



FINAL DRAFT of July 2011

The Copeland Center for Wellness and Recovery

Position paper on the elimination of seclusion, restraints, force and coercion

This paper reflects the Copeland Center for Wellness and Recovery's firmly held belief that all uses of seclusion and restraints in psychiatric services be eliminated. In addition to serving as a declaration of the Copeland Center's position on this important topic, it also aspires to stimulate an active and ongoing dialogue on alternatives to seclusion and restraints among change agents in the mental health recovery arena. The Copeland Center's Committee on Eliminating the Use of Seclusion and Restraints, which developed this paper, continues to work on developing an action plan detailing the Copeland Center's role and areas of contribution to this critical movement.

A Call for Change

The Copeland Center for Wellness and Recovery seeks the elimination of the use of seclusion and restraints (either physical or chemical) in all areas of psychiatric services. The Center also opposes the use of body bags of any kind, strait jackets and other devices that restrict movement, full body searches including body cavity searches, torture of any kind, the use of tasers and the use of force or coercion as treatment for emotional distress. The Center also believes the use of these methods in any area of psychiatric services should be outlawed by national and international law.

Definitions

For purposes of this paper, “seclusion” is defined as the involuntary confinement of a person alone in a room where he or she is physically prevented from leaving. “Restraint” is defined as the involuntary use of a manual method or mechanical device, material or equipment attached or adjacent to a person's body that is not easily removed and restricts the person's freedom or normal access to one's body. It also includes the use of medication to restrain people, commonly referred to as “chemical restraints.” It does not include the self-directed use of physical holds that someone may choose to include in his or her crisis plan, advance directive or other self-determined care plan (for example, if someone asks to be held or hugged while being talked to during an intense situation).

The Need for Change

Regardless of circumstance, the Copeland Center does not view any use of seclusion or restraints as warranted or beneficial to an individual's wellness. Literature reviews seeking to rationalize these practices find no valid support for their use as part of an individual's recovery. Rather, seclusion and restraints are quite often used subjectively and inconsistently and for non-therapeutic reasons such as staff convenience, punishment for “bad behavior,” a means for staff to feel in control or for them to maintain order. The use of seclusion and restraints represents system failure, rather than treatment. Not surprisingly, it has been well documented that people who have been in seclusion or restraints have experienced the following:

- Feeling humiliated, violated and disempowered,
- Long term psychological trauma (including retraumatization),
- Serious physical injury, and
- Death.

It also has been documented that direct care staff have experienced physical and psychological injuries resulting from their role in these incidents. Often staff who implement these interventions are in high stress environments yet have not received the educational and other supportive resources they need to safely and effectively defuse situations. Given the appropriate training and supports, staff would have better skills and options to utilize with individuals in intense situations and thereby avoid using seclusion and restraints.

The Path to Change

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Unfortunately, a culture that perpetuates the use of seclusion and restraints remains prevalent throughout much of the mental health system. After all, seclusion and restraints have been used for centuries and have long been mistakenly considered therapeutic interventions—not surprisingly, their use has become accepted and ingrained in practice patterns. Yet seclusion and restraints have nothing to do with therapy and wellness and have no place in a recovery-oriented system of care.

A cultural shift away from these historic and misguided attitudes is essential to creating the right foundation upon which to continue building a person-centered, wellness- and recovery-focused mental health system that is free of seclusion and restraints altogether. Once this new cultural foundation has been laid, focus can shift to implementing the various components of a system-wide change essential to successfully eliminating these practices. This effort must actively involve all stakeholders and must include:

- New commitments from leadership
- Changes in policy
- Improvements in assessment
- Recovery-based treatment approaches, including peer-delivered services
- Enhanced staff training

Despite the persistence of strong beliefs among some that alternatives to seclusion and restraints are not possible, there are growing signs that the mindset is shifting. Numerous initiatives at both the federal and state level are underway to reduce and ultimately eliminate the use of seclusion and restraints:

- In 2004 and 2007, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued awards to a total of 16 states under its Alternatives to Restraint and Seclusion State Incentive Grant (SIG) aimed at reducing and ultimately eliminating the use of seclusion and restraints in institutional and community-based mental health settings.
- In 2006, SAMSHA published a training curriculum, entitled “Roadmap to Seclusion and Restraint Free Mental Health Services,” to equip mental health providers with current information on prevention strategies and alternative approaches to avoid and reduce the use of seclusion and restraints.
- NASMHPD’s National Technical Assistance Center has trained senior provider and leadership staff from over 46 state mental health agencies using a prevention-based training curriculum geared toward reducing and eliminating seclusion and restraints.
- Most notably among state initiatives, from the mid-1990s to 2001, Pennsylvania saw its combined incident rates of seclusion and restraints per 1,000 patient days reduced by 90% and its hours of use per 1,000 patient days decline by 95% following inception of its sweeping changes. And by 2010, Pennsylvania had virtually eliminated seclusion in all of its state hospitals while the use of restraints continues to decline.
- In late 2000, Massachusetts began an effort to reduce and ultimately eliminate the

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use of seclusion and restraints in all of its child and adolescent inpatient and intensive residential treatment facilities. As evidence of its commitment, from November 2000 to January 2005, episodes of seclusion and restraints per 1,000 patient days decreased 84.4%, 80.4% and 78.7%, respectively, in child (ages 5-12), adolescent and mixed child/adolescent units.

While the Copeland Center certainly applauds these efforts and is encouraged by the progress, we remain committed to the unfinished task of eliminating these practices.

Copeland Center Resources for Change

“The principle of good education is to create people who are capable of doing new things, not simply repeating what other generations have done.”

-Jean Piaget

To effect cultural change requires education—this will allow us to stop doing what other generations have done, as Piaget suggests. The Copeland Center’s goal is to stop the use of seclusion and restraints and is dedicated to offering its educational and technical expertise to bring about this cultural change and facilitate the implementation of new skills and problem solving strategies, new ways of working together in difficult situations.

All stakeholder groups within the system of care must be involved in these transformational efforts—not just the direct care staff most closely involved with implementing these practices. A change such as we are advocating is unlikely to be realized without a clear, convincing and consistent message from top leadership and policy makers within the mental health system. With such an edict, and employing the necessary educational and other supportive resources, all parties can work together toward change—leadership and policy makers, key administrators, direct care and other hospital/facility staff, peers, family members and advocates.

The Copeland Center seeks to inform this important dialogue and effect lasting change through partnerships with others. It is uniquely equipped to educate the various stakeholder groups about alternatives to seclusion and restraints through the use of webinars, face-to-face and virtual consultations, targeted training events, and the implementation of a network of WRAP-trained facilitators. Our educational and technical assistance focuses on:

- Dispelling myths about seclusion and restraints
- Emphasizing wellness and trauma-informed values of care
- The importance of peer support and advance directives
- Creating supportive, wellness-based environments through development of individual and group Wellness Recovery Action Planning® programs

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We welcome any dialogue or opportunity to provide educational training and technical assistance on this important shift in thinking and practice. Please visit the Copeland Center website at www.copelandcenter.com on an ongoing basis to learn about future opportunities for training and additional information on this important topic or telephone us at 1-802-254-5335.

This paper was prepared by the Copeland Center Committee on Eliminating the Use of Seclusion and Restraints, whose members include: Mary Ellen Copeland, Matthew R. Federici, Ellie Goldfarb, Erica Buffington, Carol Bailey Floyd, Gina Calhoun, Cheryl Sharp, Sarah Bourne, Audrey Garfield, Ed Anthes, Christine Allers, and Katie Wilson.