were restrained

Central New York PC
Kirby Forensic PC
Mid-Hudson PC
Rochester PC

Psychiatric Services in General Hospitals
(September 1992)

Hospital	*Seclusion*		*Restraint*	
	% Patients Secluded*	Orders Per 100 Patients**	% Patients Restrained*	Orders Per 100 Patients**
A. Barton Hepburn Hospital	3%	5	5%	10
A. O. Fox Memorial Hospital	0%	0	0%	0
Albany Medical Center Hospital	3%	30	0%	0
Arden Hill Hospital	0%	0	1%	3
Auburn Memorial Hospital	0%	0	6%	22
Bayley Seton Hospital	0%	0	5%	13
Bellevue Hospital Center	4%	13	9%	45
Benedictine Hospital	0%	0	1%	3
Beth Israel Medical Center	9%	26	4%	32
Booth/Memorial Medical Center	0%	0	0%	0
Bronx - Lebanon Hospital Center	19%	38	1%	1
Bronx Municipal Hospital Center	10%	50	1%	2
Buffalo General Hospital	2%	5	3%	1
Cabrini Medical Center	21%	25	14%	39
Central General Hospital	4%	14	13%	64
Clifton Springs Hospital & Clinic	0%	0	0%	0
Community General Hospital - Sullivan County	0%	0	0%	0
Community General Hospital - Syracuse	0%	0	0%	0
Coney Island Hospital	0%	0	2%	4
Cornwall Hospital	3%	11	9%	17
Cortland Memorial Hospital	0%	0	0%	0
CVPH Medical Center	0%	0	2%	13
Eastern Long Island Hospital	0%	0	0%	0
Erie County Medical Center	3%	7	0%	0
Ellis Hospital	0%	0	1%	3
Elmhurst Hospital Center	3%	14	5%	28
Franklin Hospital Medical Center	0%	0	12%	47
Genesee Hospital	9%	42	0%	0
Glens Falls Hospital - Community MH	0%	0	2%	10
Good Samaritan Hospital	0%	0	4%	6
Harlem Hospital Center	0%	0	12%	21
Hempstead General Hospital	2%	7	4%	27
Hillside Hospital LIJMC	4%	10	4%	8
House of the Good Samaritan/Mercy Center	0%	0	0%	0
Huntington Hospital	2%	6	0%	0
Interfaith Medical Center	0%	0	0%	0
John T. Mather Memorial Hospital	0%	0	0%	0
Kings County Hospital Center	0%	0	7%	27

*Percent of total patients served in month (September 1992) secluded/restrained.

**Total monthly orders (September 1992) per 100 patients in average daily census

Hospital	*Seclusion*		*Restraint*	
	%Patients Secluded*	Orders Per 100 Patients**	%Patients Restrained*	Orders Per 100 Patients**
Lenox Hill Hospital	5%	11	5%	11
Lincoln Medical and MH Center	5%	15	1%	6
Long Beach Memorial Hospital	2%	5	12%	33
Maimonides Medical Center	0%	0	11%	31
Mary Imogene Bassett Hospital	0%	0	0%	0
Mercy Medical Center	4%	14	5%	111
Methodist Hospital	0%	0	3%	4
Metropolitan Hospital Center	23%	29	0%	0
Montifiore Medical Center	13%	18	0%	0
Mount Sinai Medical Center	3%	33	7%	20
Nassau County Medical Center	0%	0	2%	5
New York Hospital - Westchester	3%	21	3%	43
New York University Medical Center	6%	88	3%	71
Newark/Wayne Community Hospital	2%	7	0%	0
Niagara Falls Memorial Medical Center	0%	0	5%	188
North Central Bronx Hospital	14%	68	1%	2
North General Hospital	0%	0	15%	14
North Shore University Hospital - Glen Cove	0%	0	2%	6
North Shore University - Cornell	5%	27	5%	336
Northern Westchester Hospital Center	0%	0	2%	29
Olean General Hospital	0%	0	0%	0
Oswego Hospital M.H. Center Division	0%	0	2%	5
Our Lady of Mercy Medical Center	4%	13	0%	0
Park Ridge Hospital	12%	80	0%	0
Payne Whitney Psychiatric Clinic	3%	18	2%	38
Phelps Memorial Hospital Center	0%	0	0%	0
Presbyterian Hospital (Columbia)	2%	7	0%	0
Putnam Hospital Center	4%	35	16%	106
Queens Hospital Center	8%	51	7%	25
Rochester General Hospital	2%	4	18%	68
Samaritan Hospital	0%	0	7%	22
Saratoga Hospital MH Unit	0%	0	0%	0
Soldiers and Sailors Memorial Hospital	4%	56	4%	33
South Nassau Community Hospital	0%	0	12%	60
Southside Hospital	3%	6	3%	6
St. Barnabas Hospital	5%	24	4%	21
St. Clare's Hospital and Health Center	0%	0	0%	0
St. Elizabeth Hospital	0%	0	4%	11
St. Francis Hospital	0%	0	2%	10
St. James Mercy Hospital	0%	0	0%	0
St. John's Episcopal Long Island	0%	0	0%	0
St. John's Episcopal Hospital So. Shore	3%	4	29%	40

*Percent of total patients served in month (September 1992) secluded/restrained.

**Total monthly orders (September 1992) per 100 patients in average daily census

Hospital	*Seclusion* %Patients Secluded*	Orders Per 100 Patients**	*Restraint* %Patients Restrained*	Orders Per 100 Patients**
St. Joseph's Medical Center	4%	18	4%	100
St. Joseph's Hospital - Elmira	0%	0	3%	18
St. Josephs HHC Syracuse	8%	17	5%	10
St. Lukes - Roosevelt Hospital Center	5%	9	15%	51
St. Mary's Hospital CMHC	0%	0	3%	128
St. Vincent's - Westchester	1%	1	4%	08
St. Vincent's Hospital - NYC	8%	59	1%	24
St. Vincent's Medical Center of Richmond	0%	0	12%	59
Staten Island University Hospital	3%	4	40%	270
Strong Memorial Hospital of the University of Rochester	8%	56	1%	7
Summit Park Hospital	0%	0	2%	5
SUNY HSC University Hospital - Syracuse	3%	31	0%	0
Syosset Community Hospital	3%	5	0%	0
Tompkins Community Hospital	2%	31	5%	92
United Health Services - Binghamton	1%	5	7%	245
United Hospital Medical Center	10%	43	7%	171
University Hospital Brooklyn	0%	0	7%	27
University Hospital Stony Brook	4%	11	10%	52
Westchester County Medical Center	11%	20	14%	23
White Plains Hospital Center	0%	0	0%	0
Winthrop University Hospital	0%	0	0%	0
Womens Christian Hospital - Jones	3%	11	0%	0
Woodhull Medical and M.H. Center	0%	1	5%	25

State Psychiatric Centers

Hospital	*Seclusion* %Patients Secluded*	Orders Per 100 Patients**	*Restraint* %Patients Restrained*	Orders Per 100 Patients**
Binghamton P. C.	0%	0	2%	3
Bronx P. C.	10%	18	0%	9
Buffalo P. C.	6%	12	0%	0
Capital District P. C.	13%	35	6%	13
Central Islip P. C.	0%	0	0%	0
Central New York P. C.	0%	0	28%	74
Creedmoor P. C.	5%	7	2%	4
Elmira P. C.	0%	0	6%	19
Harlem Valley P. C.	2%	3	4%	9

*Percent of total patients served in month (September 1992) secluded/restrained.

**Total monthly orders (September 1992) per 100 patients in average daily census

Hospital	*Seclusion*		*Restraint*	
	%Patients Secluded*	Orders Per 100 Patients**	%Patients Restrained*	Orders Per 100 Patients**
Hudson River P. C.	3%	6	3%	15
Hutchings P. C.	0%	0	1%	2
Kings Park P. C.	0%	1	7%	15
Kingsboro P. C.	0%	0	5%	8
Kirby P. C.	18%	57	17%	313
Manhattan P. C.	1%	2	1%	1
Mid-Hudson P. C.	3%	25	19%	349
Middletown P. C.	1%	2	2%	16
Mohawk Valley P. C.	2%	7	2%	3
NYS Psychiatric Institute	5%	31	1%	10
Pilgram P. C.	0%	0	1%	3
Rochester P. C.	2%	2	24%	36
Rockland P. C.	5%	7	2%	4
South Beach P. C.	1%	3	6%	24
St. Lawrence P. C.	1%	1	8%	25
Willard P. C.	0%	1	6%	6

*Percent of total patients served in month (September 1992) secluded/restrained.
**Total monthly orders (September 1992) per 100 patients in average daily census

Appendix B

NYS Office of Mental Health's Response to Draft Report

NEW YORK STATE
OFFICE OF MENTAL HEALTH
44 Holland Avenue, Albany, New York 12229

RICHARD C. SURLES, Ph.D., Commissioner

July 18, 1994

Clarence J. Sundram
Chairman
NYS Commission on Quality of Care
for the Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, NY 12210-2895

RE: ***Restraint and Seclusion Practices in New York Psychiatric Facilities*** and ***Voices From the Frontlines: The Psychiatric Patient's Perspective on Restraint and Seclusion Use***

Dear Mr. Sundram:

OMH is in receipt of the Commission's two draft reports on the use of restraint/seclusion at New York State psychiatric centers. It is gratifying to note the high degree of concurrence of these reports with OMH's recently completed study on the use of restraint/seclusion and its resultant recommendations. Both of our studies share the preeminent goal of reduction in the use of restraint and seclusion as interventions.

Similar to the Commission, I had been concerned about a number of issues related to the use of restraint/seclusion. Therefore, in March, 1992, I appointed a Task force to review the use of these interventions in NYS psychiatric centers. The Task Force met for one year and produced a set of recommendations. These recommendations were sent to all inpatient programs and other interested parties for review. In addition, a workgroup was convened to review the recommendations from a recipient perspective. The final recommendations were arrived at after consideration of input from the Task Force, the Recipient Advisory Committee, and the field and are included in the attached report.

OMH Senior Staff is currently reviewing these recommendations in order to identify implications from a clinical, regulatory and fiscal perspective. Following this review and analysis, a comprehensive implementation plan will be developed.

Also attached is a Best Practices Report which contains information on practices which have been successfully applied in several of our hospitals and are associated with reduced use of restraint/seclusion as interventions.

In addition to these two documents, responses to the Commission's specific recommendations are attached.

Thank you for the opportunity to respond to the draft reports. If you have any questions regarding the information provided, please feel free to contact Dr. Sandra Forquer, Deputy Commissioner for Quality Assurance and Information Systems at (518) 473-6383.

Sincerely,

Richard C. Surles, Ph.D.
Commissioner

Attachments

cc: S. Forquer, Ph.D.

Response on Restraint and Seclusion

RECOMMENDATION (1)

The NYS Office of Mental Health should periodically (but at least semi-annually) collect and analyze restraint and seclusion usage data of state psychiatric centers and other state-licensed inpatient psychiatric facilities. Reports identifying the restraint and seclusion usage rates of these state's psychiatric facilities should be shared with all state-operated and state-licensed psychiatric facilities at least annually.

Since March 1992, OMH has been collecting and analyzing restraint/seclusion usage data for all state operated psychiatric centers. On a monthly basis, these facilities report data via electronic mail to OMH regarding their use of restraint/seclusion. These data are then analyzed to identify:

- Individual hospital rates of restraint/seclusion per 1,000 patient days
- Hospitals that are outliers in terms of their patterns of restraint/seclusion usage

This information is then compiled for all adult, children and forensic psychiatric centers, allowing for comparison across facilities, regions and patient populations. The resulting restraint/seclusion usage report is available to key Central Office staff and all state operated facilities on a daily basis via electronic mail. For those facilities identified as outliers, the OMH Quality Assurance Division undertakes follow-up activities which may include an on-site review by a clinical team.

RECOMMENDATION (2)

The NYS Office of Mental Health should require state operated and state-licensed psychiatric facilities to examine their restraint and seclusion use periodically, measuring their performance both against their own past performance and the performance of other psychiatric facilities in their community and the state. The objective of these activities should be to ensure the facility has taken all reasonable steps to minimize its use of these interventions, and these facility monitoring activities and their outcomes should be consistently reviewed by Office of Mental Health officials in their regular reviews of care and treatment in psychiatric facilities.

In addition to the restraint/seclusion usage report, OMH psychiatric centers conduct extensive internal analyses of their use of restraint/seclusion at the facility level. Training in statistical quality control techniques, as well as other analytic tools, has been provided to facilities to assist them in analyzing restraint/ seclusion usage. Each facility designs its own format for the reporting of this data. An example of this type of facility specific analysis is attached for illustrative purposes.

RECOMMENDATION (3) and (4)

The NYS Office of Mental Health should facilitate the sharing of best practices of state psychiatric centers, licensed psychiatric services of general hospitals, and private psychiatric hospitals which have consistently demonstrated very low (or no) usage of restraint/seclusion. Administrators and clinical staff of these facilities should be encouraged to share their perspectives of the explanations of their facilities' low use of restraint/ seclusion in Office of Mental Health newsletters and other publications and in training sessions and seminars with administrators and clinicians of other psychiatric facilities.

Review of restraint/seclusion practices at these facilities should also constitute a distinct focus of the Office of Mental Health's certification reviews of these licensed facilities.

- *In this context, it will be especially important for the Office of Mental Health to make a careful study of restraint/seclusion use at its forensic state psychiatric centers, where rates of restraint and seclusion were substantially higher than at other state psychiatric centers, and especially at Mid-Hudson and Kirby Psychiatric Centers which had combined monthly restraint/seclusion rates of well over 300 orders per 100 patients.*

- *Similarly, the Office of Mental Health should direct priority attention to the 16 psychiatric services of general hospitals which had combined monthly restraint and seclusion rates of over 75 orders per 100 patients.*

In order to identify best practices in the use of restraint/seclusion, site visits to OMH psychiatric hospitals were conducted in January and February of 1994.

Three hospitals with high rates of restraint and/or seclusion use were compared to two comparable hospitals with low use, to determine the reasons for low use, an identified goal of the agency. The hospitals with low use differed from the high use facilities in several areas which appear to be crucial to the reduction in the use of restrictive measures. These areas were:

- Strong administrative oversight of the use of restraint/seclusion, with a concurrent message that use is to be limited and/or reduced.

- Training in the use of alternative measures and an emphasis on training as a priority for all staff.

- A partnership in treatment among all levels of staff and between patients and staff that fosters an atmosphere of trust rather than of control.

- A comfortable ward atmosphere for patients and staff.

The results of this Best Practices Survey (attached) will now be shared with all state operated psychiatric centers and licensed psychiatric units of general hospitals in order to facilitate the transfer of these techniques and philosophy to their own settings.

Additionally, there are a number of recommendations in the OMH Restraint/Seclusion Report dealing with the need for training. A training strategy is now being developed to implement these recommendations. It is planned that the initial focus of training will be on those facilities that have demonstrated the highest rate of restraint/seclusion use.

In regard to the use of restraint/seclusion at the forensic psychiatric centers, OMH agrees with the importance of monitoring their higher usage rates. An on-site review was recently conducted at Mid-Hudson Psychiatric Center by the Quality Assurance Division. This review included recommendations and technical assistance to the facility aimed at reducing their use of restraint/seclusion. A similar review is planned for Kirby Psychiatric Center.

In regard to the use of restraint/seclusion at non-state operated psychiatric units of general hospitals, OMH agrees with the goal of reducing the use of these interventions in these settings. The OMH restraint/seclusion report advises that its recommendations (as applicable) be extended through regulation to apply to Article 28 inpatient programs licensed by OMH.

Presently, OMH includes the use of restraint/seclusion as an area of review during certification visits to licensed facilities. In addition, licensed facilities are required to report serious incidents (including those that involve restraint/seclusion) to OMH regional offices who then report these to OMH Central Office.

At the present time, OMH does not have the resources to monitor the use of restraint/ seclusion in licensed facilities with the same degree of oversight and intensity given to those facilities directly operated by OMH. In an attempt to positively impact practice at the licensed facilities, OMH will continue its present monitoring through certification reviews and incident reporting and will share with the licensed facilities any curricula/training materials that are developed. In addition, the Best Practices Report will be shared with these programs and they will be strongly encouraged to undergo training similar to that planned by OMH.

RESTRAINT/SECLUSION EPISODES:

The number of April episodes (n = 169) increased 27% from the previous month. Of the 169 episodes, 120 were *4 point restraints*, a 8% increase from the March data. Beginning in October 1992, rates based on patient days were utilized. Thus, a rate of 5.63 per 1000 patient days was observed for April 1994. The April patient days rate was 34% higher than March patient days rate of 4.20. Six units had April rate increases. Particularly, rates for *ITU*, and *Building 43B* increased 197% and 194%, respectively, over the March data.

UNIT	MARCH			APRIL		
	Episodes	Patient Days	Rate Per 1000	Episodes	Patient Days	Rate Per 1000
BLDG. 15	1	4588	0.22	1	4424	0.23
BLDG. 21	0	7761	0.00	2	7461	0.27
BLDG. 43A	24	3871	6.20	13	3776	3.44
BLDG. 43B	4	4076	0.98	11	3818	2.88
22 ADMS.	58	6747	8.60	72	6331	11.37
BTU	21	1600	13.12	17	1463	11.62
ITU	10	327	30.58	37	407	90.91
STU	15	930	16.13	16	810	19.75
C.P.U.	0	1707	0.00	0	1533	0.00
FAC. TOTAL	133	31,607	4.20	169	30,023	5.63

RESTRAINT/SECLUSION INTERVENTION

Figure H1 - illustrates the comparison of March and April 1994 restraint episodes by unit. The number of restraint events by month and unit was not statistically significantly different. However, episodes attributed to patients from the BTU/ITU/STU complex increased substantially from 46 (34%) in March to 70 (41%) occurrences in April. The *22 Admissions* contributed the largest proportion of all April episodes (43%; n = 72). When episodes attributed to this unit were contrasted against the March findings, a 24% increase in April events was observed.

Figure H2 - shows the dispersion of restraint events across time. No statistically significant trend was observed when the data were examined across a 52 month interval.

FIGURE H1: RESTRAINT / SECLUSION EPISODES BY UNIT
March 1994 versus April 1994

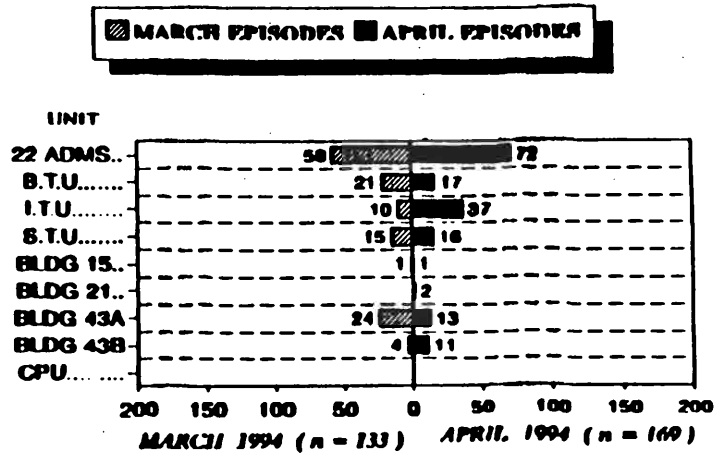
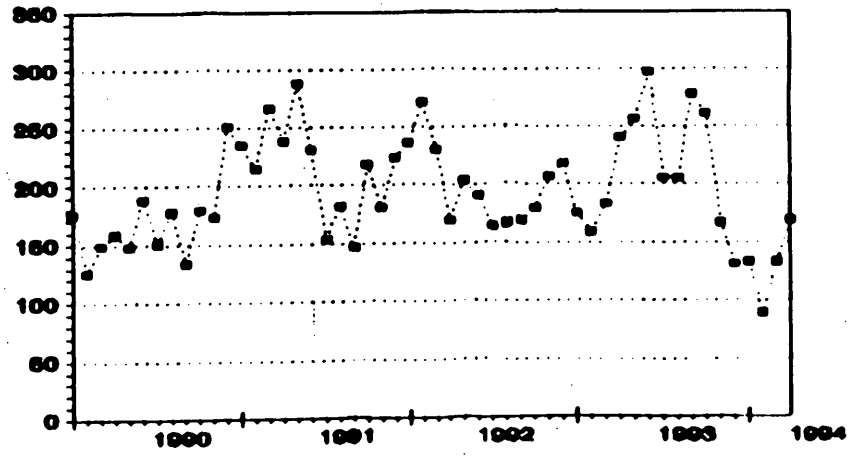


FIGURE H2: RESTRAINT / SECLUSION EPISODES
January 1990 - April 1994



RESTRAINT/SECLUSION BY MONTH OF OCCURRENCE

The table below shows restraint/seclusion episodes, restraint time, the average time in restraint and the rate of restraint/seclusion per every 1000 patients served for the past 13 months. Statistically significant differences in the number of restraint episodes and total number of restraint hours were observed between the March and April 1994 data. In April, restraint events increased 27% and the total number of restraint hours were up 21% over the previous month's findings.

MONTH AND YEAR	RESTRAINTS			
	Restraint Episodes	Restraint Hrs/Mins	Monthly Mean Time	Rate Per 1000
APR 1993	241	663:48	2:45	183
MAY 1993	257	707:52	2:45	197
JUN 1993	297	871:45	2:56	229
JUL 1993	203	545:35	2:41	156
AUG 1993	206	577:50	2:48	158
SEP 1993	278	802:32	2:53	213
OCT 1993	261	728:06	2:47	218
NOV 1993	167	488:57	2:55	140
DEC 1993	131	385:55	2:56	111
JAN 1994	133	359:38	2:42	114
FEB 1994	89	234:30	2:38	78
MAR 1994	133	393:20	2:57	116
APR 1994	169	475:55	2:48	149
TOTAL	2,565	7,235:43	2:49	----

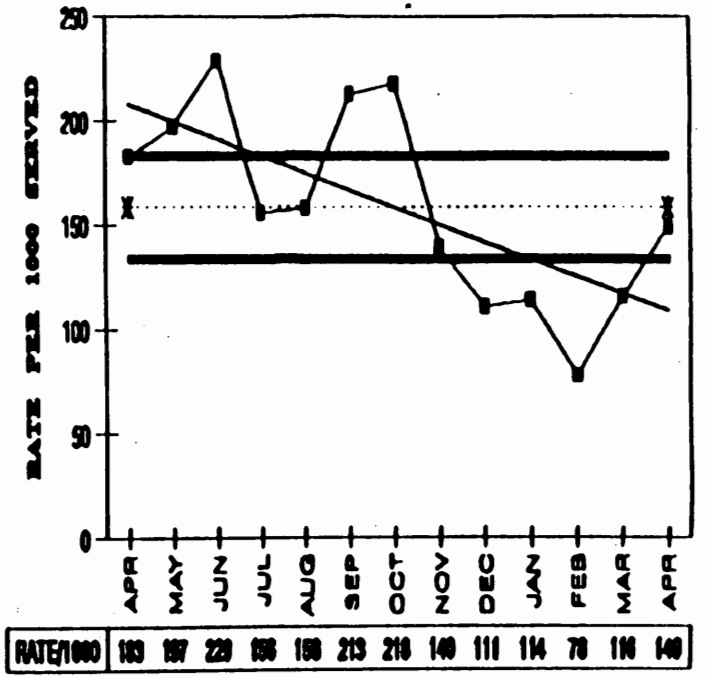
RESTRAINT/SECLUSION INTERVENTION

Figure I - illustrates a April 1994 facility restraint/seclusion rate (149/1000) increase of 28% from the April 1994 rate of 115/1000 patients served. When compared to the April 1993 rate (183/1000), a 18% decrease was observed. A trend analysis of the past 13 months was statistically significant. Since November 1993 restraint rates were within or below the 95% confidence limits.

A review of Executive Reports (available through PROFS) indicated that in March 1994 Kings Park contributed (24%) of the 475 Adult Psychiatric Service restraints and 4% of the 396 seclusion episodes reported by the 22 Adult Psychiatric facilities.

FIGURE I: RATE OF RESTRAINTS / SECLUSION PER 1000 SERVED

April 1, 1993 through April 30, 1994



TREND ANALYSIS USING 95% CONFIDENCE LIMITS

Department of Information Management and Evaluation

BEST PRACTICES TO REDUCE THE USE OF RESTRAINT AND SECLUSION

NYS Office of Mental Health
Quality Assurance Division
June 1994

BEST PRACTICES TO REDUCE THE USE OF RESTRAINT AND SECLUSION

EXECUTIVE SUMMARY

June 1994

Site visits to Office of Mental Health Psychiatric Hospitals were conducted in January and February 1994 to identify best practices in the use of restraint and seclusion. Three hospitals with high rates of restraint and/or seclusion use were compared to two comparable hospitals with low use, to determine the reasons for low use, an identified goal of the agency. The hospitals with low use differed from the high use facilities in several areas which appear to be crucial to the reduction in use of these restrictive measures. These areas were:

- Strong administrative oversight of the use of restraint and seclusion, with a concurrent message that use is to be limited and/or reduced.
- Training in the use of alternative measures and an emphasis on training as a priority for all staff.
- A partnership in treatment among all levels of staff and between patients and staff that fosters an atmosphere of trust rather than of control.
- A comfortable ward atmosphere for patients and staff.

SITE VISITS TO OMH FACILITIES TO REVIEW THE USE OF RESTRAINT AND SECLUSION

BACKGROUND

As a follow-up to the 1992 study of restraint and seclusion use at State psychiatric centers in New York State, the Division of Quality Assurance (QA) at the NYS Office of Mental Health (OMH) initiated a qualitative review of restraint and seclusion use in January-February 1994. One of the *Final Recommendations on the Use of Restraint and Seclusion* was to undertake a comparative analysis of similar facilities with high versus low rates of restraint and seclusion use, and to use the information to improve practices state-wide.

The July 1992 survey which is included in the *Report of the Task Force on Restraint and Seclusion*, March 1993, identified high and low use adult facilities. Other data which were considered in the choice of facilities to survey were September 1992 rates reported to the Commission on Quality of Care for the Mentally Disabled (CQC), and monthly rates reported to OMH on the PROFS electronic reporting system. From these data there emerged two adult facilities which were consistently high and two comparable facilities which were consistently low. Comparability included geographic area and patient population. A children's facility was chosen as an additional site both because of its high rate and for the on-site assistance which could be provided by an outside review of seclusion use[1].

SURVEY PROCESS

The five site visits were conducted by a group of seven reviewers. Two administrative staff (one from Central Office and one from a facility) interviewed administrative staff, two therapy aides interviewed direct care staff, and two central office staff, one of whom is a former recipient of mental health services, interviewed patients. At the adult facilities, a nurse or social worker interviewed nursing or other clinical staff.

The reviewers conducted separate, private interviews in which they asked administrators, direct care and professional staff, and patients to describe the restraint/seclusion process and their own involvement with the procedures and policies surrounding the use of restraint/seclusion. Interviews were held simultaneously in different parts of the facility, so that the process was completed in a one-day visit.

RESULTS

At the time of the site visits, the adult facilities with the high-use rates had already intervened to some extent to reduce seclusion and/or restraint use. However, the site visits

[1] This facility does not use restraints.

yielded some consistent patterns at the high-use and the low-use facilities which were related to the use of these interventions and which have implications for all inpatient psychiatric settings.

Administrative Oversight

There was a clear and strong message from the administrators of both of the low-use facilities that restraint and/or seclusion use was to be limited, and was to be based solely on individual patient need. One of these facilities has a policy stating that the use of restraint/seclusion is regarded as a treatment failure. At the other low-use facility, positive staff/patient interactions are emphasized and staff are re-trained or reassigned as indicated.

Training

Training at the low-use facilities occurred both at orientation and periodically thereafter. Training included alternative interventions to the use of restraint/seclusion, and clinical care and involvement rather than control of patients. Training at both of these facilities was a priority for the facility even during times of staff and funding cut-backs, and occurred directly on the wards as well as in the classroom.

Partnership in Treatment

The low-rate facilities demonstrated a partnership in treatment which involved staff at all levels and patients in decision making at the facility. Direct care staff described their role as that of a professional staff person who has been trained to intervene therapeutically as needed. For example, at one of the low-rate facilities, a hasty group meeting of patients was called to defuse an escalating confrontation between two patients. The patients felt they were listened to and had input into what happens on the ward. The empowerment of patients was especially visible in the case of several patients refusing to be interviewed simply because they did not feel like being interviewed at that time. This center also has a Director of Recipient Affairs who was very visible and active at all levels of the facility.

Monitoring of restraint/seclusion Includes Action Steps After the Event

At both low-use facilities there was a feedback loop following the use of restraint/seclusion. At one facility this is accomplished each day at the morning report for the previous day; at the other facility, a comprehensive written report after each use is shared with staff. De-briefing of the patients is an important part of the restraint/seclusion process as well.

Atmosphere

A difficult variable to assess, the ward atmosphere at the two low-use facilities was noticeably more comfortable than at the other facilities visited. The reviewers characterized this atmosphere as trusting and caring rather than controlling. Patients and staff were comfortable with the site reviews in these environments, and there was a noted absence of screening of

patients to interview, or of staff trying to listen-in on interviewers. Patients did not express fear of other patients, as they did at one of the high use facilities. They felt staff were there to help them if they had difficulty with another patient.

Implications for Care

Results of this review suggest that if the above conditions are replicated at other OMH facilities, the use of restraint/seclusion will decline. The facilities represented here include centers with high admission rates, short length of stay, and younger patient age. These variables have all been linked to high restraint/seclusion use in the past (OMH Report of the Task Force on Restraint and Seclusion, March 1993), yet these programs have reduced restraint/seclusion use substantially. When the initial review of restraint/seclusion was reported in 1984, one of the low-use facilities was among the seven facilities with the highest rate in the State. A determined effort by the administration has totally reversed the situation at this program. The implications for reducing restraint/seclusion use at other OMH facilities are clear from the information presented here. As shown by Manhattan Psychiatric Center, which reversed its rate from 1984 to 1992, this effort may be difficult and may take time, but is clearly possible.

Site Visit Team:

Gary Bauer, MSW / Ed Day, RN, Bureau of Data/Incident Management
Howard Coleman, Security Hospital Treatment Chief, Central New York PC
Neil Covatta, Bureau of Recipient Affairs
Kathleen Earle, MSW, Bureau of Data/Incident Management
Bruce Horn, SHTA, Central New York PC
Peggy Gouse / Marlene Faroni, Service SHTA, Central New York PC
Andrea Kohler, MSW, QA Office, Capital District PC
Patricia McDonnell, MSW, Bureau of Data/Incident Management

Appendix C

Commission's Response to the Office of Mental Health's Response to Draft Report

STATE OF NEW YORK
COMMISSION ON QUALITY OF CARE
FOR THE MENTALLY DISABLED
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CLARENCE J SUNDRAM
CHAIRMAN

ELIZABETH W STACK
WILLIAM P BENJAMIN
COMMISSIONERS

August 11, 1994

Richard C. Surles, Ph.D.
Commissioner
Office of Mental Health
44 Holland Avenue
Albany, New York

Dear Dr. Surles:

Thank you for your response to the Commission's draft reports: *Restraint and Seclusion Practices in New York Psychiatric Facilities* and *Voices From the Front Line: The Patients' Perspective on Restraint and Seclusion Use.* The Commission is pleased the Office of Mental Health concurs with the main conclusion of these reports that restraint and seclusion use is too high at many psychiatric facilities and that concerted efforts must be directed to reduce the use of these interventions.

The Commission appreciates the Office of Mental Health's general endorsement of the recommendations in the report *Restraint and Seclusion Practices in New York Psychiatric Facilities* as they relate to state psychiatric centers and that several initiatives are underway to address them. In this regard, the Commission would appreciate the receipt of copies of restraint and seclusion reviews conducted at Mid-Hudson and Kirby Psychiatric Centers, as well as the staff training curriculum and schedule which OMH plans to use at high restraint and seclusion use state facilities.

In your response, you acknowledge that the Commission's restraint and seclusion oversight recommendations are also applicable to state-licensed psychiatric services of general hospitals and private psychiatric hospitals, but you note that they cannot be implemented because of resource limitations.

The Commission appreciates that monitoring activities for these approximately 120 licensed programs should necessarily be tailored differently from those designed for the

state's 25 adult psychiatric centers. Yet, resting the monitoring of restraint and seclusion in these programs solely in the current certification process and serious incident review process is not an adequate alternative.

Today, these state-licensed acute psychiatric settings serve almost four out of every five New Yorkers who will be admitted for acute psychiatric inpatient care. They are the primary setting for inpatient psychiatric care, and they are the primary treatment sites where restraints and seclusion are used.

Commission staff have reviewed many certification reports on these programs in the past several years, and has noted that they examine restraint and seclusion practices idiosyncratically, or not at all. None of these reports reviewed by the Commission have critically examined the restraint and seclusion usage rates at these facilities. Indeed, the absence of periodic collection and reporting on data related to restraint and seclusion use in its licensed psychiatric facilities has left certification and inspection staff without any reliable benchmarks on which they can form these judgments.

In short, the Commission strongly recommends that the Office of Mental Health reconsider other alternatives for more thorough oversight and monitoring of restraint and seclusion practices in its state-licensed psychiatric services. For example, requirements that facilities maintain and annually report to OMH monthly restraint and seclusion usage data, and establish a mechanism for periodically assessing the satisfaction of psychiatric patients toward their care and treatment, and especially any restraint and seclusion use, would seem to be a practical alternatives.

I have also had the opportunity to review the final recommendations of the *OMH Task Force on Restraint and Seclusion*. The Commission supports most of the recommendations in the final report, and compliments OMH on its reconsideration of the draft recommendations, with substantial input from former and current recipients of services. The Commission especially supports the much stronger focus in the final recommendations on efforts toward minimizing restraint and seclusion use and on issues of patient-centered ward management

At this time, however, the Commission also wants to restate its opposition to four recommendations. These objections were also raised in the agency's comments on the draft Task Force report.

(1) As detailed in some length in my letter of May 6, 1994 (see attached), the Commission does not endorse the use of seclusion with persons who are mentally retarded. Change in this regulation is in direct opposition to the Governor's and the State Legislature's commitments in the Willowbrook Consent Decree, which have stood for two decades. This is no time to turn back the tide in special protections for persons with mental retardation.

(2) Although the Commission endorses the intent of the recommendation for including a greater emphasis on interpersonal skills in the hiring of mental

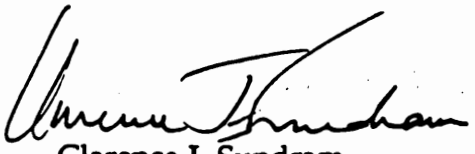
hygiene therapy aides in state psychiatric centers, the Commission restates its objection to this job selection criteria being singled out only for therapy aides, as it appears equally, if not more relevant, for all clinical and administrative staff with direct patient contact.

(3) The Commission does not support the authorization of the "blanket" restraining device. There are insufficient clinical data in the literature supporting the need for this new form of restraining device, which also has apparent potential safety risks.

(4) The Commission continues to have reservations about extending the use of PADs and it objects to any trial use of these restraints without the protections of Mental Hygiene Law.

In closing, thank you again for your response to the Commission's reports. Please feel free to contact me or Nancy K. Ray of my staff if you have any questions regarding this letter.

Sincerely,



Clarence J. Sundram
Chairman

cc: William Benjamin
Elizabeth Stack
Nancy K. Ray, Ed.D.

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COMMISSIONERS

May 6, 1994

Honorable Richard C. Surles, Ph.D.
Commissioner
Office of Mental Health
44 Holland Avenue
Albany NY 12229

Dear Dr. Surles:

I am writing to comment on OMH's proposed regulatory amendment rescinding the current restriction on the use of seclusion with persons who are mentally retarded receiving treatment in mental health treatment facilities (14 NYCRR Part 27.7 [b]).

The Commission recommends that this regulatory amendment be withdrawn until such time as the Office of Mental Health has further studied the benefits and possible disadvantages and risks of this significant regulatory change — which may have an adverse impact on many persons who are mentally retarded and who also have a concomitant mental illness requiring treatment in mental health facilities.

As detailed below, the Commission believes that this proposed regulatory change would represent a step backward from the principles articulated and the commitments made almost two decades ago in the Willowbrook Consent Decree and endorsed by both the State Legislature and the Governor. For two decades, psychiatric facilities have respected the recognized right of persons who are mentally retarded not to be secluded. No compelling justification had been advanced for the abrupt termination of this right. Its termination creates a risk that persons who are mentally retarded may be secluded in psychiatric facilities due to an absence of specialized programs or as a means of coping with staffing shortages to meet their special needs.

The Commission is aware from reading the OMH Restraint and Seclusion Preliminary Task Force Report that the proposed amendment originates in large part from the Office's finding that persons who are mentally retarded are more likely to be subjected to restraints than other patients and its belief that if seclusion could be used with these patients restraints may be used less frequently. The Commission, too, has observed that individuals who are mentally retarded are often subjected to excessive use of restraints in psychiatric facilities — yet there is no empirical evidence which sustains the proposition that such excessive restraint use should be substituted with seclusion use.

Indeed, most Commission reviews of the excessive use of restraints with adults and children who are mentally retarded in psychiatric facilities have suggested that these interventions have been used contrary to specific provisions in mental hygiene law and regulations -- requiring that these interventions only be used when the individual is dangerous to himself or others *and when other less restrictive interventions have been tried and failed and never as a substitute for programming*. To the contrary, the Commission has usually found that excessive use of restraints with persons who are mentally retarded in psychiatric facilities is usually associated with the failure of these facilities to develop and implement behavioral plans for these individuals which include other less restrictive and more instructive methods for helping the individual with difficult and sometimes dangerous behaviors.

In addition to this point, the Commission also offers the following other justifications for OMH withdrawing this proposed regulatory amendment at this time, pending further study.

(1) the current regulation forbidding the use of seclusion with persons who are mentally retarded is consistent with established professional opinion in the field of mental retardation that the use of seclusion with persons with severely compromised cognitive abilities is not a therapeutic intervention and that when periods of withdrawal from stimulation etc. are needed for persons who are mentally retarded "time-out" procedures which are more time-limited and used in conjunction with a planned behavioral management strategy are more advisable. This rationale that seclusion is an unacceptably punitive intervention for persons who are mentally retarded would seem to apply even more to persons who are both mentally retarded and mentally ill.

(2) The federal Health Care Financing Administration does not authorize the use of seclusion in intermediate care facilities for the mentally retarded, and the Accreditation Council on Services for People with Disabilities (ACD, formerly ACMRD, 1990) accreditation standards also preclude the use of seclusion in programs which it accredits that serve persons who are mentally retarded. Both of these subclasses of facilities serving persons who are mentally retarded also serve many individuals who carry a concomitant diagnosis of mental illness.

Indeed, in many states, as in New York State, a large subgroup of persons who continue to reside in state-operated institutions certified as intermediate care facilities for the mentally retarded are dually diagnosed.

(3) For many years, the NYS Office of Mental Retardation and Developmental Disabilities has operated specialized units called multiply disabled units (MDUs) in its state developmental centers for persons who are dually diagnosed. Presently, there are approximately 700 individuals with dual diagnoses residing in eight multiply disabled units under the auspice of OMRDD; by virtue of their placement in this level of care, most of these individuals are considered to have very complex and challenging treatment and behavioral needs.

It is noteworthy, especially given the treatment challenges of these individuals, that OMRDD does not authorize the use of either restraint or seclusion on these units, and instead relies extensively on behavioral management plans which are individually designed and diligently implemented. The Commission recently reviewed six of these multiply disabled units and found very impressive treatment programs, as well as very low use of unscheduled administrations of psychotropic medications and significant behavioral gains by most individuals reviewed.

We recognize that some OMRDD facilities are better staffed typically than OMH facilities. However, staffing considerations alone should not be determinative in the use of restrictions upon patients in mental health facilities.

(4) Data reported by 125 New York psychiatric facilities for September 1992 indicated that almost half of these facilities made no use of seclusion during the month studied, suggesting that many psychiatric facilities are able to treat patients effectively without seclusion. The Commission could discern no difference in the demographic profiles of the patients served by the facilities using and not using seclusion.

The few reported studies in the literature on patients' perceptions of seclusion also uniformly indicate that most patients perceive the use of this intervention as punishing and countertherapeutic (Wadeson and Carpenter, 1976; Wells, 1971; Soliday, 1985; McElroy, 1985; Chamberlin, 1985). A recent Commission survey of over 500 former patients who had been secluded in NYS psychiatric facilities revealed similar findings.

These concurrent findings suggest both that it is possible to treat psychiatric patients effectively without seclusion and that treatment with seclusion is viewed negatively by most patients. Neither of these research findings provide support for the Office of Mental Health to *extend* the authorized use of seclusion at the current time.

(5) There is no credible research evidence that suggests that authorization of the use of seclusion with persons who are mentally retarded will reduce the use of restraint with these individuals. Indeed, most research studies which have studied the impact of the restriction of one intervention on the use of the other are inconclusive (Antoinette, 1990; Miller, 1989; Sloane et. al., 1991; Tsemberis, 1988). The Commission's study of restraint and seclusion use at 125 psychiatric facilities in New York State also showed no significant association between facilities' rates of use of restraint and their rates of use of seclusion.

Instead, available literature tends to suggest that the most effective means of reducing restraint or seclusion use in psychiatric facilities is the institution and careful implementation and monitoring of administrative procedures and restrictions related to the use of both interventions. The diligent enforcement of the requirement for initial efforts to attempt less restrictive interventions prior to resorting to restraint and seclusion has proven to be especially effective (Swett et. al., 1989; Kalogera et. al., 1989; Davidson et. al., 1984; Erickson and Realmuto, 1983; Carmel and Hunter, 1990; Clenda, 1991; Wong et. al. 1988, Rybroek and Maier, 1988).

In closing, I would also note that this proposed regulation was inadequately circulated among service providers, family advocacy groups, and self-advocacy groups for persons who are developmentally disabled and mentally retarded. In preparing its comments, Commission staff contacted a number of these groups soliciting their input and opinions, only to find that none of these groups had been notified of the proposed Office of Mental Health regulatory amendment.

Sincerely,

Clarence J. Sundram
Chairman

Attachment
cc: Assemblyman Steven Sanders
Senator Thomas Libous

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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)