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MENTAL HEALTH

Extent of Risk From Improper Restraint or Seclusion Is Unknown

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Mental Health: Extent of Risk From Improper Restraint or Seclusion Is Unknown

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss the effect of improper restraint and seclusion on some of the country's most vulnerable citizens—people with serious mental illness or mental retardation. About 5.5 million adults experience severe mental illness each year, about 240,000 of them requiring residential treatment in mental hospitals, centers, or group homes. In addition, an estimated 360,000 adults and children with mental retardation lived in intermediate care facilities or smaller residential settings in 1998. Medicare, the federal program of health insurance for the elderly and disabled, and Medicaid, the federal and state program of health insurance for the poor, help pay for the treatment of eligible individuals in these settings. Because members of the Congress became concerned about the safety of patients after a series of articles in the Hartford Courant reported on restraint-related deaths, we were asked to evaluate the risks involved in using restraint and seclusion, the adequacy of current federal reporting requirements and other protections, and what certain states had done to address restraint and seclusion.

In brief, as we recently reported, improper restraint and seclusion can be dangerous to people receiving treatment for mental illness or mental retardation and to staff in treatment facilities.[1] While there is no comprehensive system to track injuries or deaths, we found that at least 24 deaths that state protection and advocacy agencies (P&A) investigated in fiscal year 1998 were associated with the use of restraint or seclusion. We believe there may have been more deaths because only 15 states require any systematic reporting to P&As to alert them to serious injuries and deaths. We also found that federal and state regulations that govern the reporting of injuries and deaths and that govern the use of restraint and seclusion are not consistent for different types of facilities. The experience of several states demonstrates that having regulatory protections and reporting requirements can reduce the use of restraint and seclusion and improve safety for individuals receiving treatment as well as for facility staff. In our September 1999 report, we made several recommendations that, if adopted, should improve the safety of patients and staff in a variety of treatment settings.

Background

People with mental illness or mental retardation who receive residential treatment—and may be subject to restraint or seclusion—do so in a variety

[1] Mental Health: Improper Restraint or Seclusion Use Places Patients at Risk (GAO/HEHS-99-176, Sept. 7, 1999).

of settings. Psychiatric patients may receive inpatient treatment in traditional state hospitals, private psychiatric hospitals, or community hospitals with psychiatric units. The trend toward less restrictive community-based settings has led to more individuals with mental illness or mental retardation living in smaller facilities and group homes.

Federal funding through Medicare and Medicaid accounts for about 40 percent of the revenue for mental health treatment facilities. Medicare provides limited mental health coverage for individuals older than 65 and some individuals younger than 65 who are disabled. In 1994, Medicare spent about $4.5 billion for mental health services in private psychiatric hospitals and general hospitals. The Medicaid program covers certain low-income individuals for residential services to treat mental disabilities. Medicaid covers children and, at state option, aged adults with mental illness, and it covers adults and children with mental retardation. Medicaid provides inpatient mental health services for children younger than 21 in general hospitals, psychiatric hospitals, and nonhospital settings. Individuals aged 65 and older may receive inpatient mental health services in a hospital or nursing home. Medicaid spending for inpatient psychiatric treatment totaled more than $2 billion in fiscal year 1996. In the same year, Medicaid spent about $9.6 billion for intermediate care facilities for the mentally retarded (ICF-MR), which provide long-term residential care and treatment. In addition, Medicaid covers care for children with mental illness and adults and children with mental retardation through the home and community-based waiver programs, which allow states to cover a broader range of services in less restrictive settings such as group homes. State Medicaid programs spent $5.6 billion in federal and state funding on home and community-based waiver services in fiscal year 1996, some of which was used to provide residential treatment. The federal government through the Health Care Financing Administration (HCFA) administers Medicare and HCFA and the states administer Medicaid.

Restraint and Seclusion Can Injure Patients and Staff

Restraint and seclusion present real risks of injury and death to individuals in treatment and the staff who care for them. Restraint is the partial or total immobilization of a person through the use of drugs, mechanical devices such as leather cuffs, or physical holding by another person. Seclusion refers to a person's involuntary confinement, usually solitary. Restraint and seclusion can be dangerous because restraining people can involve physical struggling, pressure on the chest, or other interruptions in breathing. Staff can be injured while struggling to get residents into restraints or seclusion.

Clinicians, providers, and patient advocates generally agree that when patients lose control to the extent that they or others are at imminent risk of being physically harmed, staff can legitimately restrain or seclude them in emergencies. However, many patient advocates, state mental health program officials, and representatives of the psychiatric physician and nursing profession disagree as to whether there is any other appropriate clinical use of restraint and seclusion or whether they should be used only as a last resort.

The dangers of restraint and seclusion have been recognized in the mental health community. The Joint Commission for Accreditation of Healthcare Organizations (JCAHO), which accredits most hospitals participating in Medicare and Medicaid, recently sent an advisory to hospitals warning about the dangers of restraint and seclusion. JCAHO documented 20 deaths since 1996 caused by asphyxiation, strangulation, cardiac arrest, and fire while people were in restraint or seclusion. These were similar to the causes of death the Courant listed in its investigation, which included asphyxia, blunt trauma, cardiac complications, drug overdoses or interactions, strangulation or choking, and fire or smoke inhalation.

Children are subjected to restraint and seclusion at higher rates than adults and are at particular risk. Several of the states that took part in a study sponsored by the Department of Health and Human Services (HHS) Center for Mental Health Services reported higher restraint rates for children, including one state in which children in state-run inpatient facilities were restrained four times more frequently than adults. Children are smaller and weaker than adults are, so staff used to overpowering adults may apply too much pressure or force when restraining children. The following cases reported by the National Alliance for the Mentally Ill illustrate the dangers of restraining children:

- In February 1999, a 16-year-old girl died in California of respiratory arrest with her face on the floor while being restrained by four staff members.
- Basket holds—arms crossed in front of the body with the wrists held from behind—were involved in the death of a 17-year-old girl in a Florida residential treatment center in November 1998 and the death of a 9-year-old boy in North Carolina in March 1999 after being restrained following a period of seclusion.

The use of restraint and seclusion can also result in serious injury and abuse. During fiscal year 1998, P&As received about 1,000 complaints regarding restraint and seclusion and documented instances of bruising

and broken bones. In one instance, a 24-year-old man suffered a severe fracture in his right arm while facility staff were struggling to restrain him and was subsequently placed in four-point restraints and left for 12 hours with the broken arm, despite his requests for medical attention.[2]

Even if no physical injury is sustained, patients can be severely traumatized while being restrained, especially those who had previously been sexually abused. A Massachusetts task force reported that research indicates that at least half of all women treated in psychiatric settings have a history of physical or sexual abuse. The task force found that the use of restraints on patients who have been abused often results in their re-experiencing the trauma and contributes to a set-back in the course of treatment.

Restraint and seclusion can also lead to the injury of health care workers. The occupation of mental health care worker has been found to be more dangerous than construction work. Studies have documented that the largest percentage of patient assaults on staff members occurs during restraint or seclusion and that most staff injuries are sustained while staff are trying to control patients who are being violent.

Incomplete Reporting Leaves the Full Extent of Patient Risk Unknown

While restraint and seclusion can injure patients and staff, the full extent of that risk is not known. HCFA requires treatment facilities that participate in Medicare and Medicaid to fulfill certain requirements but before August of this year did not require hospitals—including psychiatric hospitals—to report deaths that might be associated with restraint or seclusion. The lack of comprehensive reporting makes it impossible to determine all deaths in which restraint or seclusion was a factor. However, through a survey of each of the P&As for the 50 states and the District of Columbia, we identified 24 deaths during fiscal year 1998 that were related to restraint or seclusion.

Reporting Requirements Are Not Comprehensive

Neither the federal government nor the states comprehensively track the use of restraint or seclusion or injuries related to them across all types of facilities that serve individuals with mental illness or mental retardation. Federal requirements on reporting injuries and deaths and restraint or seclusion differ by type of facility. Starting in August of this year, hospitals are now required, as a condition of participating in Medicare or Medicaid, to report to HCFA deaths that occur during—or can reasonably be assumed

[2]Four-point restraints immobilize a person on a bed with a cuff around each wrist and ankle.

to be related to—restraint or seclusion.[3] Other facilities that provide residential services to mentally ill or mentally retarded individuals and that are paid by Medicare or Medicaid are not required to report such deaths to HCFA. Federal regulations require ICF-MRs and nursing homes to provide, during their regular oversight surveys, information that can be used for tracking the use of restraint and seclusion. However, there are no federal reporting requirements on the use of restraint and seclusion for any other type of facility, such as community-based group homes funded under the Medicaid waiver program or residential treatment centers for children.

Most states do not comprehensively track data on either the use of restraint or related injuries. Further, JCAHO recently surveyed states regarding their requirements to report sentinel events. "Sentinel event" is defined as an unexpected occurrence involving death or serious physical or psychological injury or the risk of such death or injury. While the results are preliminary, only half the states that had responded by March 1999 indicated that they had a law that required reporting sentinel events to a state agency. In our survey of P&As, we found that only 11 states track restraint use in private psychiatric facilities.

JCAHO does not require hospitals to report sentinel events but encourages voluntary reporting. JCAHO reports that since it adopted its current policy on voluntary reporting of sentinel events in 1996, it has received reports of 24 restraint-related deaths in facilities it accredits. It published a Sentinel Event Alert based on these reports in November 1998 with a summary of the analyses of 20 restraint-related deaths from the sentinel event database. However, voluntary reporting to JCAHO is not complete. JCAHO found out about at least three deaths that had not been reported to it as a result of the Hartford Courant's report of deaths. Even if a sentinel event is not reported to it, JCAHO expects hospitals to conduct an internal review to determine how to avoid similar incidents.

Deaths Reported to Protection and Advocacy Agencies Understate the Problem

Because reporting is so piecemeal, the exact number of deaths in which restraint or seclusion was a factor is not known. We contacted the P&As for each state and the District of Columbia and asked them to identify people in treatment settings who died in fiscal year 1998 and for whom restraint or seclusion was a factor in their death. The P&As identified 24, but this number is likely to be an understatement, because many states do not require all or some of their facilities to report such incidents to a P&A.

[3]Federal Register, Vol. 64, No. 127, 36070 (July 2, 1999).

The Congress has required the states to establish or designate P&As to protect people with mental illness or mental retardation from abuse and neglect by providers when state oversight is insufficient. This system began for individuals with mental retardation in 1975, following the discovery of severe patient neglect and abuse at a state-run facility for the mentally retarded in New York, and it was expanded to individuals with mental illness when the Congress learned of similarly appalling conditions in psychiatric hospitals in 1985. P&As are charged with investigating reports of abuse, neglect, and other violations of the rights of mentally disabled individuals in institutional care and with pursuing legal and administrative remedies. In most states, the same P&A agency serves both individuals with mental illness and those with mental retardation.

Despite their charge, P&A representatives told us that they do not learn of all the deaths that may be related to restraint or seclusion. Only 15 of the 51 P&As receive any kind of systematic reports of deaths from their states or psychiatric facilities. Of the 15, 9 receive death reports for state facilities only and not for private facilities.

Because of the lack of reporting requirements in so many states, most P&As learn about deaths through complaints from family, patients, and staff as well as from on-site monitoring. Even with these ad hoc methods, only 22 of these agencies had deaths reported to them in 1998 by any means. Of the deaths reported to the P&As in fiscal year 1998, just 5 states accounted for more than two-thirds, and no deaths were reported to the P&As in 28 states.

P&As investigated only about 30 percent of the deaths they learned about. One agency in New York accounted for almost one-third of all the death investigations, while four other agencies investigated 107 deaths combined. P&A officials also told us that their ability to conduct investigations is hindered by limited resources and obstacles in obtaining records, particularly the incident reports and medical records that enable them to thoroughly investigate deaths. According to some P&A officials, health facilities often claim that these records are part of the peer review process—a process in which medical professionals in a facility review incidents. While P&As may have legal rights to review the records, a P&A may have to litigate to obtain them. This can use up its limited resources and delay needed investigations.

Information may be even more difficult to obtain from private facilities. Obtaining information from private facilities is becoming increasingly

important as more individuals with mental illness are being served in them. While many state agencies may gather data from their own facilities, private psychiatric facilities are usually not required to report data to either the state or the P&As.

Policies Governing Restraint and Seclusion Vary Among Federal Programs, States, and Facilities

Policies covering restraint and seclusion vary among federal programs, states, and types of facilities. The federal government regulates the use of restraint and seclusion in nursing homes and ICF-MRs but until recently had no such regulations for hospitals, including psychiatric hospitals. In August 1999, HCFA incorporated patients' rights provisions that address restraint and seclusion into the hospital conditions of participation. These requirements establish the right to freedom from restraint or seclusion for purposes of coercion, discipline, or staff convenience. Restraint and seclusion can be used only for medical and surgical care and in emergencies to ensure a patient's physical safety and only after less restrictive interventions have been found ineffective to protect a patient or others from harm. However, current regulations do not protect patients receiving psychiatric care in nonhospital settings such as residential treatment centers for children and group homes.

The states have varying degrees of regulation and oversight for restraint and seclusion. Some states have different standards for their state-run facilities and private providers. In addition, private psychiatric hospitals are frequently not subject to the same degree of oversight as the state-run facilities. Some states like New York and Pennsylvania that have extensive regulation of their public hospitals have not imposed the same requirements on privately operated facilities—even though they may be state-licensed or may be receiving federal or state funding.

HCFA relies primarily on the accreditation process to determine whether privately operated facilities such as hospitals are eligible to participate in Medicare and Medicaid. We found that representatives of health care providers and family advocates differed on whether the accreditation process alone is sufficient to protect patients from improper restraint and seclusion. JCAHO, which accredits about 80 percent of the hospitals that participate in Medicare, applies the same standards on restraint and seclusion in hospitals as it applies in nonhospital behavioral health care treatment facilities. In JCAHO's accreditation survey, the surveyors review records to determine whether restraint or seclusion is being used and documented according to facility policy. It does not set standards

regarding training and clinical issues such as the frequency of monitoring and the types of restraint that are preferable.

Representatives of health care providers told us that they believe that the accreditation process is the most appropriate way to ensure that patients are protected from improper restraint and seclusion. They said that a voluntary review process allows the facility to address any systemic clinical problems and develop plans for improving quality. In contrast, many advocates are concerned that the accreditation process is not sufficient to establish consistent patient protection because it stresses compliance with each facility's own policies. JCAHO surveyors tour facilities and talk with patients and staff to better understand their care issues. However, advocates have noted that the process emphasizes paperwork reviews that can miss ongoing problems with the quality of care. The HHS Inspector General recently reported that the accreditation process plays a positive role in the improvement of quality but cannot be relied upon alone to ensure patient protection.[4]

Some of the advocates and state administrators we interviewed believe that the most effective monitoring system involves a combination of internal and external oversight. External monitors complement internal quality control systems by providing an independent perspective. In some cases, courts have appointed independent monitors to ensure compliance with specific requirements and the safeguarding of basic patient rights in facilities that have had serious problems. In addition to using accreditation or state licensing surveyors and P&As, some states allow trained lay monitors to visit mental health facilities unannounced and assess environmental conditions. In Delaware, for example, if a monitor reports a concern about conditions in the state psychiatric hospital, the facility must respond within 10 days. Because staff at the facilities know that management reviews the reports and acts on them, they sometimes inform monitors about concerns that affect patient care, such as low staffing levels.

[4]HHS, Office of Inspector General, The External Review of Hospital Quality: A Call for Greater Accountability (Washington, D.C.: July 20, 1999).

Restraint and Seclusion Can Be Reduced Through Regulation, Reporting, Staffing, and Training

Several states have successfully lowered the use of restraint and seclusion in their public psychiatric health systems and put reporting requirements into place. Restraint and seclusion rates in Pennsylvania's state hospital system declined by more than 90 percent between 1993 and 1999. In Delaware, the state's ICF-MR introduced an initiative that reduced its restraint rate by 81 percent between 1994 and 1997. Typically, successful strategies to reduce restraint and seclusion rates have similar components: a defined set of principles and policies to clearly outline when these measures can be used, strong management commitment, the reporting of restraint and seclusion use, oversight and monitoring, and intensive staff training in behavioral assessment, nonviolent intervention, and using safe restraint techniques as a last resort.

Delaware, Massachusetts, New York, and Pennsylvania have adopted strategies to reduce restraint use in their public mental health or mental retardation service systems. The officials we met with at the state health departments indicated that the primary element for their success in reducing restraint use is management commitment. Management philosophy, not the severity of patients' mental disability, was the most important factor in determining restraint use among different state hospitals, according to a 1994 study conducted by the New York Commission on Quality of Care.[5] Management can take responsibility for shaping the overall culture in which restraint and seclusion are considered either routine practice or last-resort measures. An integral part of this commitment is a clearly delineated set of policies and procedures governing the use of restraint and seclusion for staff to follow.

For example, Pennsylvania, which administers a system of 10 facilities with more than 3,000 residential psychiatric patients, was able to reduce both restraint and seclusion hours by more than 90 percent between 1993 and 1999. The state mental health leadership accomplished this by first emphasizing to all hospital administrators and staff that restraint and seclusion are not treatment but, rather, represent an emergency response to a treatment failure that resulted in a patient's loss of control. The Department of Mental Health issued policies that specified that restraint or seclusion can be used only after all other interventions have failed and only when there is imminent danger of the patient or others coming to physical harm. A physician's on-site assessment is required within 30 minutes. According to state officials, there was some initial opposition to these policies within the facilities, but the department's emphasis on

[5]New York State Commission on Quality of Care for the Mentally Disabled, Restraint and Seclusion Practices in New York State Psychiatric Facilities (Albany, N.Y.: 1994).

maintaining adequate staffing and improving crisis management training allowed it to gain the support of psychiatrists and direct care workers.

Reporting requirements are central to lowering restraint use and improving patient safety. Officials in New York and Pennsylvania stated that accurate and complete reporting allows hospital administrators to compare their facilities with others. This creates an incentive for administrators with high restraint rates to find ways to reduce them so that they are more in line with those of their peers. A 1999 survey by the National Association of State Mental Health Program Directors indicates that 18 states currently collect data on restraint or seclusion in their public hospitals.

In addition to tracking restraint rates, the reporting of deaths and sentinel events to an independent agency can help improve patient safety. New York is unique among the states in its longstanding, comprehensive reporting requirement. All licensed hospitals that provide inpatient psychiatric care must report all deaths to the Commission on Quality of Care as well as to the relevant state agency and must indicate whether a patient was secluded or restrained within the 24 hours before his or her death. Mandatory reporting and investigation allow an independent entity to analyze events at multiple facilities. Because the commission and other agencies review information from the entire state, they can determine whether incidents that appear to be isolated events from the perspective of individual providers are actually part of a pattern. For example, comprehensive incident reviews led to the discovery that the use of two authorized restraints—the prone wrap-up, which immobilizes a person in a face-down position, and a towel to prevent biting or spitting—were associated with several injuries and deaths throughout the state.[6] As a result of these analyses, these two types of restraint were banned.

Clinicians, advocates, labor unions representing direct-care mental health workers, program administrators, and providers consistently stress that training and adequate staff-to-patient ratios are essential to safely minimize the use of restraint and seclusion. Nurses and direct-care staff need to have effective alternative methods for handling potentially violent patients if they are to reduce their use of restraint and seclusion. In the states we visited, training programs that address how to handle potentially

[6]Certain hospitals have authorized the use of a towel as a precaution against biting and spitting during take-down and the use of restraints to protect staff against possible infection. The commission indicated that no objects should ever be placed over or near a patient's face because of the danger of asphyxiation, and it recommended that staff wear gloves and masks and, if necessary, wrap the patient in a "calming blanket" to provide the staff with a safe barrier.

violent or aggressive patients were an integral part of the effort to safely reduce reliance on restraint and seclusion. In HCFA's interim final rule implementing new general and psychiatric hospital conditions of participation in Medicare and Medicaid, the agency has added requirements that hospitals train their staff in alternative techniques to lessen the use of restraint and seclusion, but these requirements do not extend to other facility types.

Delaware, Massachusetts, New York, and Pennsylvania have initiated training programs that emphasize crisis prevention. The goal of training is to provide staff with the skills to assess potentially violent situations and intervene early to help patients regain control. State officials as well as labor union representatives stressed that direct-care staff must be trained in alternative techniques if a facility is serious about reducing restraint and seclusion.

Delaware ICF-MR officials told us that patient and staff injuries decreased after staff had been trained in alternative ways of managing patient behavior. According to a patient advocate, Delaware's emphasis on reducing restraint rates was precipitated by a 1994 restraint-related death in the state ICF-MR. Following the implementation of a new training program that emphasized patient-centered training in crisis prevention and new management priorities, this facility reduced the number of emergency restrictive procedures by 81 percent between 1994 and 1997, with the number of procedures per resident falling from 1.38 to 0.29 during that time. Along with this reduction in restraint, the number of major injuries to residents fell by 78 percent and resident behavior improved. A psychologist from Delaware's ICF-MR noted that once staff have experienced success in calming a patient through alternative means when they would have otherwise used restraint, the new techniques become "self-reinforcing" because staff prefer to use the less drastic measures.

The mental health program officials we met with indicated that training in alternatives to restraint and seclusion and maintaining adequate staff levels are costly but that they can save money in the long run by creating a safer treatment and work environment. Data from state hospitals in New York indicated that usually facilities with higher restraint and seclusion rates had higher rates of staff injury and lost staff time. A New York official noted that many of the injuries classified as assaults actually take place during restraint and seclusion procedures. According to state officials, staff training has been found to save the state money by directly

reducing the frequency of restraint-related staff injuries, which represent the costs of sick leave and overtime payments for staff to cover the shifts.

Concluding Observations

The experience of several states shows that the use of restraint and seclusion can be reduced and that patients and staff are safer as a result. Successful strategies include ensuring management commitment, providing clear guidelines and a comprehensive reporting requirement, maintaining adequate staffing levels, and providing training.

The federal government has a major role in funding services for people with mental illness and mental retardation. HCFA has taken positive steps to ensure better reporting and patient protection through its new hospital conditions of participation. However, we believe that more can be done to ensure that Medicare and Medicaid patients with mental illness or mental retardation are protected from improper seclusion and restraint and from injuries and deaths. In our recently released report, we recommended that HCFA should develop consistent policies to ensure that mentally ill or mentally retarded individuals are given protection against inappropriate restraint and seclusion in every treatment setting that Medicare and Medicaid fund. We recommended that the use of restraint and seclusion and any associated injuries or deaths be reported to the state licensing body and state P&A. In addition, we recommended that facility staff regularly receive training in safe methods to handle agitated individuals, including training in alternatives to using restraint and seclusion. HCFA officials said that they would review and consider implementing each of our recommendations in the near future.

Mr. Chairman, this concludes my statement. I will be happy to answer your questions.

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