

## **Pennsylvania Seclusion and Restraints Reduction Initiative**

(The Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services, Leading the Way Toward a Seclusion and Restraint-Free Environment – Pennsylvania’s Seclusion and Restraint Reduction Initiative, (Harrisburg: Office of Mental Health and Substance Abuse Services, 2000)

### **Pennsylvania – A Model for Reform**

In 1997, the Pennsylvania Department of Public Welfare instituted an aggressive program to reduce and ultimately eliminate seclusion and restraints in its nine state hospitals.

Charles Curie, deputy secretary of mental health and substance abuse services, articulated the philosophy behind the change in policy: "Most of our patients are already the victims of trauma. There is no need to reinforce that trauma, or to re-traumatize."

Three years later, Pennsylvania had reduced incidents of seclusion and restraint in its nine state hospitals by 74 percent, and reduced the number of hours patients spent in seclusion and restraints by 96 percent. Its program, which includes both forensic and civil commitments, has the highest standards for S/R in the nation. *Pennsylvania’s hospitals experienced no increase in staff injuries. In addition, its changes were implemented without any additional funds, using only existing staff and resources.*

By July of 2000, Pennsylvania reported that one state mental hospital had not used seclusion for over 20 months. Another had used neither seclusion nor restraints for eight of the last 12 months. Three hospitals had been seclusion- and restraint-free for one or more consecutive months, and others were approaching zero use.

In October 2000, Pennsylvania’s Seclusion and Restraint Reduction Initiative received the prestigious Harvard University Innovations in American Government Award.

Figure 2 illustrates the reduction in seclusion and restraints that Pennsylvania achieved over the course of its three-year reform project, as measured by the Pennsylvania Office of Mental Health and Substance Abuse Services.

### **Pennsylvania Reduces Incidence of Seclusion and Restraints by 74% and Duration of Seclusion and Restraints by 96%**

#### **Elements of Reform**

Pennsylvania began its reform project by carefully tracking the use of S/R, and then used that 1997 data as its baseline to measure improvements. A workgroup of practicing hospital clinicians set about developing new policies and procedures, goals, strategies and monitoring systems to design and implement the new approach. Key among these goals was developing a new philosophy of care – one that identified S/R as treatment *failure* and restricted it to emergency use only.

Mental health officials cite a number of innovations as critical to the success of the program. Among them:

- \* Computerized data collection and analysis,
- \* Strategies for organizational change,

- \* Staff training in crisis prevention and intervention,
- \* Risk-assessment and treatment-planning tools,
- \* Patient debriefing methods,
- \* Recovery-based treatment models, and
- \* Adequate numbers of staff.

Also critical was changing the culture of state hospitals. Pennsylvania did this by requiring open public access to S/R data, by creating competition among hospitals to reduce S/R, and by giving awards and acknowledgments for improvement.

Key elements of Pennsylvania's S/R reduction policy:

Seclusion and restraints must be the intervention of last resort.

S/R are exceptional and extreme practices for any patient. They are not to be used as a substitute for treatment, nor as punishment or for the convenience of the staff.

S/R are safety measures, not therapeutic techniques, which should be implemented in a careful manner.

Staff shall include patient strengths and cultural competence to prevent incidents of S/R.

Staff must work with the patient to end S/R as quickly as possible.

A physician must order S/R.

Orders are limited to one hour and require direct physician contact with the client within 30 minutes.

The patient and family are considered part of the treatment team.

The patient advocate is the spokesperson for the patient (if the patient desires it) and is involved in care and treatment.

Patients being restrained cannot be left alone.

Chemical restraints are prohibited.

The treatment plan includes specific interventions to avoid S/R.

Patients and staff must be debriefed after every incident, and treatment plans must be revised.

Staff must be trained in de-escalation techniques.

Patient status must be reviewed prior to utilizing S/R. Voluntary patients who did not agree to these procedures must be involuntarily committed before these procedures may be initiated.

Leaders of the hospital, clinical department heads and ward leaders are accountable at all times for every phase of an S/R procedure. Accountability is demonstrated as a component of the hospital's "performance improvement" index and in staff competency evaluations.

Data regarding the use of S/R are made available to consumer and family organizations and government officials.