Eliminating Seclusion and Restraint in Recovery-Oriented Crisis Services

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The use of seclusion and physical restraint is viewed as a practice incompatible with the vision of recovery, and its therapeutic benefit remains unsubstantiated. This Open Forum describes an initiative that began in 1999 at two crisis centers that was designed to completely eliminate the practice of seclusion and restraint. Seclusion and restraint elimination strategies included strong leadership direction, policy and procedural change, staff training, consumer debriefing, and regular feedback on progress. Existing records indicated that over a 58-month follow-up period (January 2000 to October 2004), the larger crisis center took ten months until a month registered zero seclusions and 31 months until a month recorded zero restraints. The smaller crisis center achieved these same goals in two months and 15 months, respectively. The success of this initiative suggests that policy makers and organizational leaders familiarize themselves with these and other similar seclusion and restraint reduction strategies that now exist. (*Psychiatric Services* 59:1198–1202, 2008)

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The use of seclusion and physical restraint remains commonplace in behavioral health settings (1,2). Any therapeutic or treatment benefit from seclusion and restraint interventions remains unsubstantiated. (3). Furthermore, seclusion and restraint interventions may stimulate further aggression (4), may be associated with increased cost (5), and may demonstrate a lack of compliance with the legal and clinical standards of the use of seclusion and restraint (6). People who have experienced seclusion and restraint have recounted its traumatizing nature (7–11), and the use of seclusion and restraint has been questioned (12,13) as a practice that is compatible with the vision of recovery (14), a vision espoused by the President's New Freedom Commission (15). Toward this end, the Substance Abuse and Mental Health Services Administration has recently released a training guide for direct care staff designed to reduce seclusion and restraint (16), and the National Association of State Mental Health Program Directors has developed a curriculum for mental health facility leadership and policy makers for reducing violence and the use of seclusion and restraint in inpatient settings (17).

Attempts have been made over the years to reduce the use of seclusion and restraint (4,18–21). Concerns have been raised as to whether the reduction of seclusion and restraint would lead to more client or staff injuries and as to what interventions could replace these restrictive interventions (22,23). More information is needed about strategies shown to be successful that can be used to eliminate seclusion and restraint entirely (8,13,20,24,25).

This Open Forum describes an initiative begun in May 1999 at two crisis centers operated by META Services that was designed to eliminate seclusion and restraint from the crisis center operation, and it traces the initiative's impact on the use of seclusion and restraint in these two crisis centers from January 2000 to October 2004.

META Services

Setting

META Services (now Recovery Innovations) is a mental health agency that provides a range of mental health recovery-oriented services. At the time of this study, two crisis services (two sites) were operated by META Services that served about 14,500 people each year (12,000 each year at the large center and 2,500 each year at the small center), including nearly 4,600 people who were brought to the crisis centers involuntarily. META Services is accredited by the Joint Commission on Accreditation of Healthcare Organizations, certified by Medicaid for Title 19 reimbursement, and licensed by the Arizona Department of Health. The length of stay at the larger facility was 24 hours, and the length of stay at the smaller facility was up to five days.

People served

Throughout the time frame in which attempts were made to eliminate seclusion and restraint entirely, people with a wide range of issues and situations stepped through the doors of META Services' crisis programs every day. Involuntarily admitted clients (32% of the total admissions) were brought by police and others who believed them to be a danger to themselves or others. People admit-

ted voluntarily came because they were frightened by their own thoughts and feelings and needed reassurance, support, or medication. Some of the voluntary clients came because they didn't know what else to do. Some were homeless, were hungry, and had no other alternatives. Many were self-medicating with street drugs and alcohol. When both primary and secondary axis I data were considered, 44.5% of the individuals seen had a diagnosis of substance abuse. Fifty-five percent were male. [Tables describing the ethnicity, gender, and diagnostic characteristics of the people served in a one-month period are available as an online supplement at ps.psychiatryonline.org.]

Crisis center staff

A total of 95 staff worked in the two centers serving an average of 40 admissions a day. [A table identifying the professions represented by a typical shift at the higher-volume crisis center is available as an online supplement at ps.psychiatryonline.org.] No specially trained addictions counselors were recruited, because the training for all staff involved in the seclusion and restraint initiative attended to issues related to substance abuse.

Practices before the seclusion and restraint initiative

Although it was not uncommon for staff to catch a glimpse of the recovery process taking place among people who were in crisis situations, recovery was often not focused on, because it was overshadowed by the chaos that accompanies a crisis. Also, staff tended to operate in a crisis mode of management, reacting instead of responding to each situation, which only added to the crisis levels. Staff members often overlooked the consumer's inherent strengths and resources because they were focusing primarily on the problems. This left staff trying to solve problems instead of promoting a recovery-oriented response. Staff often used medications as the first intervention, seemingly independent of the consumer's reason for coming to the crisis center. Medications lessened the external evidence of a problem long enough to move the person out of the crisis center. At that time stabilization and triage were the goals of crisis services, and the staff's conversation often revolved around "clearing the room," so staff could get ready for the next group of people coming in. Did consumers leave with a renewed sense of hope and self-determination that could add meaning and purpose to their lives? Did they learn how to better manage their life circumstances so they could avoid this experience in the future? Did staff learn anything that could increase their skill in serving people? The leadership of META Services answered each of these questions in the negative.

This examination of crisis center practice was among the strongest prompts that moved META Services toward an organizational restructuring in 1999 that began their recovery transformation (12). Agency leadership focused on what the challenges and barriers were to transforming the crisis centers into facilities with a recovery orientation. The leadership observed and listened to both staff and the people served. The five challenges identified were previous staff training, fear, hopelessness, personal prejudices, and attitudes toward new peer staff.

Implementation challenges

Previous staff training. Caregivers who are faced with a person in crisis often respond with an urge to "fix" the situation as quickly as possible. Because the problem looms larger than the person, they tend to see the problem instead of the person. Most have been trained to take charge and take care of the problem. However, this orientation can cause staff to continue to overlook the person in favor of addressing the problem.

Fear. Often the people who come into crisis services, especially those who are brought in against their will, are fearful, angry, and can demonstrate behaviors that are threatening and intimidating. Although such a response could be considered normal from any person who finds himself or herself delivered to a strange place against his or her will, locked in a room with strangers, and expected to wait long periods of time for answers, it often elicits fear from the staff members who are trying to serve them. Fear can be a normal response from caregivers, but once it becomes the determining factor in how consumers are treated, the staff's effectiveness is seriously compromised.

Hopelessness. In the beginning of this seclusion and restraint initiative most of the META crisis center staff did not believe in recovery. On a daily basis they witnessed what, on some level, they considered "proof" that people rarely recover, because people came to them only when they needed significant help and were considered to be the most ill. Thus crisis center staff rarely saw consumers who were in recovery.

Prejudices. Because most people coming into a crisis service program have multiple issues, it is easy to fall into the trap of making judgments about them solely on the basis of their appearance. If the people are dirty, disheveled, intoxicated, or out of control, staff may, without thinking, begin assigning negative connotations to these people that create barriers to helping them recover.

Attitudes toward new peer staff. One of the strategies META Services planned to help seed recovery in the crisis services was the use of consumer-peers (persons who had experienced a mental illness) as paid crisis center staff. Unfortunately, many of the staff working in the crisis programs had strong feelings about adding peers to the staffing pattern. There were concerns about peers getting hurt or staff getting hurt because peers couldn't do their part and the belief that peers would compromise the quality of service delivery. Many of the staff felt that being in this setting would be too much stress for the peers and would be detrimental to the peers' own recovery.

Seclusion and restraint initiative

The question for META Services was how does an agency overcome these challenges and develop a crisis service that is consistent with a recovery orientation? META Services developed a training and organizational change manual that details these strategies (26), and this manual was

used to guide the transformation of the crisis centers. The specific strategies developed by META Services are very similar to the seclusion and restraint reduction strategies developed independently of META Services by the National Association of State Mental Health Program Directors during approximately the same period (27,28), and they also seem consistent with the Pennsylvania initiative to reduce seclusion and restraint in the state hospital system (23). None of these seclusion and restraint initiatives has examined individual strategies to determine the unique effects of each. However, many of these strategies are similar in intent. The specific strategies developed by META Services that are consistent with other independently developed seclusion and restraint initiatives included strong leadership direction, policy and procedural change, staff training on specific issues, consumer debriefing, and regular feedback on progress.

Strategies

Strong leadership direction. The president and chief executive officer (CEO) of META Services, Gene Johnson, M.S.W., met with staff and very clearly and strongly informed them that META Services would no longer be using seclusion and restraint. This was a huge culture shift for META Services, especially because the use of seclusion and restraint had always been seen as a necessary part of its business and was routinely practiced. Staff threatened to quit. Some threatened to call the Occupational Safety and Health Administration, because they believed that the company was putting them at risk. Some claimed that the company didn't care about them anymore. The CEO held his ground. Because his genuine beliefs and concerns were evident, staff had the courage to try eliminating the use of seclusion and restraint, even though many still did not believe it would work (12). At the time of META Services' seclusion and restraint initiative, data from like-minded initiatives were not available (4,20,21).

Policy and procedural change. META Services had the usual array of policies and procedures, but as is often typical, they were not routinely used by staff to direct practice. Rather, staff were making decisions based on their personal and professional beliefs and values. Thus the challenge was to find a way to teach staff new values and beliefs about recovery. Then the decisions they made every day could be guided by these new recovery beliefs and values rather than by a procedural rulebook. Any new policies that were developed for any part of the agency were based on the principles that polices and procedures should be value based, not rule based; should be flexible enough to allow individualization; should be person centered rather than business centered; and should be understandable and within accreditation standards.

Staff training on specific issues. At the beginning of the initiative, a new training protocol was developed for staff to overcome the previously identified barriers of fear, hopelessness, prejudices, and negative attitudes. Training lasted for 12 hours, which consisted of a three-hour session each week for four weeks. The CEO participated in training by talking about how the organization itself was recovering. The training package included a three-hour session on the principles of recovery, and then the following three, three-hour sessions developed aspects of the "nuts and bolts" of how to actually put recovery into practice. The training protocol detailed specific ways of assisting people who were experiencing trauma, as well as those who were experiencing issues related to substance abuse. Another strong aspect of the protocol is a section on using the language of recovery in strength-based conversations. Finally, it included ways of building resilience through self-directed treatment planning. Staff were trained in practices that would empower each consumer, instead of having staff striving for compliance and control. Training also emphasized giving consumers as much responsibility as possible for their own lives and behavior as a key to eliminating seclusion and restraints.

The previous training that had been used to train staff in crisis management was continued, but we began to teach it with an emphasis on avoiding crises rather than simply managing them. The emphasis was on immediate engagement and building relationships, instead of control and compliance. Because training in the proper use of restraints is a licensing requirement, this was included in the training. However, it was described as something that should be used only as a very last resort, and use of it was considered a treatment failure.

To counter staff's prejudices related to the possibilities of recovery, stories of recovery were added to the training. People who had been served in the crisis program came back and talked about their continuing experience of recovery. However, adding peers to the team seemed to have the most significant impact on developing positive attitudes toward the possibility of recovery. When staff began to accept peers as coworkers and began to rely on them as a crucial part of the workforce, attitudes toward recovery changed significantly, and the tendency to use seclusion and restraint became more and more remote.

The most powerful message peers brought to people in distress was, "I know how you're feeling. I was once in here as a patient myself." This almost always got the consumer's immediate attention, and from there a conversation that was relevant to the consumer's perspective followed. Focusing on hope seemed to help people hang on to their strengths instead of falling further apart.

Debriefing. Included in the training was the viewpoint of the consumers who were using the crisis centers, particularly the perspectives of those who had experienced seclusion and restraint. Consumers were asked what staff could have done to avoid restraining them, what the consumers themselves could have done to avoid this, and what staff could do in the future to keep this from happening. For example, staff learned to listen closely to people and to give them what they were asking for whenever possible. This kept staff from getting into power struggles over relatively meaningless issues like cigarette breaks, phone calls, and space to pace. The

information that staff learned from people who had previously been restrained was used to develop META Services' crisis intervention and de-escalation training manual, which is currently available from Recovery Innovations (26).

Feedback on progress

META Services' director of quality improvement began sending weekly information to all staff on the dangers of using seclusion and restraint. She also gave regular reports to staff showing them how they were progressing toward the goal of eliminating the practice.

Evaluation of the initiative

For 58 months (January 2000 to October 2004) META Services evaluated its efforts by obtaining relevant data from existing records that were then compiled by the quality assurance department. [A figure showing monthly indicators of seclusion and restraint at both crisis centers is available as an online supplement at ps.psychiatryonline.org.] The larger crisis center took ten months until a month registered zero seclusions and 31 months until a month recorded zero restraints. The smaller crisis center achieved these same goals in two months and 15 months, respectively. Staff injury data for the same period show that the staff injuries resulting from the virtual elimination of seclusion and restraint practices varied between the centers as well. Over the course of the evaluation, the smaller center decreased its yearly staff injuries from 15 to five, whereas the larger center essentially stayed the same (nine to eight). [A table with data on the number of staff injuries in each center from 2000 and 2004 and is available as an online supplement at ps.psychiatryonline.org.] Although the use of chemical restraint (29) was not specifically tracked for this study, META Services monitored medication use and found no increase in medication that coincided with the seclusion and restraint initiative. Chemical restraint is defined by state regulation and refers to the use of medication that is not standard treatment for a client's medical condition or behavioral health issue and is administered to manage a client's behavior in a way that reduces the safety risk to the client or others and to temporarily restrict the client's freedom of movement.

Conclusions

The development, implementation, and evaluation of this initiative suggest that elimination, rather than reduction, of seclusion and restraint is a legitimate goal. We speculate that the lower-volume facility was able to achieve and maintain the goal of zero restraint and seclusion long before the higher-volume facility because it was not as crowded as the other facility and because the layout and furnishings were more comfortable and accommodating (30). Also, in the lower-volume center, staff were under slightly less pressure to move people quickly through the recovery steps, so the atmosphere was more conducive to helping people relax and reflect on their options. However, despite the challenges in the higher-volume center, the outcome of zero restraint and seclusion was still a reasonable goal to set.

Staff injuries showed a similar pattern, favoring the lower-volume center. Perhaps there is a size that crisis centers should not exceed, particularly if they have a goal of zero incidences of seclusion and restraint. Since the end of this study, Recovery Innovations of Arizona (formerly META Services, a part of Recovery Innovations) continues to operate one of the two crisis centers mentioned here and reports no seclusion and restraint interventions in the past year. Recovery Innovations of Arizona also reports that chemical restraint (29) is now routinely tracked in the crisis center and that of the 1,407 people served in the quarter ending in September 2007, it was administered once to 32 consumers (less than 2.5%) and twice to one consumer.

The evaluation of the impact of the seclusion and restraint reduction initiative was purely descriptive, and no inferential statistics were used. From a research perspective the evaluation is limited with respect to its internal validity by its lack of a randomized control group that received an alternative intervention or no intervention. Therefore, no causation is inferred by the journalistic accounting of this seclusion and restraint implementation. The development of a training manual and the collection of evaluation data do provide the foundation for a rigorous test of this initiative.

It is important to recognize that eliminating a tradition that is firmly ensconced in any culture is a challenging assignment. Seclusion and physical restraint have been practiced in behavioral health settings for centuries and have been assumed to be a necessary routine in the treatment process. We now know that these methods have serious detrimental side effects and that there are better ways that can actually promote personal growth and recovery when directed by leadership and practiced with committed action by staff. The use of seclusion and restraint can be eliminated when other beliefs and principles are practiced. In addition to META Services' training and organizational change initiative, other seclusion and restraint reduction initiatives have been developed by other agencies (13,16,17).

A transformation of this magnitude can be demonstrated when leaders are willing to take a firm and compassionate stance, based on a vision of promoting recovery, and move the organization into a new paradigm. Once a shift in seclusion and restraint practices takes place, it can become a metaphor for other changes that need to occur in order to move a culture to more of a recovery orientation (31). Accordingly, META Services' organizational transformation of its crisis center operation became a stimulant for change in other programmatic areas (12).

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