
Seclusion and Restraints: A Failure, Not a Treatment

**Protecting Mental Health Patients
from Abuses**



California Senate Office of Research

March 2002

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Prepared by Laurel Mildred

**California Senate Office of Research
Elisabeth Kersten, Director**

Edited by Rebecca LaVally

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Executive Summary

Overview

Seclusion and restraint of psychiatric patients are known to be dangerous practices that can result in serious injury, trauma and even death.¹ The Harvard Center for Risk Analysis estimates that 50 to 150 deaths occur nationally each year because of psychiatric seclusion and restraints.² Here in California, at least 14 people have died and at least one has become permanently comatose while being subjected to these practices since July of 1999.³ This does not reflect those who are injured or traumatized – California does not keep track of those data.

We do know, however, that at a very conservative estimate, over 100,000 Californians are involuntarily committed to psychiatric facilities each year,⁴ and that along with voluntary patients, they are at risk of being subjected to seclusion and restraints (S/R).

Accounts of serious injuries and deaths resulting from S/R were reported in the *Hartford Courant* and other sources during 1998 and gained wide national attention. These reports found that patients became comatose, suffered broken bones, were hit in the face, bruised, needed stitches or were bleeding as a result of being placed in S/R.⁵ In the worst cases, patients died of causes that included asphyxiation, strangulation, cardiac arrest, fire or smoke inhalation, blunt trauma, drug overdoses or interactions, and choking.⁶

These revelations led Congress to adopt significant federal reforms in 1999 and again in 2000. The Joint Commission on the Accreditation of Healthcare Organizations also adopted new policies that affect about 80 percent of the nation's health care facilities. However, federal reforms have not, by themselves, prevented harm to our most vulnerable citizens, held in psychiatric

facilities against their will for what is supposedly their own well-being.

California's oversight of S/R in psychiatric facilities is a regulatory maze that impedes accountability and progress. In addition, statewide standards on S/R are piecemeal, depending upon the type of facility, and we lack a comprehensive and mandatory statewide reporting system. Consequently, the only meaningful measure of seclusion and restraints in California is when people die.

The California Office of Patient Rights is vested with responsibility for collecting and reporting information about use of S/R. However, it must rely on data supplied by counties and facilities. In 2000, the Office of Patient Rights documented a high rate of noncompliance with reporting requirements: 56 facilities, or 22 percent, submitted either an incomplete report or no report at all.⁷ Even two of the state hospitals – Atascadero and Metropolitan – did not comply with the requirement.⁸

The Office of Patient Rights cites these limitations in California's reporting system:

- ♦ *There are no specific statutory or regulatory provisions or other mechanisms for enforcing facility and/or county compliance with the regulatory requirements.*⁹
- ♦ *There are no standard procedures or guidelines for counties to establish and maintain a list of facilities that are required to comply with these reporting requirements.*¹⁰
- ♦ *Consequently, absent any routine monitoring of the Department of Health Services' licensing and certification records of licensed facilities, we cannot assert that this report reflects or contains information from all California facilities falling within reporting requirements.*¹¹

For these reasons, the Office of Patient Rights has concluded that "there is no way to accurately track or report countywide or statewide trends regarding the denial of patients' rights or the use of seclusion and restraint."¹² In addition, the California Department of Health Services reports that it does not consider data on seclusion and restraints from the Office of Patient Rights when deciding whether to conduct inspections on facilities.

Other states have imposed new restrictions in their S/R policies. Most notably, Pennsylvania has developed an award-winning model that reduced overall incidents of seclusion and restraint by 74 percent and reduced the hours that patients spent in S/R by 96 percent over a three-year period.¹³

The Pennsylvania reforms were accomplished with no additional staff or funds, and no increase in injuries to staff.¹⁴ Charles Curie, then deputy secretary of Pennsylvania's mental health and substance abuse services,¹⁵ articulated a new philosophy of care that became the basis for a comprehensive change of culture in Pennsylvania's state hospital system: "Most of our patients are already the victims of trauma. There is no need to reinforce that trauma, or to re-traumatize."¹⁶

Pennsylvania's first step was to institute a mandated and publicly accountable system of tracking seclusion and restraints. The state developed system-wide policies that required training, diffusion of conflict, accountability for using S/R, awards and recognition for reducing its use, cultural competence, a prohibition on all chemical restraints, a prohibition on using S/R on voluntary patients, and debriefings with patients, families and staff after each incident. Central to these reforms was the core concept that seclusion and restraints are not treatment – they reflect a *treatment failure*, and should be handled as such to prevent the escalation of violence. This commitment has radically changed the longstanding culture, environment and level of violence in Pennsylvania's nine state hospitals.

This analysis determines that California's piecemeal regulatory system could benefit from practices similar to those developed in Pennsylvania.

Findings and Options

The new federal reforms that govern S/R policies are only as effective as the oversight mechanisms that enforce them. There are at least two significant barriers to accountability in the use of S/R in California facilities:

- ♦ A lack of uniform statewide standards across various types of facilities; and
- ♦ A lack of mandatory, consistent and publicly accessible reporting on the use and consequences of S/R. These include deaths, serious injuries, frequency and duration of S/R and

related conditions and situations such as airway obstructions, patient falls, staff injuries and medication errors.

Private psychiatric hospitals may be the most difficult to regulate. The U.S. inspector general found in August 2000 that private facilities may be the least likely to comply with the 1999 federal S/R regulations and therefore may be the most in need of uniform state standards and enforcement.¹⁷

There is compelling evidence in the Pennsylvania experience that S/R can be dramatically reduced with a change of organizational values and culture.

The following steps could be taken with a goal of reducing S/R practices and the injuries, deaths and traumas that can result from them:

- ◆ California could develop uniform seclusion and restraint standards that match if not exceed the highest federal regulations to cover all facilities – private as well as public – that treat people with psychiatric disabilities. Federal standards vary based on licensing and accreditation, while state standards vary based on type of facility. The experience of other states has shown that a high uniform state standard improves the quality of enforcement and compliance.
- ◆ California could develop mandatory, comprehensive and publicly accessible data-reporting requirements on the use of seclusion and restraints, with meaningful consequences for noncompliance.
- ◆ A working group could be directed to review practices, policies and facilities in Pennsylvania with the goal of developing proposals to safely and cost-effectively reduce the use of S/R in California.

Part I

Seclusion and Restraints: Issues and Actions

The issue of seclusion and restraint of psychiatric and substance-abuse patients gained national notoriety in October of 1998 when the *Hartford Courant* published a five-part investigative series entitled “Deadly Restraint.” The *Courant* conducted a national survey that documented 142 deaths in the past decade that were directly connected to the use of seclusion or physical restraints (Appendix 1).

Seclusion refers to isolating a person in a locked room. Restraints are human or mechanical measures that use force or the threat of force to control someone’s actions. “Take downs,”* holding someone face-down in a prone position, strait jackets or tying someone by hands and feet are all examples of restraints. Chemical restraints are medications that are not otherwise necessary and that are used to control someone’s behavior.

The Harvard Center for Risk Analysis has estimated that deaths and injuries from seclusion and restraints are significantly under-reported. Its study of the prevalence of seclusion and restraint-related deaths statistically estimated that between 50 and 150 deaths occur nationally *each year* because of S/R use on psychiatric and substance-abuse patients.¹⁸

A national impetus for reform was triggered by incidents reported by the *Courant* and other sources:

* A “take down” is a technique to force an uncooperative person to the floor to place him or her in restraints. At least five staff surround the patient, each taking the head, an arm or leg, and force him or her down. Injury to the patient often occurs if staff sit on the person while restraints are secured. This technique is frequently violent, causing significant patient and staff injuries.

- ♦ Gloria Huntley, 31 years old, died in Central State Hospital in Petersburg, Virginia, after having been kept in restraints for 558 hours during the last two months of her life. Although she had been diagnosed with asthma and epilepsy, she was nevertheless restrained over and over again because of angry outbursts at hospital staff (*Hartford Courant*, 1998).
- ♦ Sixteen-year-old Tristan Sovern died in Charter Greensboro in North Carolina in 1998 after he was placed in restraints as “punishment” for leaving a group-therapy session. In response to his screams of, “You’re choking me . . . I can’t breathe,” a towel was shoved over Tristan’s mouth (*60 Minutes II*, 1999).
- ♦ Here in California, Kristal Mayon-Ceniceros, age 16, died of respiratory arrest in New Alternatives, a private Chula Vista residential-care facility. She died after being restrained face-down on the floor by four staff members (*Associated Press*, 1999).
- ♦ Also in California, Rick Griffin, 36, of Stockton died of cardio-respiratory failure and extreme agitation in the San Joaquin County Psychiatric Health Facility. He had been wrestled to the floor by eight staff members and bound in leather restraints (*The Stockton Record*, 1998).
- ♦ *Andrew McClain was 11 years old and weighed 96 pounds when two aides at the Elmcrest psychiatric hospital in Portland, Connecticut, sat on his back and crushed him to death. His offense? Refusing to move to another breakfast table* (Lieberman, Dodd and De Lauro, 1999).
- ♦ *Edith Campos, 15, suffocated while being held face-down after resisting an aide at the Desert Hills Center for Youth and Families in Tucson, Arizona. She was subjected to restraints after refusing to hand over an “unauthorized” personal item. The item was a family photograph* (Lieberman, Dodd and De Lauro, 1999).

Initial Response

The *Courant* series sparked congressional hearings into S/R policies and how people have been traumatized, injured and killed as a result of these practices. Congressional leaders responded with federal reform proposals. In a series of high-profile hearings,

deaths, injuries and abuses resulting from seclusion and restraints were exposed:

Unfortunately, these are not isolated incidents. They are but a few of scores of cases in which mental health patients – a disproportionate number of them children – died barbaric deaths more suited to medieval torture chambers than to late 20th century America. They died because of the improper use of seclusion and physical or chemical restraints. They died at the hands of the very people who were supposed to protect them.

- Senator Lieberman, Senator Dodd and Representative DeLauro,
July 16, 1999

The National Alliance for the Mentally Ill (NAMI) also has tracked reports of recent and past S/R abuses (Appendix 2). NAMI reported over 25 new incidents nationwide of deaths, injuries and traumas caused by seclusion and restraints after the *Courant* survey. *Currently, there is no official tracking of injury or trauma to patients or to staff in California.* NAMI, however, reported numerous incidents of serious injury – patients who became comatose, who suffered broken bones, were hit in the face, bruised, needed stitches or were bleeding as a result of restraints.¹⁹

Equally troubling is the humiliation and trauma NAMI documents, such as its many reports of patients unable to use the bathroom and left for hours in their own bodily wastes. One patient was restrained for rejecting medication because she still hoped to nurse her young child; another was placed in restraints because he couldn't stop crying. A 12-year-old was placed in a straightjacket in the middle of the floor where everyone could watch her – and staff called this a “burrito.” A patient who voluntarily admitted herself to a hospital found herself reliving former traumatic experiences:

Suddenly the guard had a huge pair of leather cuffs with padlocks on them . . . All I knew was that I was being strapped down to a bed by a strange man with a gun. This is not good therapy for a rape victim . . . All I could do was close my eyes and pretend this wasn't happening to me.²⁰

The U.S. General Accounting Office (GAO), in an October 1999 report on improper seclusion and restraints, validated the notion that patients may be severely traumatized while being restrained,

even if no physical injuries are sustained: “. . . Research indicates that at least half of all women treated in psychiatric settings have a history of physical or sexual abuse.”²¹

Citing a Massachusetts state task force on the topic, the GAO stated that the use of restraints on patients who have been abused often results in their re-experiencing their traumas and contributes to a setback in the course of treatment.

Congress adopted reforms to federal policies administered by the U.S. Centers for Medicare and Medicaid Services (CMS, formerly HCFA) in 1999. In addition, the Joint Commission on Accreditation of Healthcare Organizations has adopted new policies. The recently enacted Children’s Healthcare Act of 2000 was the third major federal reform. Explained more fully in Part II of this report, these new policies are intended to restrict and reduce S/R practices.

Despite these reforms, the federally mandated advocate organization Protection and Advocacy reports that 14 Californians have died and one has been permanently injured (in a persistent coma) while in seclusion or behavioral restraints since the new CMS rules were put into place in July 1999. Since there is no official requirement for reporting nonfatal injuries, we cannot officially confirm the types of injuries documented by NAMI, the news media and the GAO.

California’s standards governing S/R practice are different for each kind of facility. State hospitals, general acute care hospitals, psychiatric health facilities, skilled nursing facilities – all are facilities that utilize S/R. However, each type of facility is governed by a different set of state regulations. For example:

General Acute Care Hospitals – In a case of emergency, S/R can be initiated at the discretion of a registered nurse and a verbal or written order obtained from a physician afterwards. If a verbal order is obtained it shall be signed by the physician on his next visit. Orders for S/R may be for longer than 24 hours.

Psychiatric Health Facilities – In an emergency, a physician’s order can be received over the telephone within one hour of initiating S/R and must be signed in person within 24 hours. Orders for S/R may be in force for *no longer* than 24 hours.

Skilled Nursing Facilities with Special Treatment Programs – A physician may give the order for S/R by telephone and sign it in

person within five days. The order expires and must be renewed each 24 hours to keep a person in S/R.

Each facility's standards differ from the others, and on this particular issue none is as stringent as the federal standard. California's regulatory standards and some of the problems associated with them are discussed more fully under "Patchwork Oversight" on page 15.

Scope of Report

This report focuses on issues of psychiatric seclusion and restraints. It does not address issues of medical restraints, such as immobilizing a person for a surgical procedure, or placing a person's arm in a "sleeve" to prevent removing an intravenous needle. Nor does it address the important issues of S/R policies in schools or facilities for the developmentally disabled, or in correctional facilities for youths or adults. It is limited in scope to policies of psychiatric seclusion and restraints in mental health facilities.

The Pennsylvania Experience

Seclusion and restraints have been used to control the behavior of psychiatric patients since the Middle Ages.²² However, these techniques have also involved high risk of patient injury and death. Pennsylvania has been a leader in trying to change this culture and working to reduce and ultimately eliminate the use of seclusion and restraints in its nine state hospitals.

The Pennsylvania Office of Mental Health and Substance Abuse Services implemented its program because:

...these measures [S/R] do not alleviate human suffering or psychiatric symptoms, do not alter behavior and have frequently resulted in patient and staff injury, emotional trauma and patient death.²³

Expert testimony at hearings of the Joint Commission on Accreditation of Healthcare Organizations also called attention to the counter-therapeutic aspects of S/R:

The attempt to impose "treatment" by force is always counterproductive – creating humiliation, resentment and resistance to further treatment that might be more helpful.²⁴

In practice, seclusion and restraints are sometimes imposed on psychiatric patients for reasons that are not therapeutic. These uses of S/R have been discredited and are illegal under current law; however, they persist. S/R practices are sometimes used to:

- ♦ *Control the environment* – To curtail a patient’s movement to compensate for having inadequate staff on the ward, or to avoid providing appropriate clinical interventions;
- ♦ *Coerce* – To force a patient to comply with the staff’s wishes; or
- ♦ *Punish* – To impose penalties on patient behaviors.

NAMI has been a leader in the effort to end S/R on these terms. Its position is that restraints and seclusion have no therapeutic value, and therefore they are not a “treatment.” NAMI asserts that S/R are dangerous interventions and should be used only in cases of extreme emergency when someone’s physical safety is in jeopardy, and then only with careful safeguards.²⁵

The idea that psychiatric patients are treated with brutality, are seriously injured or even killed in this day and age may be difficult to believe. But the *Courant* investigation, the Harvard Center for Risk Analysis and NAMI’s report all demonstrate that these practices continue to exist, placing psychiatric patients at risk of trauma, injury and even death. In the most egregious cases, where someone has died, the causes of death are frequently violent: asphyxiation, strangulation, cardiac arrest, fire or smoke inhalation, blunt trauma, drug overdose, drug interactions, and choking.²⁶

These are our most vulnerable citizens. Since they are often held against their will, supposedly for their own well being, it would be incumbent upon the state to protect them from being injured, traumatized and abused.

To address that responsibility, this paper examines three critical issues:

- 1) Seclusion and restraints policies have received national attention and have been the focus of three successive initiatives of federal reform. Is that enough?
- 2) California’s oversight of seclusion and restraints is a patchwork quilt of confusing bureaucracy that impedes accountability and progress. Can it be improved?

- 3) Other states have taken action to improve seclusion and restraints policies on the state level. Most notably, Pennsylvania has developed a model that garnered the Harvard Innovations in American Government Award and reduced hours of seclusion and restraints by 96 percent in its state hospitals. Can California benefit from model practices developed in Pennsylvania?

Part II

Federal Reforms and State Impacts

New Federal Regulations: Three Layers of Reform

In response to the *Hartford Courant* series and the vigorous lobbying of NAMI, federal actions to revise national policy on seclusion and restraints were proposed and implemented. Reform came in three successive initiatives:

- ♦ First, the U.S. Centers for Medicare and Medicaid Services (CMS) issued new interim rules for Medicare and Medicaid hospitals in July of 1999.
- ♦ Next, the Joint Commission on Accreditation of Healthcare Organizations released revised seclusion and restraints standards that took effect January 1, 2001.
- ♦ Most recently, on May 22 last year, CMS issued Interim Final Rules under the Children’s Health Act of 2000, setting forth new regulations for psychiatric facilities that receive federal funds and for “nonmedical community-based facilities for children and youth.”

First Reform: CMS Breaks New Ground

CMS set forth interim final rules as of July 1999 that revised seclusion and restraints standards in any hospital that receives Medicare or Medicaid financing.

The preamble to the rules broke new ground by declaring: “The patient’s right to be free from restraints is paramount.”²⁷ The rules stated that S/R may only be used in emergency situations if needed to ensure the patient’s physical safety and when less-restrictive alternatives have been determined ineffective, and that

coercion, discipline, convenience of the staff or retaliation are unacceptable reasons for placing a patient in restraints.

The interim standards also required training for staff involved in S/R and, most significantly, implemented a “one-hour rule.” This required a patient placed in restraints to receive a face-to-face evaluation by a licensed professional practitioner within one hour. The new regulations also required reporting all deaths associated with seclusion and restraints in CMS facilities.²⁸

These changes in federal policy were significant, although advocacy groups argued that they did not go far enough. Some providers, however, countered that reform was unnecessary and prohibitively expensive. There was a contentious debate over whether the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) should adopt lesser standards or conform to CMS’s new interim rules.

Second Reform: JCAHO is Lobbied to Concur with CMS Rules

JCAHO’s standards are important because it gives accreditation to approximately 80 percent of the health care facilities in the country. JCAHO is a legal agency of the federal government. If a health care facility is accredited by JCAHO and meets all of JCAHO’s standards, it also is deemed to have met all of CMS’s standards and is eligible to receive Medicare and Medicaid financing.

In a protracted battle, advocates persuaded JCAHO not to adopt lesser standards than those in the CMS reforms. Some of JCAHO’s new rules (Appendix 3) are stronger than CMS’s but they meet all of the CMS minimal standards, including the hotly debated one-hour rule.

In releasing JCAHO’s new standards on seclusion and restraints, JCAHO President Dennis O’Leary, M.D., stated: “These standards underscore the importance of applying great care in using interventions that can harm or even kill patients.”²⁹

Third Reform: Children’s Health Act of 2000 Sets Strongest Rules Yet

The third and most comprehensive set of reforms were included in the federal Children’s Health Act of 2000. This act, which had 36 legislative titles,³⁰ included national standards that restricted the use of restraints and seclusion in psychiatric facilities and

“nonmedical community-based facilities for children and youth” that receive federal funds (Appendix 4). Nonmedical community children’s programs had not previously been covered by S/R standards.

Key provisions of the new federal standards:

- ◆ S/R may be imposed solely to ensure physical safety – never as punishment or for staff convenience.
- ◆ S/R may be imposed only with a written order from a physician or licensed practitioner, and must specify duration and circumstances.
- ◆ These standards should not be construed to offset or impede any federal or state regulations with greater protections, thus affirming the CMS one-hour rule.
- ◆ Facilities must report every death that occurs within 24 hours after a patient has been removed from S/R.
- ◆ CMS must set standards for adequate staffing and appropriate training for the use of S/R and alternatives.

How Does Reform Affect California?

How many people are at risk of being put into seclusion or restraints? Any person in a psychiatric facility may be at risk. Those confined involuntarily in mental health facilities in California may number more than 100,000 each year.

The RAND Corporation’s 2001 analysis of the California Client Data System (CDS) estimated that in fiscal 1997-98, nearly 52,000 people were admitted to psychiatric facilities on 72-hour involuntary holds in the state. But RAND stated that the California Department of Mental Health believes this represents only half of the true number of involuntary inpatient admissions.³¹ That’s because “mental health services paid for by private insurers and services delivered through Medi-Cal Inpatient Consolidation are not included in the CDS system,” RAND said.

An estimate of roughly 100,000 does not include people in long-term psychiatric facilities, since there is no comprehensive system for counting those patients. Nor does it include people who voluntarily commit themselves to mental health facilities. Those patients also are vulnerable to seclusion or restraints.

Patchwork Oversight

Regulatory systems that govern S/R use are extremely complicated. There are state standards, which differ by type of facility. For example, the standards are different for state hospitals than for private acute care hospitals. The federal standards cited earlier also vary by facility, depending upon whether a facility is accredited by JCAHO.

Enforcement of the rules is equally complex. JCAHO conducts inspections once every three years. A representative from the California Department of Health Services (DHS) accompanies JCAHO on these inspections, making sure that state standards are being followed. DHS also conducts random “sample validations” of 5 percent of JCAHO facilities to make sure they are following CMS standards and remain eligible to receive federal funds.

DHS inspects non-JCAHO facilities every two years to enforce both federal and state standards. In other types of facilities, the process is different still. Skilled nursing facilities, for example, have their own standards and are inspected once a year by DHS. But psychiatric health facilities and mental health rehabilitation centers are governed by different rules and inspected by a different department – the Department of Mental Health (DMH).

This table illustrates the complexity of the system. There are at least six categories of facility, two types of federal standards depending upon the accreditation, the various state standards depending on facility type, and enforcement by JCAHO, DHS or DMH.

The practical result of this complex system, this SOR report finds, is confusion, lack of accountability and inadequate protection of mental health patients from injury and death.

Figure 1: Regulatory Authority over Seclusion and Restraints in California Psychiatric Facilities

	No. Facilities	No. Beds	Licensed	JCAHO-Accredited
Acute Care Facilities				
State Hospitals	4	4,828	DHS	4
Acute Psychiatric Hospitals	41	2,846	DHS	15
Psychiatric Health Facilities	16	354	DMH	1
General Acute Care Hospitals *with Acute Psychiatric Program	124	4,421	DHS	47
Long-Term Care Facilities				
Mental Health Rehab. Ctrs.	18	1,301	DMH	0
Skilled Nursing Facilities* *with Special Psychiatric Treatment Programs	34	3,240	DHS	1

Source: California Department of Health Services and Department of Mental Health

Official S/R Reporting is Deficient

California’s system for tracking and documenting the use of S/R is fragmentary at best. Although reporting these incidents is required by state law,^{*} the information collected is incomplete and compliance is poor.

The California Office of Patient Rights is vested with responsibility for collecting and reporting this information. However, it must rely on data supplied by counties and facilities. In the year 2000, the Office of Patient Rights documented a high rate of noncompliance: 56 facilities, or 22 percent, submitted either an incomplete report or no report at all.³² Even two of the state hospitals – Atascadero and Metropolitan – did not comply with the requirement.³³

^{*} California Welfare and Institutions Code Section 5326.1.

The Office of Patient Rights points out the limitations of California's reporting system:

- ♦ *There are no specific statutory or regulatory provisions or other mechanisms for enforcing facility and/or county compliance with the regulatory requirements.*
- ♦ *There are no standard procedures or guidelines for counties to establish and maintain a list of facilities that are required to comply with these reporting requirements.*
- ♦ *Consequently, absent any routine monitoring of the Department of Health Services' licensing and certification records of licensed facilities, we cannot assert that this report reflects or contains information from all California facilities falling within reporting requirements.*³⁴

For these reasons, the Office of Patient Rights concluded that “there is no way to accurately track or report countywide or statewide trends regarding the denial of patients' rights or the use of seclusion and restraint.”³⁵

In addition, DHS reports that it does not consider S/R data from the Office of Patient Rights when deciding whether to conduct inspections on facilities.

Even when the legally required information is submitted, the process lacks teeth. In 1999, the Office of Patient Rights wrote, “John George Pavilion in Alameda County reports an astronomical use of seclusion and restraint (1,641 incidents).”³⁶ Yet in 2000, the John George Pavilion did not report at all.

Since California lacks a meaningful statewide tracking system, there is no way to measure S/R practices, except to measure when a person dies. That information is also incomplete, but what we do know about deaths and grave injuries comes from Protection and Advocacy, Inc. (PAI).

The PAI system was established by federal mandate in 1975 to protect the rights of people with disabilities; thus, mental health patients may look to Protection and Advocacy for legal representation and other advocacy services if their rights are violated. Until 1999, PAI had no systematic way to track deaths from S/R, and generally heard about instances of abuse only when it received formal complaints.

Hospital deaths or permanently disabling injuries (such as comatose conditions) that are related to seclusion and behavioral restraints must be reported to PAI under the 1999 CMS hospital regulations. PAI stresses that these numbers do not reflect the extent of the problem. The GAO, which calls the reporting “piecemeal,” concurs that the system under-represents these incidents.³⁷

Since the new rules went into effect in July 1999, PAI says that 12 deaths or serious injuries have been officially reported by CMS. PAI also says it is aware of three additional cases that were not reported to CMS. By its count at least 14 people have died and at least one became persistently comatose while in seclusion or behavioral restraints in California in the past 31 months.

Removing Barriers to Accountability

There are several significant barriers to improving outcomes and reducing the dangers of injury for patients and staff in mental health settings. Key among these is that California has no uniform standards covering all facilities. The use of S/R is governed by differing federal regulations, and the GAO cites differing standards as contributing to difficulties in obtaining accountability.³⁸

None of the new federal regulations prohibits states from setting standards that are higher than those of the federal government. Some states – Delaware, Pennsylvania, Massachusetts, New York – have reduced S/R by implementing their own more stringent standards.³⁹

Accreditation Offers No Guarantees

NAMI cites these “inadequacies” in relying exclusively on JCAHO for S/R oversight:

- ◆ JCAHO’s governing board is controlled by physicians and hospitals.
- ◆ Information collected by JCAHO is confidential and unavailable to the public.
- ◆ JCAHO does not investigate individual complaints and generally conducts site visits on a preannounced three-year cycle.
- ◆ JCAHO accreditation has not ended S/R deaths. Gloria Huntley died in the Central State Hospital in Virginia after 558 hours in restraints over two months. NAMI reports that she died the day after JCAHO inspected her hospital and awarded it with accreditation and a special

Also, there is no mandatory, consistent and publicly accessible system of reporting on S/R uses, serious injuries or deaths. Among states that have succeeded in lowering their use of S/R, mandatory reporting has been a critical tool for improving outcomes. Such reporting ideally should include – in addition to patient deaths and serious injuries – the number of S/R incidents, the duration of the use of seclusion or restraints, medication errors, falls, staff injuries, and airway obstructions.

Part III

Pennsylvania – A Model for Reform

In 1997, the Pennsylvania Department of Public Welfare instituted an aggressive program to reduce and ultimately eliminate seclusion and restraints in its nine state hospitals. Charles Curie, deputy secretary of mental health and substance abuse services, articulated the philosophy behind the change in policy: “Most of our patients are already the victims of trauma. There is no need to reinforce that trauma, or to re-traumatize.”⁴⁰

Three years later, Pennsylvania had reduced incidents of seclusion and restraint in its nine state hospitals by 74 percent, and reduced the number of hours patients spent in seclusion and restraints by 96 percent. Its program, which includes both forensic and civil commitments, has the highest standards for S/R in the nation. *Pennsylvania’s hospitals experienced no increase in staff injuries. In addition, its changes were implemented without any additional funds, using only existing staff and resources.*⁴¹

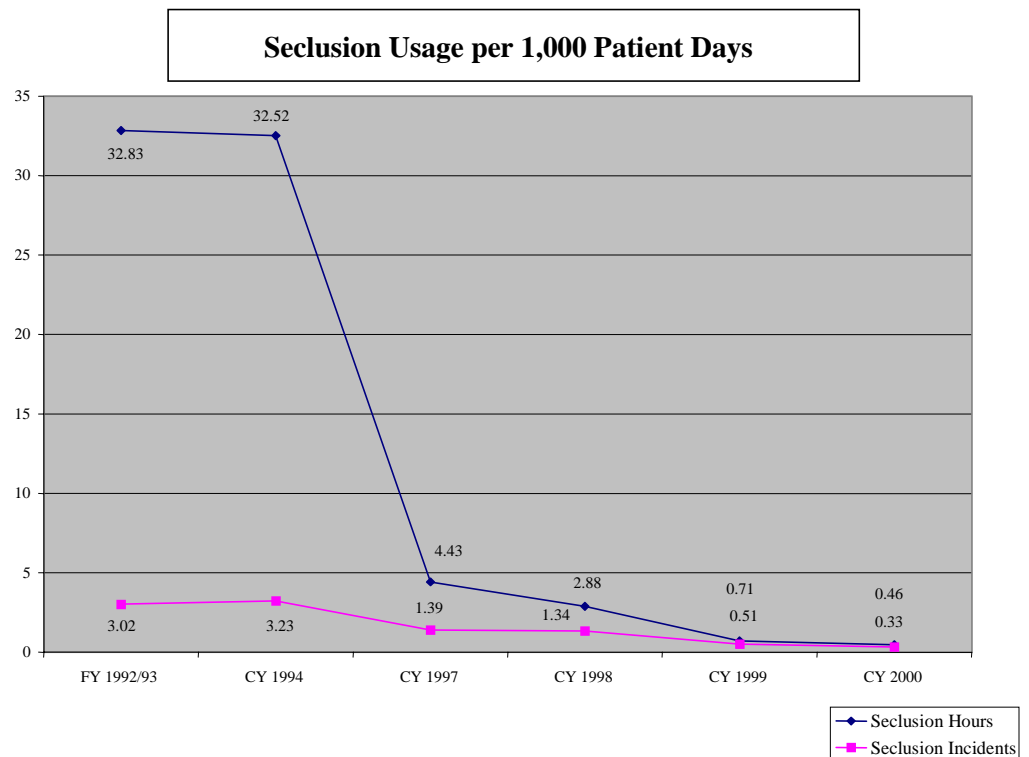
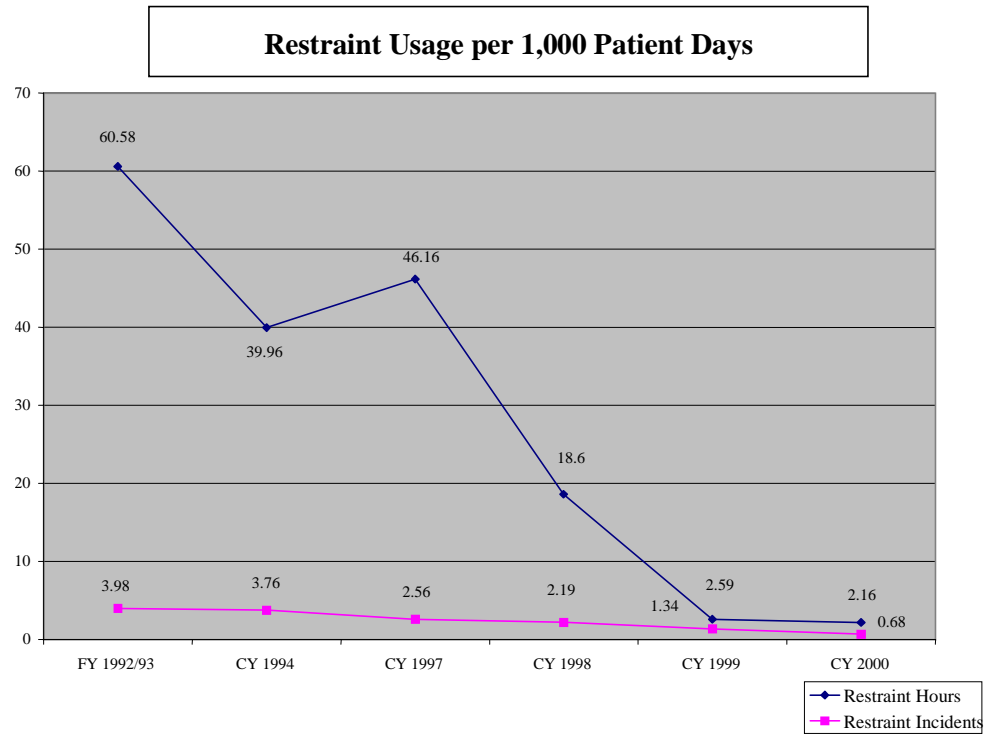
By July of 2000, Pennsylvania reported that one state mental hospital had not used seclusion for over 20 months. Another had used neither seclusion nor restraints for eight of the last 12 months. Three hospitals had been seclusion- and restraint-free for one or more consecutive months, and others were approaching zero use.⁴²

In October 2000, Pennsylvania’s Seclusion and Restraint Reduction Initiative received the prestigious Harvard University Innovations in American Government Award.

Figure 2 illustrates the reduction in seclusion and restraints that Pennsylvania achieved over the course of its three-year reform project, as measured by the Pennsylvania Office of Mental Health and Substance Abuse Services.

Figure 2

Pennsylvania Reduces Incidence of Seclusion and Restraints by 74% and Duration of Seclusion and Restraints by 96%



Elements of Reform

Pennsylvania began its reform project by carefully tracking the use of S/R, and then used that 1997 data as its baseline to measure improvements. A workgroup of practicing hospital clinicians set about developing new policies and procedures, goals, strategies and monitoring systems to design and implement the new approach. Key among these goals was developing a new philosophy of care – one that identified S/R as treatment *failure* and restricted it to emergency use only.

Mental health officials cite a number of innovations as critical to the success of the program. Among them:

- ♦ Computerized data collection and analysis,
- ♦ Strategies for organizational change,
- ♦ Staff training in crisis prevention and intervention,
- ♦ Risk-assessment and treatment-planning tools,
- ♦ Patient debriefing methods,
- ♦ Recovery-based treatment models, and
- ♦ Adequate numbers of staff.

Also critical was changing the culture of state hospitals. Pennsylvania did this by requiring open public access to S/R data, by creating competition among hospitals to reduce S/R, and by giving awards and acknowledgments for improvement.

Figure 3 shows the key elements of Pennsylvania's S/R reduction policy.

Figure 3

Pennsylvania Seclusion and Restraints Reduction Initiative⁴³

Seclusion and restraints must be the intervention of last resort.

S/R are exceptional and extreme practices for any patient. They are not to be used as a substitute for treatment, nor as punishment or for the convenience of the staff.

S/R are safety measures, not therapeutic techniques, which should be implemented in a careful manner.

Staff shall include patient strengths and cultural competence to prevent incidents of S/R.

Staff must work with the patient to end S/R as quickly as possible.

A physician must order S/R.

Orders are limited to one hour and require direct physician contact with the client within 30 minutes.

The patient and family are considered part of the treatment team.

The patient advocate is the spokesperson for the patient (if the patient desires it) and is involved in care and treatment.

Patients being restrained cannot be left alone.

Chemical restraints are prohibited.

The treatment plan includes specific interventions to avoid S/R.

Patients and staff must be debriefed after every incident, and treatment plans must be revised.

Staff must be trained in de-escalation techniques.

Patient status must be reviewed prior to utilizing S/R. Voluntary patients who did not agree to these procedures must be involuntarily committed before these procedures may be initiated.

Leaders of the hospital, clinical department heads and ward leaders are accountable at all times for every phase of an S/R procedure. Accountability is demonstrated as a component of the hospital's "performance improvement" index and in staff competency evaluations.

Data regarding the use of S/R are made available to consumer and family organizations and government officials.

Part IV

Conclusion

The crude and ancient practices of secluding and restraining mental health patients are antiquated, traumatizing and potentially dangerous. If from 50 to 150 patients die nationally each year as a result of seclusion and restraint, as the Harvard Center for Risk Analysis has estimated, deaths in California could number between six and 18 annually because the state represents 12 percent of the U.S. population. In addition, there is no official tracking of S/R *injuries* to patients or to staff.

The federal government in July 1999 instituted reforms aimed at increasing oversight of S/R and reducing its use. However, Protection and Advocacy, Inc., reports that 15 Californians have been killed or disabled while in S/R since then. PAI knows of 14 cases of death and one comatose victim.

An estimated 100,000 Californians are committed involuntarily each year in mental health facilities, and countless more voluntarily enter as inpatients. Any one of them is at risk of seclusion or restraint under today's patchwork of state and federal standards that vary by type of facility.

This confusion contributes to a lack of accountability and a dearth of protections against S/R abuses. In California, the Office of Patient Rights concludes "there is no way to accurately track or report countywide or statewide trends regarding the denial of patients' rights or the use of seclusion and restraint."⁴⁴

Yet Pennsylvania, after officially determining that S/R is a failure rather than a treatment, cut use of seclusion and restraint in its state hospitals by 74 percent in three years without increasing staff costs or injuries.

Federal reforms governing S/R policies are only as effective as the oversight mechanisms that enforce them. There are at least two significant barriers to adequate oversight in California:

- ♦ Lack of uniform statewide standards over S/R use affecting all types of facilities; and
- ♦ Lack of mandatory, consistent and publicly accessible reporting on serious injuries and deaths caused by S/R, the frequency and duration of S/R, and other issues related to its use.

Although private psychiatric hospitals may be the most difficult to regulate, they may also be the most out-of-compliance with federal standards. In 1999, the U.S. inspector general issued a report titled *Restraints and Seclusion – State Policies for Psychiatric Hospitals* that evaluated state compliance with the new federal S/R standards. The report found that many state policies had already met *some* of the new requirements, while other state policies for both public and private facilities did not.⁴⁵ The inspector general reported that state policies for the use of restraints and seclusion in private psychiatric hospitals more frequently failed to meet the new regulations.⁴⁶ The report concluded:

*We recommend that HCFA [now CMS] work aggressively to quickly raise psychiatric hospital compliance with the new Patients' Rights Condition of Participation where necessary. Particular attention should be given to policies for private psychiatric hospitals.*⁴⁷

Options

- ♦ California could develop uniform standards that at least match, if not exceed, the highest federal regulations across all facility types that treat people with psychiatric disabilities.
- ♦ California could develop mandatory, comprehensive and publicly accessible data-reporting requirements on the use of seclusion and restraints with meaningful consequences for noncompliance.
- ♦ A working group could be directed to review practices, policies and facilities in Pennsylvania with the goal of developing proposals to similarly reduce the use of S/R in California. Its members could include representatives of the state Department of Mental Health, the Legislature, county mental health

departments, patient advocacy groups and consumers, families and providers.

Hubert Humphrey believed that a just society may be measured by the way it treats its most vulnerable citizens.⁴⁸ Protecting Californians from injuries, trauma and abuse caused by isolating and restraining them is a fundamental responsibility and a measure of our society. Given the known harms that seclusion and restraints have inflicted on vulnerable Californians, policymakers may want to give serious consideration to comprehensive, safe and cost-effective ways to reduce their use.

ENDNOTES

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 - ⁷ California Office of Patient Rights, Annual Report of Denial of Rights and Seclusion/Restraint 2000, (Sacramento, 2000), p. 2.
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- ²⁴ Peter R. Breggin, M.D., Principles for the Elimination of Restraint: Testimony for the Joint Commission on Accreditation of Healthcare Organizations, (Bethesda: Center for Study of Psychiatry and Psychology, April 25, 1999), p. 1.
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Appendices

- Appendix 1:*** **Deadly Restraint: A *Hartford Courant* Investigative Report**
http://www.courantclassifieds.com/projects/restraint/death_data.stm
- Appendix 2:*** **California cases excerpted from National Alliance for the Mentally Ill (NAMI) summary of nationwide reports of restraint and seclusion abuses received between October 1998 and March 2000 (Attached)**
- Appendix 3:*** **Summary of key changes in the Joint Commission on the Accreditation of Healthcare Organizations' Seclusion and Restraints Standards (Attached)**
- Appendix 4:*** **Summary of key changes in nonmedical Community Children's Programs under the Federal Children's Health Act of 2000 (Attached)**

APPENDIX 2

California cases excerpted from National Alliance for the Mentally Ill (NAMI) summary of reports of restraint and seclusion abuses received between October 1998 and March 2000

After *The Hartford Courant* published its “Deadly Restraint” investigative series in October 1998, NAMI reported receiving “a steady stream of reports” of recent or past abuses of restraints and seclusion, including more deaths. The California incidents reported below are taken from NAMI’s Web site at <http://www.nami.org/update/hartford.html>.

“Unless otherwise indicated, the source of each report is the person actually involved in the incident,” NAMI says on its Web site. “NAMI has not independently investigated each incident, but will provide assistance to government authorities or news reporters who wish additional details about specific incidents or to talk with sources directly.”

Locale	Facility	Details of Incident	Date/Source
Berkeley	Hospital	A man who asked for something to help him sleep was placed in seclusion. Without a bathroom, he was left to defecate in his clothing.	Occurred in 1993; reported by parents 2/99.
Chula Vista	New Alternatives (private facility)	Kristal Mayon-Ceniceros, 16, died of respiratory arrest after she was put face-down on the floor with arms and legs restrained by four staff members.	2/5/99, Associated Press
Greenbrae	County hospital	A 6-foot-7 man was admitted to the psychiatric ward involuntarily after calling 911 for help. He was given anti-psychotic drugs without his consent, denied prescribed sleep medication, became agitated and struck a wall sign. Staff told him to go into a seclusion room to avoid restraints; he cooperated and was put into restraints in seclusion for 12-14 hours. Charts showed he initially was cooperative “yet they did not let him up... he started thrashing around. Then they shot him full of drugs... He was treated inhumane, denied all dignity, had to urinate on himself.”	Occurred 3/99; reported by mother on 3/29/99.

Los Altos	Described by the patient as “a very reputable, well-run” hospital.	A 29-year-old woman had her hands and feet restrained to a bed and was isolated in a room for an estimated 18 hours. Nurses entered only twice and left water out of reach. She was not informed of the nature of her illness throughout her hospitalization.	Occurred in 1995; reported 2/99.
Oakland	Hospital	A newly widowed mother of three was restrained for four hours after she refused medication because she hoped to nurse her youngest child. She considered it a punishment. “Restraints are used to break your spirit, and the humiliation puts one into a major depression... I don’t think I’ve ever recovered the confidence and self-esteem I used to have.”	Occurred in 1989; reported 2/99.
San Francisco	Inpatient mental health center	Son was put into a coma as a result of being placed in restraints.	Occurred 12/99 and reported by father.
San Luis Obispo	General hospital	A woman placed in seclusion all night defecated in her clothes and drank her urine to quench a thirst caused by lithium carbonate.	Occurred in 1997; reported by parents 2/99.
Stockton	San Joaquin County psychiatric health facility	Rick Griffin, 36, 6-foot-3 and 340 pounds, died from cardio-respiratory failure and extreme agitation after he was wrestled to the floor by eight staff members and bound in leather restraints.	Occurred in 11/98; reported by sister and <i>Stockton Record</i> .

APPENDIX 3

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

New Standards For Seclusion And Restraint – Key Changes

- Restricts use of S/R to emergencies in which there is an imminent risk of harm to self or others.
- Requires communication throughout a facility on the philosophy of using S/R only in extraordinary situations and only for the safety of the patient.
- Requires staff education to understand de-escalation techniques, medication, self-protection and to recognize signs of physical distress.
- Restricts time of an S/R incident initially to one hour for children under age 7 and four hours for adults. Subsequent renewals are limited to one hour for children under 9 and four hours for adults.
- Stipulates that only licensed independent practitioners can place orders for S/R.
- Requires continuous monitoring of individuals while under S/R.
- Requires patients under 18 to be evaluated in person by a licensed independent practitioner within two hours and adults within four hours of initiation of an S/R order. **[However, JCAHO in practice has agreed to require the stricter CMS “one hour” rule.]** If the patient continues in S/R, he or she must be re-evaluated by a licensed independent practitioner every eight hours if age 18 and over, and every four hours if under 18. If the person is released before being evaluated, a licensed independent practitioner must do a face-to-face evaluation within 24-hours.
- Requires staff to try to contact a restrained or isolated patient’s family if she or he requests it.
- Requires criteria to be established and communicated for discontinuing use of S/R.
- Requires a de-briefing within 24 hours of S/R use among the patient, staff and family of the patient (if the patient desires family participation).

APPENDIX 4

Children's Health Act Of 2000

Nonmedical Community Children's Programs – Key Changes

- S/R may be used only in emergencies and to ensure immediate physical safety.
- Mechanical restraints are prohibited.
- Seclusion is allowed only when a staff member continuously monitors the patient, face-to-face. ("Time outs" are not considered seclusion.)
- Only staff trained and certified by a state-recognized body may impose S/R. (Until a certification process is in place, only a supervisory or senior staff person with specified skills and competencies may initiate S/R or assess patients, as required, within a one-hour timeframe.)
- Skills and competencies required of such staff include relationship-building, avoiding power struggles, methods for de-escalating conflict, alternatives to seclusion or restraints, use of time limits, monitoring signs of physical distress, knowledge of asphyxia from body positioning, knowing when and how to obtain medical assistance and legal issues.
- States must develop licensing and monitoring rules for such facilities, and the U.S. Department of Health and Human Services will develop national staffing standards and guidelines.

* *These standards address only psychiatric treatment facilities – they do not affect schools, wilderness camps, jails or prisons.*

