

APNA Position Papers

2007 Position Statement on the Use of Seclusion and Restraint (Original, 2000; Revised, 2007)

Introduction

Psychiatric-mental health nursing has a 100-year history of caring for persons in psychiatric facilities. Currently, nurses serve as front-line care providers as well as unit-based and executive level administrators in virtually every organization providing inpatient psychiatric treatment. Therefore, as the professional organization for psychiatric-mental health nurses, the American Psychiatric Nurses Association (APNA) recognizes that the ultimate responsibility for maintaining the safety of both individuals and staff in the treatment environment and for maintaining standards of care in the day-to-day treatment of individuals rests with nursing and the hospital leadership or behavioral health care organization leadership that supports the unit. Thus, APNA supports a sustained commitment to the reduction and ultimate elimination of seclusion and restraint and advocates for continued research to support evidence-based practice for the prevention and management of behavioral emergencies. Furthermore, we recognize the need for and are committed to working together with physicians, clients and families, advocacy groups, other health providers and our nursing colleagues in order to achieve the reality of eliminating seclusion and restraint.

Background

In the mid-1800's proponents of "moral treatment" of psychiatric patients advocated the elimination of the practice of restraining patients. Despite the relative success of this movement in England and Europe, psychiatrists in the United States concluded that restraints could never be eliminated in the United States (Bockoven, 1963; Deutsch, 1949; Rogers & Bocchino, 1999; Strumpf & Tomes, 1993). Until recently, belief in the necessity for continuing the practice of secluding and restraining patients persisted. For example, in 1994, Fisher concluded from his review of the literature that not only was it "nearly impossible to operate a program for severely symptomatic individuals without some form of seclusion or physical or mechanical restraint" (p. 1584) but that these methods were effective in preventing injury and reducing agitation. Others, however, concluded that the practice of restraining and secluding patients was not grounded in research that supported the therapeutic efficacy of this intervention, but upon the observation that these measures interrupted and controlled the patient's behavior (Allen, 2000; Bower, McCullough & Timmons, 2003; Walsh & Randell, 1995).

Reports of patient death and injury while in restraints (Evans, Wood & Lambert, 2003; Mohr, Petti & Mohr, 2003; Nunno, Holden & Tollar, 2006; Weiss, 1998) and studies of patients' experiences in restraint and seclusion (Johnson, 1998; Holmes, Kennedy & Perron, 2004; Meehan, Vermeer & Windsor, 2000) have prompted psychiatric-mental health nurses to question the benefit of secluding and restraining psychiatric patients. These studies bring to the fore the ethical dilemmas inherent in the use of seclusion and restraints (Bower, et al., 2003; Lee, et al., 2003; Mohr, Mahon & Noone, 1998). On the one hand, this practice has the potential for physically and/or psychologically harming patients (Evans, et al., 2003; Martinez, Grimm & Adamson, 1999; Mohr, et al., 2003) and for violating the patient's right to autonomy and self-determination (Bower, et al., 2003; Prescott, 2001). On the other hand, studies of violence on inpatient units underscore the reality that violence often

cannot be predicted. Since the nursing staff are held responsible for maintaining the safety of all of the patients, they often see seclusion and restraint as a necessary last-resort intervention to maintain that safety (Alty, 1997; Lee, et al., 2003). Therefore, studies of the impact of assault on those who care for patients must be taken into consideration when developing standards for practice and when addressing organizational strategies to assure equal commitment to worker as well as patient safety (OSHA, 1998; Flannery & Walker, 2003; Kindy, Petersen & Parkhurst, 2005; Lanza, 1992; Nijman, Bowers, Oud, & Jansen, 2005; Poster, 1996; Poster & Ryan, 1994; Ryan & Poster, 1989; Ryan, Hart, Messick, Aaron, & Burnette, 2004).

Research has highlighted the influence of unit philosophy and culture, treatment philosophy, staff attitudes, staff availability, staff training, ratios of patients to staff and location in the United States on either the disparity in the incidence of seclusion and restraint or the perpetuation of the practice of secluding and restraining psychiatric patients (Bower, et al., 2003; Gerolamo, 2006; Holzworth & Wills, 1999; Morrison, 1990, 1992, 1993, 1994, 1998; Sailas & Wahlbeck, 2005). From the research, it appears that the key to seclusion and restraint reduction is prevention of aggression by (a) maintaining a presence on the unit and noticing early changes in the patient and the milieu (Delaney & Johnson, 2006; Johnson & Delaney, 2007), (b) assessing the patient and intervening early with less restrictive measures such as verbal and non-verbal communication, reduced stimulation, active listening, diversionary techniques, limit setting and prn medication (Canatsey & Roper, 1997; Johnson & Hauser, 2001; Johnson & Delaney, 2007; Lehane & Rees, 1996; Maier, 1996; Martin, 1995; Morales & Duphorne, 1995; Richmond, Trujillo, Schmelzer, Phillips, & Davis, 1996) and (c) changing aspects of the unit to promote a culture of structure, calmness, negotiation and collaboration rather than control (Cahill, Stuart, Laraia & Arana, 1991; Delaney, 1994; Harris & Morrison, 1995; Johnson & Morrison, 1993; Whittington & Patterson, 1996).

To date, there is some evidence that changes in a unit's treatment philosophy can lead to changes in patient behavior that will ultimately impact the incidence of the use of seclusion and/or restraints (Bennington-Davis & Murphy, 2004; Goren, Abraham & Doyle, 1996; Huckshorn, 2004; LeBel et al., 2004; Regan, Curtin & Vorderer, 2006). There is also growing awareness that inpatient treatment must be shaped by the principles of trauma-informed care and the recovery movement and that these philosophies will create a collaborative spirit that is essential to restraint reduction and elimination efforts (Bloom, et al., 2003; SAMSHA, 2005).

Despite the best efforts at preventing the use of seclusion and restraint, there may be times that these measures are used. Thus, it is important to be cognizant of the vulnerability of individuals who are secluded or restrained and the risks involved in using these measures (Mohr, et al., 2003; Nunno, et al., 2006; Weiss, 1998). Moreover, the dangers inherent in the use of seclusion and restraint include the possibility that the person's behavior is a manifestation of an organic or physiological problem that requires medical intervention and may therefore, predispose the person to increased physiological risk during the time the individual is secluded or restrained. Therefore, skilled assessments of individuals who are restrained or secluded will not only ensure the safety of individuals in these vulnerable conditions but also will ensure that the measures are discontinued as soon as the individual is able to be safely released.

Position Statement

APNA believes that psychiatric-mental health nurses play a critical role in the provision of care to persons in psychiatric settings. This role requires that nurses provide effective treatment and milieu leadership to maximize the individual's ability to effectively manage potentially dangerous behaviors. To that end, we strive to assist the individual in minimizing the circumstances that give rise to seclusion and restraint use. Therefore:

- We advocate for policies at the federal, state, and other organizational levels that will protect individuals from needless trauma associated with seclusion and restraint use while supporting both individual and staff safety.
- We take responsibility for providing ongoing opportunities for professional growth and learning for the psychiatric-mental health nurse whose treatment promotes individual safety, as well as autonomy and a sense of personal control.
- We promulgate professional standards that apply to all populations and in all settings where behavioral emergencies occur and that provide the framework for quality care for all individuals whose behaviors constitute a risk for safety to themselves or others.
- We advocate and support evidence-based practice through research directed toward examining the variables associated with the prevention of and safe management of behavioral emergencies.
- We recognize that organizational characteristics have substantial influence on individual safety and call for shared ownership among leaders to create a work culture that supports minimal seclusion and restraint use and that will enable the vision of elimination to be realized.
- We articulate the following fundamental principles to guide action on the issue of seclusion and restraint:
 - Individuals have the right to be treated with respect and dignity and in a safe, humane, culturally sensitive and developmentally appropriate manner that respects individual choice and maximizes self determination.
 - Seclusion or restraint must never be used for staff convenience or to punish or coerce individuals.
 - Seclusion or restraint must be used for the minimal amount of time necessary and only to ensure the physical safety of the individual, other patients or staff members and when less restrictive measures have proven ineffective.
 - Individuals who are restrained must be afforded maximum freedom of movement while assuring the physical safety of the individual and others. The least number of restraint points must be utilized and the individual must be continuously observed.
 - Seclusion and restraint reduction and elimination requires preventative interventions at both the individual and milieu management levels using evidence based practice.
 - Seclusion and restraint use is influenced by the organizational culture that develops norms for how persons are treated. Seclusion and restraint reduction and elimination efforts must include a focus on necessary culture change.

- Effective administrative and clinical structures and processes must be in place to prevent behavioral emergencies and to support the implementation of alternatives.
- Hospital and behavioral healthcare organizations and their nursing leadership groups must make commitments of adequate professional staffing levels, staff time and resources to assure that staff are adequately trained and currently competent to perform treatment processes, milieu management, de-escalation techniques and seclusion or restraint.
- Oversight of seclusion and restraint must be an integral part of an organization's performance improvement effort and these data must be open for inspection by internal and external regulatory agencies. Reporting requirements must be based on a common definition of seclusion and restraint. Specific data requirements must be consistent across regulatory agencies.
- Movement toward future elimination of seclusion and restraint requires instituting and supporting less intrusive, preventative, and evidence-based interventions in behavioral emergencies that aid in minimizing aggression while promoting safety.

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