APNA Position Statement on the Use of Seclusion and Restraint

(Original, 2000; Revised, 2007; Revised, 2014; Revised, 2018)

Introduction

Psychiatric-mental health nursing has a 100 year history of caring for persons in psychiatric facilities. Currently, nurses serve as direct 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 organizational leadership that supports care settings.

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 the use of seclusion and restraint.

Background

In the mid-1800s, proponents of "moral treatment" of psychiatric patients advocated for 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 (Fisher, 1994). Belief in the necessity for continuing the practice of secluding and restraining patients as a way to prevent injury and reduce agitation persisted until the beginning of the 21st century. Nurses then concluded that this practice was not grounded in research that supported its therapeutic efficacy, but upon the observation that these measures interrupted and controlled the patient's behavior (Sailas & Fenton 2000; Paterson & Duxbury, 2007; Steinert et al. 2010; Scanlan 2010). Regulatory changes and increased study led to recognition that seclusion and restraint are not grounded in research and are not therapeutic (World Health Organization, 2017).

Reports of patient injuries and deaths (Berzlanovich, Schöpfer & Keil, 2012; Cecchi et al. 2012; Rakhmatullina, Taub and Jacob, 2013; Duxbury, 2015) and studies of patients' experiences in restraint and seclusion (Kontio, 2011; Steinert et al. 2013; Soininen et al., 2013; Ling, 2015; Okanli, 2016) have prompted psychiatric-mental health nurses to give serious consideration to the ethical conflict inherent in the use of seclusion and restraint: between the nurse's

responsibility to prevent harm and the patient's right to autonomy (Cleary, Hunt and Walter 2010; Mohr, 2010; APNA Janssen Scholars, 2012; Ezeobele, 2013). However, violence cannot always be predicted, and since the nursing staff are held responsible for maintaining the safety of all patients, they sometimes see seclusion and restraint as the only way to maintain that safety (Duxbury, 2015). 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 workers, as well as patient safety (Flannery et al., 2011; Happell & Koehn, 2011). 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 (Happell & Koehn, 2011; Azeem et al., 2011; Chandler, 2012; Ashcraft, Bloss & Anthony, 2012; Chang et al., 2013). In 2012, NASMHPD's Six Core Strategies to Reduce Seclusion and Restraint Use program (2008) was recognized by the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices, based on the results of a five-year, eight-state research project. This multi-modal approach has been implemented widely by organizations striving to decrease seclusion and restraint use (Delacy et al., 2003; Masters, 2017).

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 (Johnson & Delaney, 2007; Ward et al., 2011; Taylor et al., 2012), (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 medication (Bak et al., 2012; Sivak, 2012; Bostwick & Hallman, 2012; Chalmers et al., 2012; Bowers et al., 2012) and (c) changing aspects of the unit to promote a culture of structure, calmness, negotiation and collaboration, rather than control (Kontio et al., 2012; Bowen, Privitera, and Bowie, 2011; Jones, 2012). The Safewards Program (Bowers, 2014; Hamilton, 2016) has helped caregivers in the United Kingdom to reduce the use of containment procedures by avoiding flashpoints that precede aggression. The Scottish Patient Safety Programme (2016) achieved reduction in the rate of restraint by promoting the idea that when people are and feel safe, staff are and feel safe. Recent evidence has shown that use of a standardized tool to improve time to first medication has been a factor in a successful restraint reduction effort in an emergency department (Winokur, Loucks and Rapp, 2018). Another important factor seems to be adequate staffing skill mix (Staggs, Olds, Kramer & Shorr, 2017).

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There is 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 (Delaney and Johnson, 2012; Goetz and Taylor-Trujillo, 2012). 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 (Hammer et al., 2011; Hardy & Patel, 2011; Subica, Claypoole & Wylie, 2012; Bowen, Privitera & Bowie, 2011; Azeem et al., 2011; SAMHSA, 2018).

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 (Nadler-Moodie, 2009; Huf & Adams, 2012; Hollins & Stubbs, 2011; Mohr & Nunno, 2011; Georgieva et. al, 2012). 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 approach 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 mechanically 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.

" 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."

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