Task Force Reports

This is the twenty-second report in a monograph series authorized by the Board of Trustees of the American Psychiatric Association to give wider dissemination to the findings of the Association's many commissions, committees, and task forces that are called upon from time to time to evaluate the state of the art in a problem area of current concern to the profession, to related disciplines, and to the public.

Manifestly, the findings, opinions, and conclusions of the Task Force Reports do not necessarily represent the views of the officers, trustees, or all members of the Association. Each report, however, does represent the thoughtful judgment and consensus of the task force of experts who formulated it. These reports are considered a substantive contribution to the ongoing analysis and evaluation of problems, programs, issues, and practices in a given area of concern.

John A. Talbott, M.D.
President, APA 1984-1985

ISBN 0-89042-222-2
Library of Congress Catalogue Card No. 84-073549

Printed in the U.S.A.

In December 1992, the APA Board of Trustees approved the following addendum to the APA Task Force Report #22 Guidelines for the Use of Seclusion and Restraint:

While guidelines for the emergency use of seclusion and restraint on page 21 are desirable and strongly encouraged, not all psychiatrists in all practice settings have the means to comply. They should follow local hospital guidelines to the extent feasible, with due considerations to their full range of professional obligations to all their patients.

SECLUSION AND RESTRAINT
The Psychiatric Uses

Report of the American Psychiatric Association
Task Force on the Psychiatric Uses of Seclusion and Restraint

Chairman: Kenneth Tardiff, M.D., M.P.H.
Members: Thomas Gutheil, M.D.
Robert Liberman, M.D.
John Lion, M.D.
Paul Soloff, M.D.

Consultants: Donald Gair, M.D.
Timothy Kuehnel, Ph.D.
Marlin Mattson, M.D.
Katherine Slama, Ph.D.
Manuel Straker, M.D.
David Wexler, J.D.
Stephen Wong, Ph.D.

This Report was Approved by the Council on Psychiatry and the Law in September 1984, and the Board of Trustees in December 1984.

Correspondence should be sent to: Dr. Tardiff, Cornell University Medical College, 1300 York Avenue, C-118, New York, New York 10021

Table of Contents

I - Background and Context

A. INTRODUCTION

The intent of this Task Force Report is to review the practices of seclusion and restraint as they are used in the treatment and management of disruptive and violent behaviors in the modern psychiatric milieu and to recommend model guidelines for their clinical application. To this end, we have reviewed the controversy surrounding the use of physical controls in psychiatry, current empirical research, state regulations, indications, contraindications and implementation of seclusion and restraint techniques. In recognition of the complexities of clinical practice and the great variations in patient populations, staff patterns and philosophies of care pervasive in our own field, the guidelines presented by this Task Force must be viewed as recommendations which may need to be adapted to the special needs of each clinical setting. Creative alternatives to seclusion and restraint through behavioral analysis and behavioral therapies as well as special aspects pertinent to the care of children, the developmentally disabled and the elderly are presented in this report.

Our attention to the use of physical controls in psychiatric practice follows public concern and legal controversy over the legitimate role of seclusion and restraint in the treatment of the mentally ill. Through a series of judicial reviews, Amicus briefs and position papers, the use of seclusion and restraint by the psychiatric profession has been examined, controversies defined and some resolutions achieved. The legal implications of physical controls, including the dual obligation to use these methods when necessary and refrain when possible, are discussed in light of recent court decisions. The Task Force affirms the paramount importance of good clinical judgement in the use of physical controls, a position fully supported by the Supreme Court in the recent Youngberg v. Romeo decision which is discussed in section D. of this chapter. The recommendations presented by the Task Force comport with what we believe to be sound clinical practice and under the recent Romeo decision, we believe these recommendations comply with the constitutional guarantees of the patients. An important caveat, however, is that, in certain jurisdictions, state statutes and administrative regulations are far stricter than they need to be to satisfy Romeo's constitutional mandate. In these jurisdictions, some of the leeway given to clinical judgement by our guidelines may run counter to state law. It is

therefore essential that clinicians be familiar with legal limitations that may operate in the states in which they practice.

As a matter of policy, however, the Task Force is of the view that matters of seclusion and restraint may, at least for the present, best be dealt with not through legislation but rather through the more flexible, and more easily amendable, mechanisms of hospital policy and administrative regulations. Therapists, hospital superintendents, and state mental health program directors seem ideally suited to understand, address, and formulate policy regarding these complex interlocking issues.

Any discussion of seclusion and restraint of the psychiatric patient in the modern milieu must begin with the question as to why they are needed? To the non-clinician, the use of physical controls must appear distinctly anachronistic, a reminder of past abuse and repression of the mentally ill. The need to control and contain disturbed and violent behavior remains the principal reason for the persistence of seclusion and restraint in the modern milieu as in the past.

The last great debate on seclusion and restraint began with the Enlightenment of the 18th Century. The great reformers, Pinel of France, Chiarugi of Italy and Tuke of England, introduced the moral treatment of the mentally ill based upon principles of humane care, education, and above all, a belief in non-restraint. The reformers did not all together abandon security in the name of their moral philosophy. While abolishing all personal instrumental restraint, they recognized the need for emergency treatment by physical isolation of the violently disturbed patient and developed the use of the seclusion room. Seclusion was defined as a treatment modality in contrast to instrumental restraint which was universally.condemned as a method of custodial management.

In 1815, a widely celebrated case of abuse at the Bethlem Hospital led to parliamentary inquiries into the conditions of the insane. The parliamentary inquiry first documented a need for legislative control over the care of the insane, then guided the passage of legislation which supervised all that pertained to the management of the insane including annual inspection, certification and licensure. Records of admissions, discharges, deaths, hours of restraint and seclusion were to be kept and regularly inspected. The legislative regulation of the lunatic asylums was a critical step in the reformation of the mad house into a hospital, a major milestone in the history of psychiatry.

In America, Benjamin Rush advocated the abolition of instrumental restraint in the service of custodial control; however he enthusiastically used the tranquilizer chair as an instrumental form of treatment. As the debate took shape in America, Isaac Ray stated the position of American psychiatry in 1844 at the founding meeting of the Association which was to

become the APA: "Resolved that it is the unanimous sense of this convention that the attempt to abandon entirely the use of all means of personal restraint is not sanctioned by the true interests of the insane."

Today the scope of this problem, its social and professional implications are poorly understood outside of psychiatric circles and underestimated by many within the mental health field. Simply stated, we live in violent times, a fact of American life which extends to the working reality of the psychiatric treatment setting. We have no cures for violence, yet social forces outside the profession direct our efforts toward the care of violent patients in ever growing numbers. Social policy decisions, legislative funding priorities and rising social expectations have increased the visibility of violent patients and the demands that the mental health profession deal with them.

One example of such social policy is the national trend toward deinstitutionalization of the chronic mental patient, a product of economic necessity as much as enlightened psychiatric reform. With deinstitutionalization has come a flood of chronically disturbed patients,often poorly prepared for independent existence, inadequately supported by community resources, increasing the visibility and frequency of disturbing and violent behaviors in the community. No longer the responsibility of large state hospital systems, these patients turn in increasing numbers to the emergency rooms of the community mental health center or general hospital and a variety of acute psychiatric inpatient settings for support and treatment.

Other social pressures which have increased the visibility and frequency of violent behavior at the community level include the epidemics of drug abuse among the young, most recently among the affluent children of the middle class. Epidemics of drug induced violence have followed the widespread abuse of psychotomimetics such as LSD, amphetamines and the most deadly phencyclidine, which especially has been associated with homicides, suicides, and self-mutilation.

Rising social expectations concerning the ability of mental health professionals to deal with disruptive behavior has encouraged the redefinition of alcohol related offenses and family violence as symptoms of emotional illness rather than criminal offenses. In many cities, the community mental health center emergency room has all but replaced the local police "drunk tank" for the management of this socially defined illness. Violent family arguments are brought to the emergency room rather than the precinct. Using a similar justification, disruptive and disturbed behavior in the jail setting itself often prompts referral to the local mental health center for psychiatric evaluation and treatment. Although occasionally well justified by such presentations as homosexual panic, suicidal gesture and drug related psychoses, the interest of police authorities in obtaining "psychiatric

clearance" for their disruptive or threatening jail inmates results in a further burden of violent patients referred to the mental health centers. Finally, within the field itself, psychiatrists have progressively taken on the burden of treating impulsive character disorders and borderline personalities in inpatient psychiatric settings. All of these practices incur the inevitable risk of increasing the frequency of violent and disruptive behaviors on the inpatient unit.

Agitated, belligerent and overtly combative patients still exist within psychiatric facilities despite the development of psychotropic drugs and techniques of behavioral intervention which have done much to reduce the disruptive symptoms of their illnesses. However the limited efficacy of pharmacotherapy or behavioral interventions in the prevention, treatment and management of acute violent behavior is further complicated by medical, legal and even social constraints on the use of medication or behavioral therapies to control violent patients. Legislation regarding patients' rights, coupled with sensitivities to the acute and long-term detrimental side effects of drug treatment have led clinicians to reconsider the value of physical restraint and seclusion.

Despite the persisting need for physical controls, seclusion and restraint of psychiatric patients has come under increasing public scrutiny and legal review. In response to an action paper by the membership of the American Psychiatric Association, the APA Council on Governmental Policy and Law (now the Council on Psychiatry and Law) recommended that a Task Force be formed and charged "to prepare a review of published data and psychiatric literature on seclusion and restraint; to conduct a survey of state mental health commissioners on current regulations and problems and to present the Task Force's view on optimum clinical practice involving seclusion and restraint, considering that different criteria may be applicable to children, adolescents, adults, the elderly, and the developmentally disabled." At the end of 1981, Daniel X. Freedman, M.D., APA President, appointed the Task Force. This is the report of the deliberations and work in the three years that followed. For more extensive coverage of the historical, clinical and legal issues concerning seclusion and restraint, the reader is referred to the full text of the work of the members and consultants of the Task Force published by the American Psychiatric Press under the title, The Psychiatric Uses of Seclusion and Restraint (1). We hope this report and book will be of use to all who are involved in the management of violent psychiatric patients, both from the clinical as well as policy making and legal perspectives.

B. Review of Individual Quantitative Studies

Despite the limiting factor that the relatively few empirical studies of seclusion and restraint are descriptive, rather than experimental in nature, some useful general data emerge. The task of extracting such information, however, is rendered particularly difficult because of differing methodologies, settings, and patients.

A number of methodological problems, moreover, were common enough to mention here. First, very few of the studies corrected their data for "days at risk," the principle that a longer time in hospital may increase the time available during which seclusion may occur, which is a possible source of distortion of the data. Second, the use of medication was often ambiguously described. Medication may shorten duration of seclusion; may make seclusion unnecessary if given early; or may be precluded in a given case, making seclusion the only safe intervention by default. Third, some settings had policies about seclusion, with and without relevant considerations as to medication. Some used seclusion preferentially, since it introduces no pharmacologic distortions to the diagnostic assessment; others view seclusion as a last resort, to be employed only after other measures (sometimes even including restraint) have been tried and have failed. For certain settings where violence is uncommon, seclusion may represent a serious treatment failure and defeat; an ambivalently held, conflicted procedure of dubious civil-rights validity; or a clumsily-performed, unpracticed brawl, leaving a host of injuries and grudges in its wake. In contrast, in violent-offender settings, it may represent a routine familiar to the point of ennui, smoothly and thus safely performed by well-trained and practiced staff, to the benefit of all patients on the ward. These vastly differing perceptions and practices must affect the final data obtained often in very subtle ways.

We here briefly summarize empirical studies, more extensively addressed elsewhere (1). The first study in our series was retrospectively performed by Tardiff (2) using chart review, standardized recording forms and direct interview of patient and treating staff on a population of 5580 patients residing for over one month in Long Island state hospitals. He found that 106 patients were secluded or restrained, a relatively low percentage of 1.9%. The population studies included large numbers of chronic patients, but the episodes of emergency interventions, seclusion, involuntary medication and restraint tended to affect younger patients early in their hospital course. In short, the more acutely ill individuals showed more evidence of clinical disorganization.

In one of the rare prospective studies Soloff and Turner (3) studied the use of seclusion on two acute treatment units in a university hospital. Their study contained both public and insurance-funded patients and used a

forced choice questionnaire. Over an eight month period out of a total population of 561 patients, 59 (10.5%) patients were secluded and accounted for 107 episodes of seclusion. In studying precipitants the authors found that "physical attack on staff with actual physical contact" was significantly the leading violent precipitant. The leading non-violent precipitant, and the second most common precipitant, was "patient escalating, unable to control behavior, inappropriate behavior, etc." In contrast to other studies, chronicity, commitment and race appeared to be clearly related to the incidence of seclusion, yet statistically independent of each other. The study's main point is that seclusion was used primarily to contain physical violence, a condition representing a valid psychiatric emergency.

The third study by Schwab and Lahmeyer (4) used a routine reporting form as well as a questionnaire to examine seclusion prospectively in a general hospital psychiatric unit in a university teaching hospital. The setting mandated a "drug free period" for each newly admitted patient to aid in the diagnostic assessment and evaluation, a policy decreasing use of medication in acute management of patient dyscontrol. Out of 142 patients in six months, 52 patients were secluded in an unspecified number of episodes, a percentage representing 36.6%, a fairly high percentage in our series of studies; 18% of patients were also in restraints. The reasons given by staff for initiating seclusion frequently presented in a triad; namely, "destimulation," "agitation," and "poor impulse control." High census, youth, and mania were related to seclusion; race was not.

Plutchik, et al. (5) retrospectively studied via chart review 450 patients in the public sector in a psychiatric teaching unit of a general hospital. They found 118 (26%) patients were secluded in contrast to an equal number of non-secluded controls. The secluded population was distinguished by again being younger, longer term patients, more often schizophrenic. Precipitants were personal agitation, uncontrolled behavior, and physical aggression toward other patients. The main purpose of seclusion was given as isolation from overstimulation and frustration.

Convertino et al. (6), using chart review and standard report forms, presented the first systematic examination of inpatient seclusion at a community mental health center serving a public sector population. Of a total of 121 patients, 25 patients (21%) were involved in 56 episodes of seclusion. These authors found no significant differences between the secluded and randomly selected non-secluded patients in terms of age, diagnosis and sex or race.

Wells (7) retrospectively studied seclusion in a psychiatric unit in a general hospital with public and private sector patients. The exact study method was unclear. However 13 patients out of 319 were secluded in an

unspecified number of episodes for a seclusion rate of 4%. Nearly all patients received medications during seclusion. Seclusion correlated with acuteness of illness, schizophrenia and hypomania. The major precipitant was violent behavior unresponsive to all other measures.

Mattson and Sacks (8) retrospectively examined a psychiatric voluntary private sector unit in a university hospital. They found 63 patients out of 875 were secluded in an unspecified number of episodes for a seclusion rate of 7.2%. Compared with 160 controls, younger, disorganized schizophrenic patients clearly predominated in the secluded group. The leading precipitant was behavior disruptive to the therapeutic environment, closely followed by assaultiveness to others. A problem with seclusion was the staff's occasional tendency to "turn off the monitoring" of patients in seclusion. The authors stress that seclusion is not itself treatment but a place where treatment can occur, particularly a safe setting in which to allow antipsychotic medication to work.

Binder (9) retrospectively reported, using chart review, on the use of seclusion in a public sector inpatient crisis intervention unit. Of 50 patients, 22 (44%) patients were secluded in 28 episodes of seclusion in a one and a half month period. Younger, schizophrenic patients predominated, with leading precipitants being agitation, uncooperativeness, anger, and a history of violence. Actual assault placed 12th in precipitants. The atypical patient population were unscreened individuals brought in crisis to the unit, many by police, and were particularly difficult and dangerous. This probably accounts for the high rate.

The last and most recent study of seclusion is that of Oldham and his colleagues (10), which retrospectively examined the records of 313 patients sequentially admitted to a 25-bed inpatient unit of a university psychiatric hospital. Of these patients, 57 (18%) were secluded. The secluded patients were more likely than the nonsecluded patients to be younger, never married, manic, and involuntary patients with a history of previous hospitalization. The most common precipitant was escalating agitation; the next most frequent precipitants were threats or assaults against staff and property damage. Seclusion was more likely to occur earlier in hospitalization, and the total seclusion time was less than three hours. The peak occurrences of seclusion were during the weekdays at times in the day characterized by unstructured patient time and by staff unavailability because of meetings and other scheduled duties. The authors concluded that early and judicious use of seclusion is compatible with modern hospital work and that patterns of use reflect both clinical and milieu parameters.

Though the literature on systematic reviews of seclusion is scanty, it dwarfs the literature on restraint. Soloff's studies (11, 12) are the only

empirical work, though a handful of descriptive/prescriptive articles exist as well (13, 14) the last of these addressed to decreasing use of restraint. Some of the previously reviewed seclusion studies include combinations of seclusion with restraint, but meaningful patterns are difficult to discern, in part because of obscurity in recording. Since we are limited by space, readers are directed to the longer treatise (1) for a more extensive exploration of this topic.

To summarize, younger, more acute and more disturbed males are secluded on the basis of a clinically dangerous state, a condition relatively independent of diagnostic and other variables, correlated with states of perceptual, cognitive and behavioral disorganization with consequent disruption of the therapeutic milieu. Most importantly, our review specifically confirms that seclusion is principally used to contain violence and thus serves a legitimate and irreplaceable purpose on the modern inpatient ward.

Despite the low level of comparability among the subject populations served in these studies, it is also clear that severity and refractory nature of the illness, "acuteness" of setting, and membership of patients in the public sector appear to have a gross positive correlation with seclusion.

Since all the studies here reviewed have been descriptive and none were truly experimental, we lack empirical evidence of the actual effectiveness of seclusion or restraint. The Task Force hopes that this conclusion will spur readers to undertake experimental studies designed to overcome this deficiency.

Perhaps the most difficult issue to assess in these studies is the fact that seclusion or restraint never occur in a contextual vacuum: each is as much an event of multivariate etiology as other clinical phenomena. All studies however, do reflect a close fit between seclusion or restraint as an intervention and the various forms of dyscontrol that they are designed to ameliorate. These conclusions further appear to indicate the need for uniform and systematic reporting methodologies, as well as uniform study designs.

C. A Survey of State Mental Health Directors

Through the National Association of State Mental Health Program Directors, the directors in the 50 states were surveyed concerning their regulations governing the utilization of seclusion and restraint. They were asked about the existence of written guidelines as well as any clinical problems or legal challenges to their guidelines. In addition, they were asked to submit a copy of their written regulations. Using a work sheet with items covering various aspects of the seclusion and restraint procedures,

the Task Force reviewed each submission by the state mental health program directors and present the results in this section.

There were 36 (72%) responses from the state directors. There were 23 states with state-wide written regulations and 20 states with written regulations established by each state institution. Thus some states had both state-wide as well as individual institutional guidelines. There were only two states without any written regulations. Regulations had been challenged in three states and in two states they were upheld. In the third state the legal challenge involved pending litigation over the use of seclusion in a facility for mentally ill offenders. The suit maintains that there should be some form of due process reviews in the seclusion of mentally ill offenders.

There were eleven directors who stated that there have been clinical problems with the implementation of their states' regulations. These problems included: 1. whether only physicians should be able to order seclusion or restraint as opposed to other mental health professionals; 2. excessive time demands made on physicians to regularly evaluate patients placed in seclusion/restraint; 3. time demands on other professional staff for monitoring patients once secluded or restrained; 4. questions of duration; 5. appropriated indications for seclusion and restraint; 6. effectiveness of seclusion; 7. differentiation of medical restraints from other types of restraints; 8. informing staff about written guidelines and making certain they use proper procedures for implementing and managing seclusion and restraint; and 9. some staff have questions as to when to remove patients from seclusion or restraint.

In reviewing state regulations submitted, the Task Force was impressed by the variability in the length and specificity of written regulations. It should be borne in mind, however, that the regulations submitted were usually those that were state-wide, thus raising the possibility that local institutions may have more specific regulations in certain states.

Of the respondents, 19 had no definition for seclusion and 23 had no definition for restraint in their regulations. Of those states defining seclusion, most included the concept of isolation of the patient in a room which was locked or from which there was no means of leaving. Most of the states, namely 25, did not mention any differentiation of time out or other behavior modification from other types of seclusion. However, in cases where it was mentioned, the states did distinguish time out from other types of seclusion.

For those state regulations defining restraints, most agreed that it was a technique or use of a device to restrict or control a patient's movement. Five states gave examples of devices for restraining patients. Four states included "chemical restraints," that is the use of medication for purposes of controlling dangerous behavior, in their regulations on restraining patients.

Most states did not mention whether medical restraints were included in their definitions. Of the 13 states mentioning this, eight excluded medical restraints from their regulations and five stated that medical restraints should be used following the same regulations covering other restraints.

Most state regulations specified the indications for seclusion and restraint, however, nine state regulations did not. Indications for seclusion and restraint were basically the same. In 23 states indications for seclusion or restraint were to prevent harm to the patient or other persons. However, eight regulations included the prevention of substantial property damage and two included disruption of the treatment environment as indications. Seven states mentioned that seclusion or restraint was indicated in the emergency situation. However, four allowed that their use could be part of a regular treatment plan as well. The rest of the regulations did not mention the issue of use in emergencies versus non-emergency situations.

Most states required documentation to support the use of seclusion or restraint. However, states differed in terms of how specific the documentation must be and the form it should take. Some merely mentioned that a progress note should be entered in the patients' record, while others were more extensive in terms of recording precipitating circumstances, rationale, prior use of less restrictive intervention, the time the patient was placed in seclusion or restraint and the duration of the episode. In a few states, state regulations included forms or logs to be used for patients in seclusion or restraints.

The person empowered to order seclusion or restraint was the physician in 12 states, and the physician or other professionals in 11 additional states. In their regulations submitted, 13 states did not mention who was empowered to order seclusion or restraint. If only a physician was allowed to order seclusion or restraint, three states indicated that the physician should examine the patient and write the order within one hour after the initiation of the seclusion or restraint episode, one state within two hours, four states within four hours, one state within eight hours and three states within twelve hours or more.

The maximum time limit for each seclusion or restraint episode for most states was 24 hours. However, for three states it was eight hours, for one state it was four hours, and for one state it was one hour. Few states limited the number of episodes of seclusion or restraint for a patient. However, most did indicate a maximum period of seclusion or restraint after which an off-unit review would be necessary. For nine states, 24 hours was the maximum time a patient could be secluded or restrained before an off-unit review took place. However, for three states any seclusion or restraint episode lasting longer than eight hours had to be called to the attention of a hospital director. For one state, once seclusion for a patient ended it could

not be reinstated for that patient in the next two days without a review by the facility director. Four states required the release of patients from restraints every two hours for a brief period of time. Most regulations did not comment on the use of PRN orders for seclusion or restraint. Of the 13 regulations with comments about this, only three states allowed orders for PRN seclusion and only two allowed PRN orders for restraint.

In terms of nursing observations during seclusion or restraint, most regulations specified that patients should be observed at least every fifteen minutes. Few indicated what measurements should be done or what observations should be recorded. Sixteen of the state regulations indicated that a patient in seclusion or restraint should be given access to toileting and bathing as well as fluids and food. Few specified time intervals for these functions, and one state indicated that a patient should be given access to toileting every two hours.

Only five state regulations mentioned complications that can occur from seclusion or restraint. In most cases this involved outlining security measures that must be taken before and during the seclusion or restraint episode. For example, dangerous objects such as belts, matches or sharp objects, as well as glasses, shoe laces, cigarettes and dangerous ingestable items should be removed from the patient. The seclusion room should be free of potentially dangerous room furnishings. Some stated that the dignity of the patient should be preserved during the seclusion or restraint episode.

Only eight states gave detailed recommendations about techniques for safely placing patients in seclusion and/or restraint. Eight states gave some specifications of the seclusion room. These included general specifications such as the seclusion room should be large enough as not to be confining but not so large as to be overwhelming or that it should be inspected regularly and, of course, be sanitary and appropriately heated or cooled.

With regard to techniques of safely placing patients in restraints, recommendations included assurances that personnel and equipment are ready before beginning the episode and that any potentially dangerous items should be removed from personnel; for example, jewelry or glasses. Several states were very specific about maneuvers to restrain patients and one itemized techniques that were not permissible.

Last, only four state regulations indicated who is responsible for ending the seclusion and restraint episode. In all four regulations a nurse or other professional staff present were the persons responsible for ending the seclusion or restraint episode, although guidelines for determining whether the episode should be terminated were not given.

To summarize, most respondents indicated that their states had written regulations concerning the seclusion and restraint of psychiatric patients and submitted these guidelines for review. Of course, we have considered

the possibility that directors in states without regulations were more likely not to respond to the survey. Few states reported legal challenge of the regulations, but a number did report problems with implementation of their regulations.

Most states agreed on basic indications for seclusion and restraint, namely to prevent harm to the patient or other persons. Few mentioned more controversial areas such as use in non-emergency situations, before a dangerous act has occurred, use on a PRN basis, use for the protection of the treatment environment and in behavior modification programs. They agreed that an off-unit review should take place after a patient was secluded or restrained beyond a certain time period, usually 24 hours, and that a patient should be monitored while in seclusion or restraint, namely every 15 minutes. Most commented in general terms on the basic bodily needs of patients in seclusion or restraint.

There was great variability in very important aspects of seclusion and restraint such as who is empowered to order these procedures and the time in which a physician should see the patient once an emergency has resulted in seclusion or restraint. There were important omissions in the regulations of many states such as documentation of seclusion or restraint. Only a few states had regulations which suggested an understanding of the importance of appropriate techniques for using seclusion or restraint as well as possible complications that can arise from their use.

This survey further supports the national need for comprehensive, widely disseminated, and, hopefully, fully implemented guidelines for the seclusion and restraint of patients. These regulations from a number of states, along with a review of the literature and the experiences of the members and consultants of the Task Force, have formed the base for the guidelines that follow.

D. Legal Aspects of Seclusion and Restraint

The law of seclusion and restraint revolves largely around the 1982 Supreme Court case of *Youngberg v. Romeo.* (15) Romeo, a profoundly retarded man, was committed in Pennsylvania to the Pennhurst State School and Hospital. While at Pennhurst, Romeo was injured on numerous occasions, due sometimes to his own violence and due at other times to the reactions of the residents to him. Furthermore, Romeo was often physically restrained while at Pennhurst. Claiming that his constitutional rights had been violated, Romeo sued the institutional administrators for damages. Romeo claimed he had a constitutional right to safety, to freedom of movement, and to training.

The Supreme Court ruled that committed patients are entitled constitutionally to personal security and to freedom from bodily restraint, although, as will be seen, the Court qualifies those rights considerably. The Court construed even more narrowly Romeo's right to training or "habilitation." Since Romeo was so profoundly retarded that no amount of training would enable him to leave the institution, the case did not raise the question whether a patient has a right to treatment to facilitate his release. Similarly, the case did not present the question whether a patient possesses a general right to habilitation *per se.* Instead, the case presented only the question whether a patient is entitled to training in order to avoid unconstitutional infringement of his rights to bodily safety and freedom from physical restraint. In that narrow context, the Court upheld a right to training. If, for example, training in self-care might reduce a patient's frustration and therefore seemingly reduce his aggressivity (and correlative need to be restrained), a right to training would probably be in order. In the Court's words (pp. 2462-2463), "It may well be unreasonable not to provide training when training could significantly reduce the need for restraints or the likelihood of violence."

Although the Supreme Court found patients to possess an interest in safety, an interest in freedom from bodily restraint, and, to a lesser extent, an interest in habilitation, the Court recognized that these interests are far from absolute and that in fact the interests in bodily safety and bodily freedom are to some extent even in conflict (p. 2460). Cognizant of management concerns, the Court commented (p. 2460):

> In operating an institution such as Pennhurst, there are occasions in which it is necessary for the State to restrain the movement of residents—for example, to protect them as well as others from violence. Similar restraints may also be appropriate in a training program. And an institution can not protect its residents from all danger of violence if it is to permit them to have any freedom of movement.

Accordingly, the Court noted that "the question . . . is not simply whether a liberty interest has been infringed but whether the extent or nature of the restraint or lack of absolute safety is such as to violate due process" (p. 2460). In answering the question whether a state has unconstitutionally infringed a patient's rights, the Court employed a standard particularly deferential to clinical judgment. Eager to avoid burdening unduly the administration of institutions and to avoid restricting unnecessarily the exercise of professional judgment regarding patient needs, the Court adopted a constitutional standard that requires only that "the courts make certain that professional judgment in fact was exercised" (p. 2461). Thus,

since "administrators, and particularly professional personnel, should not be required to make each decision in the shadow of an action for damages" (p. 2463), *Romeo* makes plain that if a lawsuit alleging constitutional deprivation is filed following the seclusion or restraint of a patient, "the decision, if made by a professional, is presumtively valid" and "liability may be imposed only when the decision by the professional is such a substantial departure from accepted professional judgment, practice or standard as to demonstrate that the person responsible actually did not base the decision on such a judgment" (p. 2462).

Perhaps the most important point about *Youngberg v. Romeo* is not the precise rule of law announced by the case but rather its general and clear-cut attitude about the propriety of deferring to professional judgments and clinical considerations. The ensuing discussion will focus on some of the more commonly discussed uses of seclusion and restraint. The discussion will seek to analyze the extent to which those uses would be sanctioned by *Romeo* or by related rules of law.

Emergencies—Surely, where a patient, whether voluntary or involuntary, is regarded as posing an immediate threat of violence to self or others, *Romeo* teaches that legal and ethical concerns will give substantial flexibility to clinicians. Clinicians then possess substantial flexibility in "emergency" situations. Perhaps the most clear-cut definition of an emergency is a substantial danger of imminent and serious violence to oneself or to others. Presumably, however, emergency restrictive action would also be justified to prevent some serious situations not involving personal violence. One example might be to terminate uncontrollable excitement likely to lead to exhaustion. Moreover, *Romeo's* flavor, and its concern for institutional administration, suggests that emergency seclusion or restraint may well be warranted to prevent behavior that would be seriously destructive to the physical environment or seriously disruptive to the therapeutic environment.

Ideally, to ensure that emergency action is being taken only in true emergencies, the factors suggesting the need for emergency action should be clearly documented. The easiest case to document is where emergency action follows a subject's actual violent conduct or a serious threat or attempt to engage in violent behavior. A somewhat more difficult case is presented where a clinician concludes on the basis of clinical judgment that emergency intervention is required. Even before *Romeo*, however, legal cases defining emergency action did not seem to require a specific violent act, threat, or attempt on the part of the subject. One case, for example, referred only to sudden, significant changes in the patient's condition that gave rise to the danger of violent conduct. *Romeo* will presumably underscore the propriety of using clinical judgment in such instances, particularly where experience with a given patient suggests that engaging in certain specified behaviors is, for that particular patient, a precursor to violence or to other serious uncontrollable behavior. Documentation and after-the-fact review will, however, be easier in cases where overt violent action on the subject's part has occurred and is recorded.

Behavior Therapy and Techniques Resembling Seclusion and Restraint

The use of seclusion and restraint in *non-emergency* situations is, even after *Romeo*, considerably more complex and unsettled than it is in situations of emergency. In large part, that is because a prime non-emergency use of methods closely resembling seclusion and restraint is for purposes of behavior therapy. Accordingly, such use of seclusion and restraint-like methods is actually part of the larger question of a committed patient's possible right to refuse various sorts of intrusive or restrictive non-emergency treatment (a voluntary patient would presumably have a choice of accepting treatment or of leaving the hospital). The law regarding the right to refuse treatment is itself very far from settled. In the context of psychotropic medication, the right to refuse treatment question was recently presented to the Supreme Court in *Mills v. Rogers* (16) in 1982, but the Court decided the case on other grounds, thus leaving the major substantive question unaddressed.

The essential legal features relating to behavior therapy and seclusion and restraint-like techniques such as locked time-out and contingent restraint may be summarized as follows:

1. If a restrictive behavioral technique such as locked time-out or contingent restraint is used as part of a behavioral program and is invoked only when one is engaging in or believed likely to engage in seriously dangerous, disruptive, or destructive behavior, the program, though explicitly therapeutic in design, will likely be sustained under *Romeo's* principles of emergency management.

2. If a restrictive behavioral technique such as locked time-out or contingent restraint is used in a program designed to reduce target behaviors that are *not* seriously dangerous, disruptive, or destructive (e.g., sloppy eating or self-care behaviors), the restrictive action will not be easily sustained by the emergency management rationale. Such a case will raise the question of the right of a patient, particularly a competent patient, to refuse *non-emergency* restrictive treatment modalities. That question has not yet been squarely addressed by the Supreme Court and remains legally risky. Such use of locked time-out and contingent restraint is not, however, generally regarded by professionals as clinically indicated.

3. If a seclusion or restraint-like measure is employed following a target

behavior that is seriously dangerous, destructive, or disruptive, but is employed only after the incident is already over (rather than where the incident is ongoing or predicted), the emergency action rationale should again be unavailable. Such use of seclusion or restraint would, therefore, raise the question posed above and might also raise the question whether the use is actually a punitive one—a use which, for reasons discussed in the brief subsection below, is not generally advocated.

Punishment, Discipline, and Criminal Law Analogies

It may not be *per se* impermissible to punish mental patients, so long as they are punished for rule-breaking behavior and not for their status of being mentally ill. If they are punished, however, due process protections will probably need to be imported from the correctional arena to the mental health setting. Thus, there will be a need for some sort of due process fact finding mechanism or hearing, some necessity for rather clearly promulgated rules of behavioral proscriptions, of appropriate penalties and so forth.

Yet, constructing such a system may run into real difficulty. If disciplinary hearings are analogized to a criminal trial, there is the question whether a mentally disturbed patient would be "competent to stand trial" and the further question whether the patient's mental illness should make him "nonresponsible" for the behavioral infraction. The mere fact of mental illness does not, of course, establish incompetence to stand trial or nonresponsibility for offenses. Yet, it will often be difficult to establish that a patient is not being punished for his status of being a patient. In any event, the law and the public may look askance at attempts to punish those who are in a mental health setting for treatment.

To summarize from the preceding analysis, a few points deserve to be isolated and reiterated. First, *Romeo* suggests that clinicians will possess a great deal of legal leeway in administering seclusion and restraints in emergency situations. Second, the punitive use of seclusion and restraints, while conceptually possible, bristles with clinical, legal, ethical, and policy difficulties and should not ordinarily be resorted to. Third, the propriety and practicality of using seclusion and restraint-type procedures explicitly for treatment purposes is, at the moment, quite unclear, particularly with regard to competent patients. Nonetheless, if an approved behavior therapy program seeks to use methods such as locked time-out and contingent restraint only with regard to patients engaging in or about to engage in behavior that is seriously dangerous, destructive, or disruptive, the program would presumably be sufficiently akin to an emergency management technique to be sustained as such under the reasoning of *Romeo*.

II - Indications and Contraindications

The clinician experienced with inpatient work can readily recognize that seclusion and restraint fit into the definition of patient management in that they have indications and contraindications. The clinician managing a ward practices conservatively by secluding early, that is, by maintaining a low threshold for seclusion if there is any doubt about its indication. Therefore, in applying these guidelines, the Task Force recommends exercise of reasonable clinical judgment rather than use of rigid regulations, statutes or checklists. We believe that the judgment of experienced professionals on the scene is the factor most consistent with sound care of the patient.

Indications for Seclusion and Restraint:

1. To prevent imminent harm to the patient or other persons when other means of control are not effective or appropriate;
2. To prevent serious disruption of the treatment program or significant damage to the physical environment;
3. For treatment as part of an ongoing plan of behavior therapy (discussed separately in Chapter IV);
4. To decrease the stimulation a patient receives;
5. Use at the request of a patient.

Clinical Issues

The patient can be a danger to him or herself in two ways: first, in terms of deliberate suicidal acts or self-mutilation; or second, by a degree of excitement or behavioral dyscontrol which, if it continues, will result in exhaustion or injury. The patient can be a danger to others by deliberately trying to harm them through assault, using a weapon or, in other ways, intentionally endangering them; or harming others unintentionally as a result of marked disorganization of behavior.

Likewise, significant damage to the physical environment or the damage the environment are often the result of psychotic thinking on a functional or organic basis, involving a number of familiar clinical entities. Most commonly this is manifested as paranoid delusional thoughts where the assault is seen by the patient as self defense against staff, other patients or

environmental forces, which are perceived as intending to harm the patient. In cases of grossly disorganized behavior there is often incoherent speech, flailing or hyperactivity, fecal smearing and incontinence, wordless screaming or other manifestations. In some settings willful and/or non-psychotic violence is valid grounds for administrative discharge rather than seclusion or restraint.

If the etiology for the disorganized violent behavior is not known, seclusion or restraint may be indicated to maintain the patient in a safe and secure setting so as to perform the requisite evaluation in a drug-free state if needed and to make possible observation over time and safe differentiation of toxic from functional states. In addition, a violent patient may be preferentially managed in seclusion and restraint because of medical illness or drug allergies which would preclude the use of certain medications to treat the condition underlying the violent behavior.

Under certain circumstances, seclusion of a patient may be indicated for both the patient's benefit and that of the environment. The delicate balance of competing interests (namely the patient, other patients, the milieu,) is often difficult to achieve. Patients who are seriously disruptive to the environment or who are seriously interfering with the rights of other patients generally do so because of the underlying disease process. Certain events, such as uncontrollable screaming or abuse, public masturbation, denudative behavior, uncontrolled intrusiveness on others or fecal smearing, may indeed constitute indications for seclusion or restraint that derive from need for a therapeutic environment, but clearly these symptoms also convey the patient's own need for external controls.

Many staff use seclusion or restraint procedures in anticipation of imminent dangerous behavior by the patient. With appropriate documentation, staff may rely on the patient's known history of violent episodes and their known predecessors, such as escalating, excited motor behavior, increase in muscle tone or generalized tension, pacing, loud or profane speech and the like.

In using seclusion or restraint, the staff should have considered or tried other means of control, particularly verbal and environmental interventions. Prosocial behavior occurs in the context of a humane, stimulating, and normalizing therapeutic environment. The first step in a therapeutic environment is to ensure that patients have continuing opportunities to participate in their environment, to become engaged in activities, and to talk or interact with staff and other patients. Staff should be trained, encouraged, and supervised to optimize their social engagement with patients. This must take into account, on one hand the well-known relationship between overstimulation and symptomatic exacerbation in psychotic disorders and on the other hand understimulation and the social

breakdown syndrome with social withdrawal, poverty of speech, passivity and slovenliness. Thus it is necessary to design environment and individual treatment programs that fit the tolerance and need for social stimulation of patients with various disorders.

Recreational materials and structured activities should be readily available on all inpatient and day hospital units. Some patients need assistance and prompting to productively engage in the use of recreational and rehabilitative activities. Thus, a continuum of active outreach by staff is necessary to ensure that patients are engaged in an appropriate level of activity, given their deficits, assets, and symptomatic handicaps. A therapeutic environment then, would not only prevent the loss of skills through patients' institutional nonuse, but would also structure and reinforce the practice of social, recreational and role skills that a patient needs for adapting to the hospital and to the community.

In terms of other alternatives, the use of medication as opposed to seclusion or restraint cannot meaningfully be seen in the context of which is less restrictive (17); the decision as to whether one uses medication, seclusion, restraint or other modalities to control dangerous behavior must be made in terms of the individual patient. For example, the use of neuroleptic medication to control dangerous behavior in the mentally retarded may not be as desirable as using restraint or seclusion first. Yet use of medications first may well suit treatment of an unmedicated paranoid schizophrenic patient who is acting on his paranoid delusions. This point is discussed further in Chapter V-C on the developmentally disabled.

Seclusion may be used for decreasing stimulation, usually for psychotic patients; the quiet atmosphere of the seclusion room may be a relief from sensory overload found in some clinical states (18). This may be an experience, as one patient described it, similar to that of being in "a combined rock concert and light show while having your skin sandpapered at the same time." Secluding a patient for this indication must not be done casually, but rather be used in severe cases or to prevent escalation to violent behavior.

Secluding or restraining a patient on the patient's own request represents a valid indication governed by certain caveats. The patient's wish to be in seclusion may be a responsible attempt to avert an incipient or escalating state which might result in dangerous behavior, or to prevent sensory overload. However, especially with patients with borderline personality, voluntary self-seclusion may serve regressive pathologic, rather than therapeutics ends. Other maladaptive requests for seclusion include those of the adolescent attempting to test the limits of staff tolerance or to foster a "macho" self image. Thus, the clinical differentiation of the meaning of a request for seclusion may require that some patients' requests for seclusion

be refused and that alternative interventions or hospital locales be offered.

Finally, the use of seclusion and restraint as part of a regular behavior treatment program is described later in this Task Force report. Use in this regard differs from the other indications in that it is planned beforehand and monitored so as to lead to a long term change in the patient's pattern of responding rather than as only a method of addressing immediate concerns.

Clinical Contraindications

Seclusion or restraint may be contraindicated when precluded by the patient's clinical condition. The patient's unstable medical status, resulting from infection, cardiac illness, disorders of thermoregulation or metabolic illness, and some orthopedic conditions,may make restraint preferable. In some neurologic conditions, including encephalitis, deliria and dementia, the patient's vulnerability to sensory deprivation as a pathogenic force may lead to worsening of the total clinical state contraindicating seclusion (19).

Other situations representing relative contraindications to seclusion include: patients experiencing a paradoxical excitement reaction to phenothiazine medication; patients who have just taken overdoses and require close monitoring; patients presenting with the symptoms of serious and uncontrollable self-abuse and self-mutilation; and the environmental problem of seclusion rooms that cannot be sufficiently cooled on hot days for patients on drugs, for example, phenothiazines, which impair thermoregulation.

With physical restraint, a possible adverse effect is circulatory obstruction, which can be minimized by temporarily releasing one of four point restraints every 15 minutes. If a patient is lying on his back while restrained, one must guard against aspiration by constant monitoring.

Seclusion of a patient as a purely punitive response is contraindicated. Similarly, absent a patient's specific clinical needs, a patient should never be secluded: 1. for the pure comfort or convenience of the staff, though, as noted above, it is common for patient and staff distress to coexist; 2. for mere mild obnoxiousness, rudeness or other unpleasantness by the patient to others; 3. for staff anxiety alone, though the distinction of this state from contagion of the patient's own anxiety is not always easy to make on the clinical scene, or 4. solely because of factors in ward dynamics. The Task Force does not condone excessive or poorly implemented seclusion or restraint resulting from inadequate staffing or other resources.

III - Emergency Use of Seclusion and Restraint

Initiation of a restraint procedure or placement of a patient in seclusion is usually an emergency procedure carried out by nursing and other professional staff in accord with established hospital policy for seclusion and restraint. Nevertheless, such "hands-on" procedures (other than for purposes described in Chapter IV) require a physician's review and order for continuation. The physician should be notified as soon as possible, and preferably within the hour. For the first episode of seclusion and restraint, the physician should see the patient, *usually within three hours and preferably within one hour* after an initiation of the seclusion or restraint episode. The Task Force emphasizes that the timely examination of the patient to assess indications and possible contraindications of seclusion or restraint is essential and part of good medical practice. When notified by telephone, the physician should indicate his approval pending personal examination of the patient. During the visit the physician will document this in the patient's record. This episode will be reviewed by the patient's physician and treatment team. For each subsequent seclusion or restraint episode for that patient, a physician will be notified *within the hour.* However, the physician will exercise professional judgment as to whether a visit is needed and will indicate any special precautions which must be taken or monitoring which must be done by the nursing or other professional staff.

Physician Monitoring

The physician should see a secluded or restrained patient as frequently as necessary to monitor any changes in the patient's physical or mental status. Frequency of these visits may vary, however *a minimum of two visits a day, approximately 12 hours apart* seems reasonable. Obviously, some patients will require more frequent visits, for example, patients with concurrent medical problems, patients receiving medical treatment which may complicate seclusion or restraint, cases of organic brain syndrome, such as those related to drugs or alcohol and situations where hyperthermia may occur. When the physician sees the patient, the order for seclusion or restraint should be reviewed and the need for continued seclusion or restraint should be documented in the patient's record.

Time Parameters

A physician's order is generally valid for 12 hours. The physician should examine the patient and document in the patient's record the justification for continued seclusion or restraint taking into account the mental and physical status and degree of agitation, adverse effects of seclusion (physical and emotional), and other factors such as staff and their ability to handle the patient. The Task Force recognizes that in some busy institutions which handle large numbers of violent patients, more than one individual will be in seclusion or restraint. This severely tests the staff's capacity to handle other unsecluded agitated patients because of the need for observations and toileting of those who are secluded or restrained. Thus hard and fast rules cannot be easily established; if the physician can document that nursing staff are unable to handle the patient at that point and time, this provides some limited justification for continued restraint or seclusion. The actual condition of the ward and its composition must be considered before a patient is safely released from seclusion or restraint. Although this decision must be made with the patient's condition primarily in mind, it is good clinical practice to consider available resources and the ward situation.

If seclusion or restraint is used in excess of 72 consecutive hours for a patient, the director of the hospital or designee must review and approve continued use.

General Comments About Restraint and Seclusion Maneuvers

The Task Force makes the following recommendations concerning the maneuvers for restraint and seclusion, based upon the realization that uniform techniques are lacking nationwide.

First, the technique of restraint practice within a particular facility should be rehearsed and approved by the hospital staff, including the chief of service of the institution. If the particular technique and modality such as four point leather restraints or wet packs is viewed as normal practice, that should be specifically noted in the policy manual of the hospital and be disseminated to all members of the clinical staff as part of the service training. Written instruction, photographs, and videotapes are desirable. The Task Force calls attention to the model program developed by Lion and his colleagues to teach restraint techniques.

Certification of mental health personnel in restraint and seclusion techniques is currently being carried out by the Department of Health and Mental Hygiene of Maryland under the Violence Evaluation and Management Training Grant. Practice sessions in the safe and effective use of

restraint garments as well as certain "take-down" procedures are given on a regular basis to key state mental health employees who in turn teach the skills to their fellow hospital workers. For further information concerning this program, contact John R. Lion, M.D. or Denis J. Madden, Ph.D., Department of Psychiatry, University of Maryland Hospital, Baltimore, MD 21201 (301) 528-6475 or 358-4204. A variety of restraint devices exists on the market and the Maryland group has also compiled a "formulary" of appliances such as Velero and leather limb restraints, body vests, and full body jackets.

Second, the Task Force recommends that legal representatives for the institution be consulted regarding the use of the particular restraint methods and their acceptability within the prevailing regulations and laws of the hospital and state.

Third, the Task Force recommends that specific instructors on restraint and seclusion be designated within a hospital facility to teach these skills to both new clinical staff and as part of in-service training.

Specific Techniques of Seclusion and Restraint

The implementation of seclusion and restraint procedures place staff and patients at high risk for injury. Lion has reported that half of all assaults upon staff occur during the process of secluding or restraining disruptive patients, or in the management of the seclusion. (20) The proper execution of a predetermined and well rehearsed set of actions can minimize this risk. Several important principles of seclusion and restraint techniques apply to most clinical settings and warrant specific review:

1. Once the decision has been made to proceed with seclusion or restraint of an agitated or disruptive patient, a seclusion or restraint "leader" is chosen among available clinical staff.

2. Sufficient personnel, at least one person per limb and the leader, must be gathered to present the patient with a "show of force;" that is, sufficient manpower to assure that the orders of the staff will be followed and can be enforced by physical means should the patient refuse to comply. While psychologically intimidating, the show of force need not be displayed in a humiliating or threatening manner. Rather than appear "combat ready," the supporting staff should convey an air of confidence and calm, a measured control, reflecting a detached and professional approach to a routine and familiar procedure.

3. A seclusion monitor is designated to clear the area of other patients and physical obstructions to entering the seclusion room. In addition, the monitor stands clear of the physical action, noting any and all injuries or

difficulties with physical technique, allowing for an accurate critique of the seclusion procedure after the event.

4. This confrontation with the patient begins with a clear statement of purpose and rationale for the seclusion or restraint. The patient is given few and clear behavioral options without undue verbal threat or provocation. For example, the patient is told that his or her behavior is out of control and that a period of seclusion is required to assist the patient to regain control. The patient is then asked to walk quietly to the seclusion room accompanied by staff. Since the decision for seclusion has already been made, negotiation or psychodynamic interpretation at this juncture is superfluous and leads only to an escalation of disruptive behavior, potentially aggravating the violence of the event.

5. At this point the team has positioned itself around the patient in such a manner as to allow rapid access to the patient's extremities. At a predetermined signal from the leader, physical force commences, with each staff member seizing and controlling the movement of one extremity. Using non-injurious physical technique, the patient is brought to the ground through backward movement and each limb restrained at the joint by a member of the team. The patient's head must be controlled to prevent biting. This may be accomplished by crossing the arms over the head, creating a vise. An additional advantage of this maneuver is that a single attendant may control both arms and head simultaneously while the patient is recumbent.

6. With the patient completely restrained on the ground, additional staff may be called to secure the limbs and to prepare to move the patient to the seclusion room or to apply the mechanical restraints desired. In the most violent of cases, this may require additional staff to physically lift the patient in the recumbent position with arms pinned to sides, legs held tightly at the knees, head controlled, with lift applied uniformly to the back, the hips and legs. More compliant patients may be walked to seclusion with adequate control over both arms.

7. Once the patient is in seclusion, he/she is positioned on his/her back with the head toward the seclusion door and feet in the opposite direction. Street clothes are removed, with special attention paid to rings, belts, shoes and other potentially destructive objects. Medication may be injected at this time while the patient is physically restrained. For the most violent patients, the cross arm-vise maneuver is again established, allowing one attendant to control head and both arms in preparation for leaving the seclusion room. The staff exit in a coordinated fashion, one at a time, releasing legs first, arms last, the final staff member moving backward out of the seclusion room door, which is quickly secured.

8. A debriefing follows each seclusion or restraint maneuver. The seclu-

sion monitor reviews the technique and progress of the event, allowing an emotional release of tension for the staff members. The event should be discussed openly among the patient population to allay or uncover fears associated with the eruption of violence and staff use of force.

Observation

During the period of time the patient is in seclusion or restraint observations regarding behavior should be made every 15 minutes by members of the nursing staff. In the past, such observations have been traditionally referred to as "checks" which are often made by simply looking through the observation glass window of the seclusion room. For severely agitated or violent patients, such "checks" may be the only feasible method of observation short of opening the seclusion room door and placing the nursing staff at risk for injury.

Visual checks usually include description of the patient's behavior for example "pacing, yelling" and merely ascertaining that the patient is not injuring himself/herself by such maneuvers as banging his/her head on the wall, or attempting to destroy a wall in the seclusion room. The Task Force recommends that once a patient is quiescent, direct observation with the seclusion room door open be made so that the state of the patient and a description of verbal interchange can be documented on the patient's chart. A direct visitation should occur no less than every two hours for previously agitated patients or those who have received psychotropic medication in addition to being placed in seclusion. Observations serve to ascertain the safety of the patient and to make sure that he/she is not at physical risk for injury through excessive agitation and exhaustion or through self-mutilation or self-destructive activities. The second reason for observation relates to the assessment for the removal from seclusion which will be discussed below.

Care of the Patient

Toileting of the patient should be allowed *at least every four hours*. The design of some seclusion room facilities is such that the physical exiting of the patient may be necessary in order to accomplish this or, the patient may have to be removed from restraint devices. In situations where this cannot be carried out for reasons of danger, toileting can be done through the use of a bed pan. Privacy is problematic here.

Meals should be brought to the patient at regular intervals when the

remainder of the ward is served. All articles should be blunt; plastic knives and forks can be used as weapons. Meal time can be dangerous for belligerent patients who can use food as a weapon. In certain rare instances with severely regressed patients, the food tray may be placed within the room and the patient may be allowed access to it without staff persons being present. However, the rationale for this solitary meal should be strictly documented in nursing notes; whenever possible, feeding should be a time of interaction between patient and staff.

The proper administration of fluids is particularly important for patients in restraint or seclusion who may perspire profusely and be prone to dehydration. Documentation of fluid intake, though often difficult with regressed patients, is still requisite.

Safety of the Patient and Staff

A full awareness should exist regarding the hazards of the seclusion room. Theoretically, the seclusion room is an empty cubical with a high ceiling and recessed lamp fixtures. All walls and ceilings should be made of material that cannot be gouged out by a patient's intent upon harming himself/herself. For example, plaster board walls are not acceptable. Protuberances such as oxygen jets are dangerous. Windows must be constructed of safety plexiglass or otherwise shielded from breakage. The mattress itself, the only "furnishing" of such a room should be constructed of durable foam and not fiber or other substance which the patient could conceivably use to hang or suffocate with. The mattress should not be flammable. Patients should always be searched before being placed alone in seclusion.

Patients in seclusion may exhaust themselves from physical activity. A hyperpyretic response, resulting from the cumulative effect of exertion and medication is a risk. Somatic exhaustion is also a potential hazard. Other hazards include fractures and self-mutilation. These are discussed further in another section.

There exist some severely regressed patients who are menstruating or prone to fecal soiling. While not dangerous, such behaviors are often sufficiently repugnant to others to cause avoidance. Hence, the patient is ignored and approached with trepidation. Negligence is thus a potential hazard in the seclusion of such patients.

There exists the possibility of a worsening of a psychosis due to decreased sensory stimulation inherent in seclusion room use. The patient may become more delusional as a function of being alone and isolated. It has

been suggested that the emotional impact of seclusion is severe and some debriefing" is necessary following removal from seclusion to mitigate against painful memories.

Removal from Seclusion and Restraint

Patients may be released from seclusion when the goals of the treatment have been achieved; that is, the patient's behavior is under control and no longer poses a threat to self or others or a further disruption to the therapeutic milieu. How may this best be determined? The ability of a patient to control his/her behavior is observed many times during the course of seclusion. At each entry into the seclusion room for the purpose of feeding, bathing or examining the patient, responsiveness to verbal direction may be judged. The first entries into the seclusion room should be preceded by specific behavioral requests. For example, the patient may be asked to sit on the floor against the wall farthest from the door to minimize any potential act of aggression. In the case of extremely threatening or violent patients, seclusion is always entered with a repeat show of force. If the patient remains a danger despite aggressive and rapid neuroleptization, consideration must be given to the concomitant use of mechanical restraints or sedating medication to minimize injury in caring for the patient. However the Task Force cautions against impatience which may needlessly result in polypharmacy and side effects. Cooperation with physical examinations, psychiatric interviews, medical procedures, bathing and toileting, together with nursing observations and assessments of the patient's behavior will develop a data base for making the decision to wean the patient from seclusion. Likewise, the patient in restraints should be gradually released in the case of four point restraints.

Medication

The conjoint use of medication with restraint or seclusion depends upon the nature of the condition, degree of agitation and the qualitative nature of the aggressiveness. If the patient is flagrantly psychotic or in an extremely agitated manic state, medication may be indicated. Medication, if rationally used, may shorten the length of stay in seclusion by helping the patient to gain mastery and control over aggressive urges. One hazard, however, of medication of assaultive patients involves the "snow phenomenon" whereby the patient is rendered so lethargic and helpless by drugs that he becomes disorganized and combative as a function of organic impairment.

(21) Clinicians need to tread a line between under and over medication and document specific target symptoms that respond to psychotropic agents. The indiscriminate use of parenteral PRN medication should be replaced by a rationale fixed dose plan which allows the physician to evaluate the patient at regular intervals with regimens. With PRN dosages, the patients can receive widely varying dosages as a function of nursing shifts. This makes assessment problematic. Some patients in seclusion can be offered medication orally; this may be preferable to the repetitive and demeaning injection of medication to a patient who is in restraint or in seclusion.

Clinicians involved in the care of violent patients should be familiar with rapid neuroleptization techniques primarily described for haloperidol. (22) This technique utilizes the repetitive administration of small amounts of medication until some degree of control is achieved by the patient over violent impulses. The use of parenteral medication is rarely curative of an underlying psychosis but is used basically to induce symptomatic improvements. Further and more vigorous treatment must ensue before the core symptoms such as delusions and hallucinations abate.

Other Uses of Restraint and Seclusion

It is possible to use various restraint devices in a creative fashion which allows the patient to mingle with others on a ward or within the room. The use of garments which restrain extremities or bind patients to a wheelchair may allow that individual to participate in group meetings and receive milieu enrichment which he/she might otherwise not obtain if placed in the isolation of a seclusion room.

IV - Behavior Analysis and Therapy and Restrictive Procedures

Clinicians skilled in behavior analysis and therapy employ procedures similar to seclusion and restraint for therapeutic purposes within a highly developed theoretical framework and applied technology. Behavior therapists have given thorough consideration to the legal and ethical issues associated with these interventions. Standardized policies and review processes have been developed to prevent their abuse. On both theoretical and empirical grounds behavioral analogues to seclusion and restraint should be considered as distinct from their traditional counterparts.

Traditional vs Behavioral Applications of Restrictive Procedures

Traditional and behavioral applications of restrictive interventions converge with respect to the behaviors that they deal with, but diverge on the goals and implementation of treatments. Both approaches use seclusionary and restraint-like techniques to control highly aggressive, destructive, self-injurious, and disruptive actions by patients. In a traditional framework, however, these procedures are emergency reactions with only an immediate objective—to manage the present outburst and prevent injury or property destruction. Behavioral applications, in contrast, are planned treatment programs whose details are formulated beforehand and whose objective is long term change in the patient's pattern of responding. Because behavioral applications are treatment-oriented, parameters of restrictive procedures are adjusted to maximize their impact and programs incorporating these procedures are monitored to evaluate their therapeutic efficacy.

Target behaviors must be objectively specified so that consequences can be administered consistently and so that treatment progress can be monitored. Assault could be defined as pushing, shoving, pinching, hitting, scratching, pulling hair, kicking, biting, spitting on, tripping, grabbing, throwing an object at someone, touching another's genital area in public, or hanging on to someone without their consent. By writing clear response

definitions, professional and nursing staff can reach a consensus as to which behaviors they will and will not attend to.

Procedures for Reducing Maladaptive Behavior Through Prompting and Reinforcement of Appropriate Behavior

Behavioral procedures akin to seclusion and restraint are never applied alone but rather are always joined with positive programs to initiate and maintain appropriate responses. Interventions to decrease problem behaviors should be coupled with one, and preferably more than one, of these positive techniques.

Token Economies

Token economies are comprehensive treatment programs that harness most of the available reinforcement in the patient's environment and, through structured contingencies, use it to strengthen desired responses (23-25). Tokens and their back-up rewards are utilized as incentives for improved self-care, prevocational, academic, and interpersonal behavior. Truly effective token economies require a milieu that is enriched beyond what is customarily available in custodial setting.

Reinforcement of the Absence of Inappropriate Behavior (DRO, DRI, and DRL Schedules)

Laboratory research has shown that when behaviors other than a target behavior are reinforced on an intensive schedule, the target behavior will lessen in frequency. Several variations of this procedure have been developed and can serve as the cornerstone of behavioral programs aimed at decelerating aggressive or destructive responses.

1. Differential Reinforcement of Other Behavior (DRO). In a DRO schedule, rewards are delivered to a patient after a specific period of time in which the maladaptive behavior has not occurred (26-28). In general, DRO schedules enable a patient to be rewarded for engaging in almost any behavior other than aggression, and hence capitalize on the unique and full repertoire of the individual.
2. Differential Reinforcement of Incompatible Behavior (DRI). The DRI is a type of DRO schedule where reinforcement is administered for performance of a specific behavior that is topographically incompatible with the maladaptive target behavior.
3. Differential Reinforcement of Low Rates of Responding (DRL). In a DRL, the patient is reinforced only if a specific period of time has elapsed since the last episode of the undesired behavior.

Social Skills Training

Aggressive and destructive behavior can sometimes be an indicator of deficits in interpersonal skill. Patients may become violent and disruptive to satisfy their needs, if they are unable to use solicitation, persuasion, and negotiation. Behavior therapists have used social skills training to promote interactive behavior that is both instrumentally effective and contextually appropriate.

The Teaching Interaction

Many minor disruptive and pre-aggressive behaviors can be managed effectively through a structured social skills training sequence, termed *the teaching interaction*, which consists of 10 components; 1. expression of affection (a smile, special greeting, physical contact, joke); 2. praise for what has been accomplished or for some positive progress or adaptive behavior of the patient; 3. description of the inappropriate behavior; 4. description of the appropriate behavior; 5. rationale for the appropriate behavior; 6. description of the present consequences; 7. request for acknowledgment; 8. practice; 9. feedback during practice; praise and correction; 10. reward with praise and tangible reinforcers or points.

Activity Programming

Operating along the same principle as the DRO schedule, activity programming encourages the performance of desired behaviors thereby replacing aggressive and destructive behavior.

Reducing Dangerous Behavior Through Behavioral Procedures Likened to Seclusion and Restraint

Indications for the Use of Restrictive Behavioral Procedures

A number of issues should be considered when planning a behavioral intervention for an aggressive, self-injurious, destructive, or disruptive patient.

1. Can a positive intervention be used rather than a restrictive one to effectively deal with the problem behavior(s)?
2. What is the relative effectiveness and restrictiveness of the available treatment procedures?

When behavior therapists apply seclusionary and restraint-like procedures, they attempt to balance the restrictiveness of the intervention against the seriousness of the problem behavior. This is done both to encourage the use of less restrictive treatments and to reserve strong consequences for

truly harmful and destructive responses. Therefore, more restrictive techniques such as seclusionary time out, overcorrection, and contingent restraint are only recommended for severe aggressive, self-injurious, and destructive behaviors.

3. What are the undesirable short-term side effects that might be associated with a particular procedure?

4. How feasible and efficient is the procedure in terms of its duration, frequency of administration, and staffing requirements?

5. Will the procedure benefit the patient's social, medical, and psychiatric status or operate primarily for the convenience of staff?

6. Has a behavior analysis been performed to ascertain the relationships between target behaviors and environmental antecedents and consequences?

Continuum of Behavioral Procedures Likened to Seclusion and Restraint

1. *Social Extinction*

Social extinction refers to the withdrawal of attention from a patient, immediately contingent upon the patient's exhibiting some undesirable behavior. Extinction is most commonly employed with mild aggressive or disruptive behavior not resulting in physical injury such as threatening gestures or loud vocalizations. Social extinction is invariably combined with programs to selectively attend to prosocial and acceptable behaviors.

The key challenge in implementing an effective extinction program is in getting all members of the interdisciplinary treatment team to be consistent in ignoring the maladaptive behavior.

2. *Sensory Extinction*

In cases where self-injurious behavior is self-stimulatory, (that is, where self-injury is a mechanism by which the patient produces kinesthetic, tactile, or vestibular stimulation that is reinforcing) removing sensory consequences of the response can reduce or eliminate self-injury. Sensory extinction procedures are particularly attractive as behavioral interventions because they do not interfere with the patient's participation in milieu activities, or self-care and they enable staff to concurrently provide positive reinforcement for adaptive behaviors.

3. *Contingent Observation*

In contingent observation, a patient who has done something inappropriate is instructed to step away from the ongoing activity, sit nearby for a few minutes, and watch the appropriate behavior of other patients. (29) It is indicated for minor disruptive acts such as verbal aggression or behavior conflicting with approved tasks and it is most likely to be therapeutic if participation in the ongoing activity is positively reinforcing.

4. *Required Relaxation*

In required relaxation, mandatory performance of a response incompatible with the undesired behavior is combined with time-out from reinforcement. (30) At the first sign of inappropriate behavior, the patient is told to lie down and relax in bed for two hours. If the patient is still agitated during the last 15 minutes of the two hours, the relaxation period is extended until he/she is calm for 15 consecutive minutes. This procedure has been effective in controlling disruptive, aggressive, and self-injurious behavior in retarded patients and hospital attendants rate the procedure high on social acceptability and humaneness. A limitation of required relaxation is that it is best suited for patients who voluntarily comply with staff instructions.

5. *Seclusionary Time-out (Time-out from Reinforcement)*

Seclusionary time-out involves placing the patient in a special area devoid of reinforcement contingent on the occurrence of maladaptive behavior. Several aspects of seclusionary time-out distinguish it from traditional seclusion. Unlike traditional seclusion, whose application is largely left up to individual staff discretion, seclusionary time-out is administered immediately following each display of the specified target behavior. Seclusionary time-out is also carried out with the minimum of emotional expression or verbal interaction, other than for briefly announcing why the consequence is being applied. In addition, time-out usually is a shorter duration than traditional seclusion—it can be as brief as five minutes and rarely lasts longer than one hour.

6. *Overcorrection*

Overcorrection is an educative procedure that combines a number of consequences for aggressive, destructive, and self-injurious responses (31). Immediately contingent upon any sign of violent behavior, the patient is provided with re-education (a brief statement explaining the intolerability of the patient's actions and the coming consequences), removal of reinforcement for the behavior (e.g., stolen articles are retrieved; arguments and fights with other patients are stopped), time-out from positive reinforcement (e.g., temporary removal from participating in the ward milieu), and an effort requirement.

The effort requirement is a distinguishing element of the overcorrection procedure. For a patient who has urinated in a public hallway, the effort or restitutional requirement might be to scrub the walls and floors not only of the hallway but of the entire ward. For a patient who has hit someone, the effort requirement might be apologizing not only to the object of the assault but to all other persons on the ward. The rationale for overcorrection is to re-educate offenders in prosocial responses by having them restore the situation that they disturbed to a state improved over the original condition.

7. *Contingent Restraint*

Contingent restraint involves the immobilizing of some part of a patient's body either by a device (e.g., soft ties, restraint chair, cuffs and belts, posey jacket) or by a therapist physically restraining that patient for a brief period of time following the occurrence of a specified violent act, for example, self-mutilation. (32,33) Contingent restraint is similar operationally to conventional restraining methods, however, it demands the immediate and consistent administration of restraint after each episode of the target behavior. Furthermore, while contingent restraint is being applied, the patient is in time-out from reinforcement: staff members give no attention to the patient other than what is necessary for medical and health reasons.

Implementation of Behavioral Procedures Likened to Seclusion and Restraint

Staff Competency and Training

Only professionals whose training best prepares them to supervise the administration of these procedures should be responsible for design, implementation and quality control. While psychologists at the Ph.D. and M.A. levels most often have university and internship training in behavior analysis and therapy, psychiatrists and other professionals who have formal training and practical experience in behavior therapy could design and apply these procedures.

Authorization

It is evident that behavioral procedures call for a different process of authorization than emergency medical procedures such as seclusion and restraint. Behavioral procedures must be applicable on an immediate, moment-to-moment basis depending on the patient's behavior, if they are to serve as effective consequences. As a member of the interdisciplinary team, the physician should be aware of the patient's therapy regimen and approve his/her plans in writing; however, M.D. approval should not be required every time a behavioral intervention is employed. This requirement would surely delay and impede treatment. In addition, the time period for which behavioral programs need to be instituted will usually exceed the period for which physician's orders for seclusion and restraint are valid. The reduction of aggressive and destructive behavior in chronic mental patients can occur very slowly over weeks or months (34), and the repeated renewal of physician's orders every 12-48 hours would be extremely cumbersome, if not unworkable. Both of these factors weigh against

sole reliance on medical authorization for each episode of restrictive behavioral treatments.

Instructions Accompanying Behavioral Procedures

Restrictive behavioral interventions involve staff giving verbal instructions to patients but these instructions can be countertherapeutic unless delivered correctly. When attempting to weaken unacceptable responses, it is important to minimize the social reinforcement associated with the training procedures. Staff members can lessen the likelihood that they are unintentionally dispensing reinforcing attention by employing a set of discreet verbal and nonverbal skills: 1. Remain calm with a neutral tone of voice and facial expression; 2. State the rule and the consequence for breaking the rule; 3. Ignore subsequent verbalizations; 4. Follow through quickly.

Duration of Behavioral Procedures

Duration is an objective dimension of behavioral interventions that can and should be prescribed and monitored. Clocks and timers are readily available and can be set to signal the end of the treatment interval. Staff should be aware that duration is a parameter of behavioral procedures which partially determines their therapeutic effect. Because of individual differences in responsiveness to these interventions, it may be necessary to vary their duration to obtain a potent treatment.

Care and Observation of the Patient

For safety's sake, a patient should be quickly but thoroughly searched before entry into a time-out room or placement in restraints. While in the time-out room or while restrained, the patient should be observed periodically (e.g., every 15 minutes) to see that he/she is causing no harm to himself/herself or the environment. Observations should be done as unobtrusively as possible (e.g., through a peephole in the time-out room door or a closed-circuit video system) to minimize the attention given.

Quality Assurance Safeguards in the Use of Behavioral Procedures

Quality control of the professional, efficacious and ethical use of behavioral procedures such as those for managing aggression, disruptiveness, and destructiveness, lies in three major areas:

1. Treatment procedures are described in detail in a manual written by behavioral experts on the interdisciplinary treatment team. The procedures are reviewed and approved by an institutional board or committee (e.g., Human Rights Committee), and are periodically reviewed by professional peers, and extramural advisers.

2. Systems for measuring and monitoring patients' progress, or the lack of it, are part of the daily clinical operations of the hospital unit. The systems generate data needed by the interdisciplinary team for making clinical decisions.

3. Competency-based staff training and quality assurance through certification and periodic re-evaluation of staff ability are built into the professional standards of the facility.

To summarize, behavioral analysis and therapy procedures that are akin to traditional methods of seclusion and restraint include "time out from reinforcement," "overcorrection and positive practice," "contingent observation," "contingent restraint," and "extinction." These behavioral procedures differ from the more traditional methods in that they are designed and implemented pro-actively as part of the overall treatment plan for a patient. They are not used as emergency procedures requiring the post-hoc and immediate review of a physician but, instead, are aimed at preventing or reducing the frequency of established patterns of assault and property destruction and are developed and supervised by practitioners skilled in behavior analysis and therapy.

Prior to the institution of behavioral methods for reducing dangerous behaviors, programs should be implemented that enhance the adaptive behavioral repertoires of patients. Often, increasing and strengthening prosocial behaviors replaces undesirable acting-out and minimizes or makes unnecessary restrictive behavioral interventions. Programs to increase prosocial behavior should always be concurrent with restrictive interventions. Quality assurance procedures are built-in to behavior therapy methods through routine measurement and monitoring of the behaviors of interest which provide ongoing informational feedback for clinical decisions by the treatment team. Other quality assurance provisions should include annual reviews by Human Rights Committees and external peer review bodies. Behavior analysis and therapy procedures have been documented as efficacious with assaultive and destructive patients; hence, their availability and proper utilization constitute patients' "right to treatment."

V - Seclusion and Restraint in Special Populations

A. Children and Adolescents

Objections to seclusion and controversy over its use are understandably intensified when the patients involved are children. Ironically, the incidence of seclusion among some populations of psychiatrically hospitalized children is even greater than it is for most groups of hospitalized adults. This should not be suprising in view of the fact that the intrinsic need for external controls that characterizes all of childhood, including adolescence, is additive to the effects of mental illness which lead to deficiencies in both judgment and self-control. The image of violent children, however, is not readily accepted by the general public nor even by psychiatric professionals who do not see them.

Psychiatric hospitalization itself is frequently indicated because of the same kinds of dangers from lack of adequate self-control that justify seclusion of patients while in the hospital. For some patients hospitalization alone with its external structure and protection is sufficient to allow the newly admitted patient, child or adult, to act with sufficient self-restraint to preclude the necessity for seclusion. For many others, this is not the case. Proper inpatient treatment calls for the bringing to bear whatever among all of the parameters of treatment are found to be indicated after careful assessment of each child, with subsequent changes made on the basis of continuous monitoring. However, without adequate limits of uncontrolled behavior when it may arise, any treatment program will break down.

Psychiatric hospitals admitting children can be classified by their capacities and willingness to manage certain difficulties: self-harm; violence to others; destructiveness to property; chaotic behavior such as smearing, denudativeness; and running away or wandering off. Some facilities will not accept children presenting some or any of these risks or will not keep them if the behavior becomes overt. Other facilities will neither exclude children because of these problems nor discharge them for such behavior. The characteristics of the facilities that accept and keep patients manifesting the behavioral extremes listed above are locked doors to the outside of

the hospital and seclusion rooms or other capacities to restrain the children as may be indicated. Child psychiatric expertise and staffing depth are *not* in themselves sufficient to make the difference.

When children are hospitalized, custody is not imposed. It is an instance of transfer of their immediate custody from their parents or surrogates to the hospital staff. Children below the relevant age of consent are not forced into the position of being in the custody of others when they become hospitalized nor do they surrender any legal autonomy. This is an important distinction between the psychiatric hospitalization of children and that of adults. Although the specific contractual transfer of custody is to the director of the hospital, the functioning parental surrogates in the hospital are the ward nursing staff who are with the children around the clock. School personnel, for those hospitals that have associated schools, are similarly endowed with significant immediate surrogate function for the hours the children are with them. Seclusion, as is any intended activity impinging on a patient in a mental hospital, is imposed under the ultimate authority of the director of the hospital. However, it is most often initiated by the nursing staff immediately present.

The use of seclusion on psychiatric wards for children is a natural extension of the caretaking practices that protect the children on the wards and in the activities of the hospital. It is an ultimate in the limit-setting procedures which are interwoven with the child-rearing aspects of hospital care. Self-injurious, violent, destructive or chaotic behavior must be interrupted if overt or as soon as it is clearly threatened. If it cannot be stopped by any other means available at that time, then it becomes an indication for seclusion or restraint.

Although the use of seclusion is an ultimate form of limit-setting intervention, it is analogous to parents sending a misbehaving child at home to his or her room, but it is clearly not identical. Children who require hospitalization because of lack of self-control have not responded to such traditional limits at home. In addition, children in the hospital may be sent to their rooms as an early attempt to interrupt deteriorating behavior. However if they are not in control of themselves, this may be dangerous because of the profusion of potentially dangerous objects in a child's regular room or dormitory. Placement in a seclusion room is then indicated.

Comparative data about seclusion incidence in different psychiatric hospitals for children are not presently available, although such studies are under way. However, the spectrum of hospitals already referred to clearly exists, and the statistics for seclusion and restraint from hospitals with seclusion rooms but with open wards will be different from those with locked wards. Accessibility to mandatory admission from the courts will also affect the population in a psychiatric ward for children.

Indications and procedures for use of seclusion are generally identical with those for adults, however much this may surprise the uninitiated. Even seven to ten year old children may require as many as five adults to safely manage them when they are violently out of control. Adolescents overlap with adults in number of staff required for physical control when necessary.

Although the physician, or other professional legally responsible for clinical administration of the ward, is characteristically not immediately involved in initiation or termination of seclusion, he or she is very much involved in other ways. After notification, preferably within one hour, continued use is on his or her authority. Prolonged stays require direct examination. The Ward Chief's role is vital in conducting regular review of the use of seclusion both in general and for each child involved, ensuring proper use and being on the alert for evidence of staff sadism or scapegoating of a child. Equally important is seeing to it that the total program for a child addresses the issues that arise explosively in the behavior that necessitates incidents of seclusion or restraint.

Legislation and regulations need to include more enabling language in addition to the primarily restrictive language in order to maintain proper availability of these procedures for children and adolescents that are vital when they are indicated.

B. The Elderly

The literature on the use of seclusion and/or restraint in the elderly is very sparse, in spite of the special clinical features associated with this psychiatric population. As with all patients, seclusion and/or restraint is described as a specific intervention along a therapeutic spectrum. This includes both environmental and interpersonal prevention and intervention techniques, as well as the use of calming psychotropic medications. Seclusion or restraint is never to be applied as a punitive measure, but only to attain therapeutic objectives. The decision must be based on clear clinical indications, after considering the benefits and possible adverse effects and consent of the patient is to be obtained when feasible. The patient in seclusion or restraints must be under observation according to established procedures and returned to full autonomy as soon as possible. The following comments take into consideration the special features which apply for the elderly patient.

While the use of the seclusion and/or restraint shows a remarkable variation as a psychiatric intervention, it appears that patients over the age of 65 are far less frequently secluded or restrained than are younger

patients. For elderly patients, Tardiff reported an incidence of 0.3% (2), while Wells reported that two patients out of 15 in this group were secluded in another setting (7). Convertino found none over 65 in a group of 25 patients (6). In a still unpublished study, Straker found that of 3106 patients admitted in 1982 to a VA psychiatric hospital, 5% were over age 65, but there was not a single elderly patient placed in seclusion or restraints during that time (35). This suggests that when the staff is faced with difficult, disorganized, objectionable behaviors in an elderly patient, the preference is for other interventions that may be useful in coping with the situation.

Indications for Elderly Patients

Seclusion and/or restraint are used primarily to prevent or stop harm to self or others, or to temporarily remove a patient whose disruptive behavior damages the physical or therapeutic environment. In that regard, one needs to balance the welfare of all against the interests of one. Restraint may also be necessary in order to carry out life saving interventions for a patient who is confused, uncooperative or incompetent.

The elderly are often perceived as being helpless and victimized by family, society, and a paternalistic health care system (36). Butler (37) and Eisdorfer (38) warn against the abuse of psychoactive drugs, the special risks of over medication, and suggest that physical restraint or forced medication must be used only in a true emergency. There is also the perception that old people are not prone to dangerous violence, although assaultive behaviors can occur in patients of all ages. Tardiff and Sweillam studied the Long Island state hospital population for assaultive behaviors and reported this occurred in 10% of the patients. In this assaultive group, 14% were over age 65 (39). In a study of a state hospital geriatric unit, Petrie reported that among 222 patients, 8% manifested violent behaviors (40). Tardiff has cautioned that staff must be made aware that serious violence can occur in older patients. At the same time, he commented that in the structured hospital environment, such behaviors tend to be suppressed (41).

Consent to Treatment

Since the use of seclusion or restraint imposed movement restrictions and may have aversive effects related to the temporary suspension of patient rights, there is a potential conflict between the legal protection of rights and medical judgment about treatment regarded as essential. One needs to consider as well, the preservation of security, and the personal and treatment rights of others. Measures which impose behavioral controls can be upsetting to the patient and to others, yet some investigators note that it is precisely to restore authority and to reestablish threatened controls that

will prompt staff to decide on seclusion and/or restraint rather than some other intervention (4,18). If that is true, one could expect that an untrained, anxious staff will make such decisions more often.

In an emergency, clinical judgment should prevail without delays to obtain consent. As soon as the emergency subsides, a debriefing is indicated. If the patient is persistently non-compliant, consideration must be given to alternative modes of treatment or conversion to involuntary status. The matter of consent in the elderly poses special problems, when there is some cognitive impairment present. It is useful when there is doubt regarding competence to consent to consult family members and to solicit consultation from both medical and legal sources. This is only one of a number of unsettled issues in the field of medical ethics (42).

Potential Adverse Effects

Restraints may cause abrasions and can also cause humiliation, rage and increased agitation. The multiple medical impairments, so common in the elderly, make a close supervision of the secluded or restrained patient essential. The latter condition may also add the burdens of isolation and understimulation and lead to panic or confusion. The risk of these aversive effects in the elderly encourage alternative measures, such as providing interpersonal support, small doses of medication, and open seclusion in the company of a trusted person.

To summarize, assaultive behaviors occur at any age, but the perception that old people are less dangerous than the young may result in a lower level of responsive anxiety in the staff. Staff tends to choose other interventions than seclusion and/or restraint to manage disruptive behaviors or deal with emergencies in the elderly patient. Because there may be greater risks, there should be clear indications, close monitoring, consent when feasible and early termination. Under these conditions, the procedures may fill the patient's needs better and more safely than alternative treatments.

C. The Developmentally Disabled

Procedures similar to seclusion and restraint with developmentally disabled patients typically involve the systematic application of behavior analysis and therapy discussed earlier in this report. Developmentally disabled patients often show seriously aggressive behaviors for which proper treatment requires restraint or seclusion-like procedures (43,44). Several characteristics of the developmentally disabled population may lead to aggression or make aggression more difficult to treat. Severe skill deficits frequently exist in the areas of self-care, vocational, leisure, social,

communicative, academic, and independent living skills. These skill deficits interact with aggression in at least three ways.

First, developmentally disabled people often lack the strategies and methods used by people of normal intelligence to fulfill their needs and attain their goals. Developmentally disabled people frequently cannot communicate well (45), or have hearing or other sensory impairments which inhibit their interaction with others (46). Second, a developmentally disabled person's aggression may interfere with learning adaptive skills such as self-care, language, home care, leisure and social skills. The presence of aggressive behavior often necessitates placement in a more restrictive environment such as an institution (47,48). In such settings, the likelihood of an impoverished environment is greatest, with minimal social interaction, let alone constructive skill-building teaching interactions. Third, decreasing aggression in the developmentally disabled does not necessarily lead to the establishment of appropriate alternative responses to replace the undesirable behavior (49,50). Unlike most mentally ill patients, developmentally disabled people often do not have a repertoire of adaptive living skills established prior to the onset of the disorder. Thus only controlling aggression until florid symptomatology has been reduced is not an effective strategy with most mentally developmentally disabled people.

Treatment for severely aggressive behavior begins with prevention. This can be facilitated by training care providers to ignore early signs of aggression, to give attention to the victim but not the aggressor, and to prevent the aggressor from gaining the ends for which aggression occurred. It is also important to provide an environment in which the patient receives much attention and approval for appropriate behaviors and problem-solving skills. Environmental interventions can help prevent the occurrence of aggression and consequent use of restraint or seclusive procedures.

When serious aggression occurs and a more restrictive intervention is required, follow the steps mentioned earlier in performing a careful behavior analysis to identify antecedents and consequences and employ this analysis to aid in the choice of the appropriate restraint or seclusive procedure. There are some important considerations in making contingently applied restraint and seclusive procedures effective. First, they should be designed to be consistently implemented. If not, the aggression may inadvertently be reinforced occasionally, and therefore become more difficult to extinguish. Second, it is necessary to specify clearly exactly which behaviors will receive which contingencies, so that all staff are consistent. Third, there must be training in alternative appropriate behaviors which can serve the purpose formerly served by the aggression. When using partial restraint procedures which allow a patient to remain in the treatment environment, it is important to make that environment a

positive learning and reinforcing environment. Similarly, the use of seclusionary time-out with the retarded "presupposes that the individual is functioning in a 'time-in' environment which is highly enriched and reinforcing" (51). Consideration must also be given regarding protecting the restrained patient from aggressive peers. Ignoring and timeout will generally be effective only with patients who enjoy being with others, receive enough attention to be able to discriminate timeout conditions, do not perform aggressive acts in order to escape responsibilities, will not self-injure to escape timeout, and do not engage in such intrinsically reinforcing activities as self-stimulation while in timeout.

The use of psychotropic medications to control problem behaviors may occur in as many as 55% of all developmentally disabled people (52-54),despite estimates of psychotic symptoms in only 24-38% of this population (55,56). Since 1973, developmentally disabled patients have had a "right to be free from unnecessary or excessive medication" and from quantities of drugs "that interfere with the resident's habilitation program" (57). Contrary to legal mandates (57-59), physicians seldom evaluate effectiveness adequately (60). Many developmentally disabled individuals receive antipsychotic medications for extended periods of time, increasing the chance of serious and undesirable side effects (61). Review of the research of the effectiveness of psychotropic medications on the developmentally disabled yields little solid evidence of its efficacy in specifically ameliorating behavioral disorders. However, distinguishable psychiatric disorders are clearly manifested by some mentally retarded persons (62). The better studies, in terms of diagnostic screening, report prevalence estimates of psychotic symptoms in the 24% (55) to 38% range (56). These prevalence estimates are significantly below the recent estimates of 55% of this population who are receiving anti-psychotic drugs.

Another serious drawback to the use of anti-psychotic medications is that they have been documented to decrease the rate of learning in some developmentally disabled patients (63-65), an effect which is especially unfortunate in a population whose principal shared characteristic is a slowness to learn. It is not surprising that the effectiveness of behavioral interventions on undesirable behaviors has been reduced when combined with a medication regimen (66-68). It appears critical, then, to assess adaptive behaviors, such as rate of learning and changes in self-care skills, as well as maladaptive behaviors when evaluating the effect of a medication regimen.

Many developmentally disabled patients show improvement or no change when withdrawn from antipsychotic medication (53,60,69,70), but no patient characteristics have been identified which predict this response. Therefore physicians should exercise extreme caution before instituting

such medications with developmentally disabled patients. With those already on psychotropics, gradual withdrawal of such medication, staggered across patients, should be carried out while a consistent training program is continued (63). Withdrawal effects, which often include behavioral disruption, may last as long as 16 weeks, so the medication withdrawal should last at least this long (71).

To avoid the biases which often exist concerning medication among staff who work with developmentally disabled people, staff blind to drug condition should take data on both adaptive and maladaptive behaviors (61,72).

It is crucial that the effectiveness of the seclusive and restraint procedures discussed in this chapter be evaluated in terms of their effects on the target behaviors for which they are employed. However, it is often difficult to collect data of sufficient reliability and usefulness in clinical settings. The minimally acceptable data system for evaluating interventions in a clinical setting and for ethically justifying the use of restrictive procedures should have the characteristics of reliability, validity, appropriate frequency and utility in helping the physician and treatment team. Many of these and other relevant clinical evaluation issues are discussed in greater depths in the literature (1,73).

Summary

The Task Force has reviewed empirical studies, state regulations and legal parameters concerning the psychiatric use of seclusion and restraint. From this review and the experience of the Task Force has come guidelines in regard to indications, contraindications and implementation of seclusion and restraint procedures in the emergency management of patients as well as part of behavioral treatment programs. These guidelines may be adapted to special needs of each clinical setting and the legal limitations of each state. The Task Force affirms the importance of good clinical judgment in the use of physical controls, a position fully supported by the Supreme Court in the recent *Youngberg v. Romeo* decision.

The use of seclusion and restraint is only one aspect of the management and treatment of patients and must be seen in the context of a therapeutic environment where patients have the opportunity to become engaged in activities and to talk and interact with staff and other patients. In addition, the decision as to whether one uses medication, seclusion, restraint or other modalities must be made in terms of the individual patient on a clinical basis and not in terms of which is more or less restrictive.

Indications for seclusion and restraint are 1) to prevent imminent harm to the patient or other persons when other means of control are not effective or appropriate, 2) to prevent serious disruption of the treatment program or significant damage to the physical environment, and 3) for treatment as part of an ongoing plan of behavior therapy. For seclusion, additional indications are 1) to decrease the stimulation the patient receives and 2) use at the request of the patient. Seclusion and restraint may be contraindicated when precluded by the patient's clinical condition, for example unstable medical status resulting from infection, cardiac illness, disorders of thermoregulation and metabolic illness. In some orthopedic conditions, restraint may be preferable and in some neurological conditions, a patient's vulnerability to sensory deprivation may contraindicate seclusion. Other situations representing relative contraindications to seclusion include patients who have just taken overdoses and require close monitoring, those with symptoms of serious and uncontrollable self-abuse and self-mutilation, and the environmental problem of seclusion rooms that cannot be sufficiently cooled on hot days for patients on neuroleptics. Seclusion or restraint of a

patient as a purely punitive response is contraindicated and should never be for the pure convenience or distress of the staff or because of inadequate staffing or other resources.

For the first episode of the emergency use of seclusion and restraint, the physician should see the patient usually within three hours and preferably within one hour after the initiation of the seclusion and restraint episode. For each subsequent episode for that patient, a physician should be notified within the hour. However the physician will exercise professional judgment as to whether a visit is indicated and will indicate any special precautions which must be taken or monitoring which must be done by the nursing or other professional staff. The physician should see a secluded and restrained patient as frequently as necessary to monitor changes in the patient's condition with a minimum being two visits a day, approximately 12 hours apart. The physician's order is generally valid for 12 hours. The physician should examine the patient and document on the patient's record the justification for continued seclusion and restraint. If seclusion and restraint is used for longer than 72 consecutive hours the director of the hospital or his/her designee must review and approve continued use.

The Task Force has made specific recommendations on seclusion and restraint maneuvers. The techniques for seclusion and restraint should be written, rehearsed and approved in each hospital. The Task Force recommends that these techniques be reviewed by the legal representatives of the institution and that instructors be designated within the hospital facility to teach these skills to both new clinical staff an as part of in-service training. During the period of time the patient is in seclusion and restraint, observations regarding a patient's behavior should be made every 15 minutes by members of the nursing staff. Proper care of the patient including toileting and meals should be made at regular intervals. The decision to remove a patient from seclusion or restraint is based on observations of the patient's ability to control himself/herself and cooperate with physical examinations, interviews, medical procedures, bathing and toileting and other interactions with staff. All observations and decisions must be documented in the patient's record, preferably on a standard form.

The Task Force has described behavioral applications of seclusion and restraint procedures which differ from their use in emergency situations in that behavioral applications are planned treatment programs whose details are formulated beforehand and whose object is long-term change in the patient's behavior. The Task Force has described these procedures and has recommended that only professionals trained in behavior therapy should be responsible for design, implementation and quality control of these behavior treatment programs.

There are special considerations for some populations of patients. The

use of seclusion for children may be a frequent occurrence in hospital settings because of problems with self control and because seclusion may be regarded as a natural extension of the care-taking, limit-setting procedures which are interwoven with child rearing. Seclusion and restraint may be used less frequently for the elderly since other means of controlling violent behavior may be more effective in this population. Potential adverse affects of seclusion and restraint may be exaggerated in the elderly and thus monitoring is of the utmost importance. For the developmentally disabled the systematic application of seclusion and restraint as part of behavior therapy in many cases may be preferable to the use of neuroleptic medications since in this population, in the absence of psychotic symptomology, these medications may not be indicated and in fact may further impair these patients' rate of learning.

The Task Force believes this report reflects a definite body of knowledge on the proper use of seclusion and restraint, and that its recommendations should guide clinicians called upon to manage violent behavior as well as hospital administrators, lawyers and those charged with formulating treatment policy.

References

1. Tardiff K (ed): The Psychiatric Uses of Seclusion and Restraint. Washington D.C., American Psychiatric Press, 1984
2. Tardiff K: Emergency measures for psychiatric inpatients. J Nerv Ment Dis 169:614-618, 1981
3. Soloff PH, Turner SM: Patterns of seclusion: a prospective study. J Nerv Ment Dis, 169:37-44, 1981
4. Schwab PJ, Lahmeyer RN: Uses of seclusion on a general hospital psychiatric unit. J Clin Psychiatry 40:228-231, 1979
5. Plutchik R, Karasu TB, Conte HR, et al: Toward a rationale for the seclusion process. J Nerv Ment Dis 166:571-579, 1978
6. Convertino K, Pinto RP, Fiester AR: Use of inpatient seclusion at a community mental health center. Hosp Community Psychiatry 31:848-850, 1980
7. Wells DA: The use of seclusion on a university hospital psychiatric floor. Arch Gen Psychiatry 26:410-413, 1972
8. Mattson MR, Sacks MH: Seclusion: uses and complications. Am J Psychiatry 135:1210-1213, 1978
9. Binder RL: The use of seclusion on an inpatient crisis intervention unit. Hosp Community Psychiatry 30:266-269, 1979
10. Oldham JM, Russakoff LM, Prusnofsky L: Seclusion: patterns and milieu. J Nerv Ment Dis 171:645-650, 1983
11. Soloff PH: Behavioral precipitants of restraint in the modern milieu. Compr Psychiatry 19:179-184, 1978
12. Soloff PH: Physical restraint and the non-psychotic patient: clinical and legal perspectives. J Clin Psychiatry 40:302-359, 1979
13. Rosen M, DiGiacomo JN: The role of physical restraint in the treatment of psychiatric illness. J Clin Psychiatry 39:228-232, 1978
14. Guirgnis EF: Management of disturbed patients: an alternative to the use of mechanical restraints. J Clin Psychiatry 39:295-303,1978
15. Youngberg v.Romeo 102 S. Ct. 2452 (1982)
16. Mills v. Rogers, 102 S.Ct. 2442 (1982)
17. Gutheil TG, Appelbaum PS, Wexler D: The inappropriateness of least restrictive alternative analysis for involuntary interventions with the institutionalized mentally ill. J Law Psychiatry, (in press)

18. Gutheil TG: Observations on the theoretical bases for seclusion of the psychiatric inpatient. Am J Psychiatry 135:325-328, 1978
19. Gutheil TG, Appelbaum PS (eds.): Clinical Handbook of Psychiatry and the Law. New York, McGraw-Hill, 1982
20. Lion JR, Snyder W, Merrill GL: Underreporting of assaults on staff in a state hospital. Hosp Community Psychiatry, 32:497-498, 1981
21. Appleton WS: The snow phenomenon: tranquilizing the assaultive patient. Psychiatry, 28:88-93, 1965
22. Donlon PT, Hopkin J, Tupin JP: Overview: efficacy and safety of the rapid neuroleptization method with injectable Haloperidol. Am J Psychiatry, 136:273-278, 1979
23. Ayllon T, Azrin NH (eds): The Token Economy: A Motivational System for Therapy and Rehabilitation. New York, Appleton-Crofts, 1968
24. Liberman RP, Wallace C, Teigen J, et al: Interventions in psychotic behaviors, in Innovative Treatment Methods in Psychopathology. Calhoun K, Adams H, Mitchellk (eds), John Wiley & Sons, New York, 1974
25. Kazdin AE: The Token Economy. New York, Plenum Press, 1977
26. Bostow DE, Bailey J: Modification of severe disruptive and aggressive behavior using brief timeout and reinforcement procedures. J Appl Behav Anal 2:31-37, 1969
27. Vukelich R, Hake DF: Reduction of dangerously aggressive behavior in a severely retarded resident through a combination of positive reinforcement procedures. J Appl Behav Anal 4:215-225, 1971
28. Repp AC, Deitz SM: Reducing aggressive and self-injurious behavior of institutionalized retarded children through reinforcement of other behaviors. J Appl Behav Anal 7:313-325, 1974
29. Porterfield JK, Herbert-Jackson E, Risley TR: Contingent observation: an effective and acceptable procedure for reducing disruptive behavior of young children in a group setting. J Appl Behav Anal 9:55-64, 1976
30. Webster DR, Azrin NH: Required relaxation: a method of inhibiting agitative-disruptive behavior of retardates. Behav Res Ther 11:67-78, 1973
31. Foxx RM, Azrin NH: Restitution: a method of eliminating aggressive-disruptive behavior of retarded and brain damaged patients. Behav Res Ther 10:15-27, 1972
32. Hamilton J, Stephens L, Allen P: Controlling aggressive and destructive behavior in severely retarded institutionalized residents. Am J Ment Defic 71:852-856, 1967
33. Reid JG, Tombaugh TN, Heuvel KV: Application of contingent physical restraint to suppress stereotypic body rocking of profoundly mentally retarded persons. Am J Ment Defic 86:78-85, 1981
34. Wong SE, Slama KM, Liberman RP: Behavioral treatment of aggressive psychiatric and developmentally disabled patients, in Clinical Treatment and

Management of the Violent Person, Roth LH (ed) (NIMH Monograph). U.S. Government Printing Office, Washington D.C., (in press)

35. Straker M: Unpublished report
36. Steuer J, Austin E: Family abuse of the elderly. J Am Geriatr Soc. 28:372: 1980
37. Butler RN, Lewis MI: Aging and Mental Health: 2nd Edition. St. Louis, C.V. Mosby Co. 1977
38. Eisdorfer C, Stotsky BA: Intervention treatment and rehabilitation of psychiatry disorders, in Handbook of the Psychology of Aging. Birren J, Schaie K (eds), New York, Van Rostrand Rheingold: 1977
39. Tardiff K, Sweillam A: The relation of age to assaultive behavior in mental patients. Hosp Community Psychiatry 30: 709-711, 1979
40. Petrie WM, Lawson EC, Hollender MH: Violence in geriatric patients. JAMA 248:443-444, 1982
41. Tardiff K: Editorial: Violence in geriatric patients. JAMA 248:471, 1982
42. Jonsen AR, Siegler M, Winslade WJ: Clinical Ethics. New York, MacMillan Publishing Co. Inc. 1982
43. Johnson WL, Baumeister AA: Behavioral techniques for decreasing aberrant behaviors of retarded and autistic persons, in Progress in Behavior Modification, vol 12. Herson M, Eisler RM, Miller PM (eds.), New York, Academic Press, 1981
44. Eyman RK, Call T: Maladaptive behavior and community placement of mentally retarded persons. Am J Ment Defic 82: 137-144, 1978
45. Talkington LW, Hall SM, Altman R: Communication deficits and aggression in the mentally retarded. Am J Ment Defic 76:235-237, 1971
46. Talkington LW, Hall SM: Hearing impairment and aggressiveness in the mentally retarded. Percept Mot Skills, 28:303-306, 1969
47. Plaska T, Ragee G: The intensive training project: a program to prepare aggressive and disruptive residents for community placement, in Behavioral Systems for the Developmentally Disabled II: Institutional, Clinic, and Community Environments. Hamerlynck L (ed), New York, Bruner/Mazel, 1979
48. Ross RT: Behavioral correlates of level of intelligence. Am J Ment Defic 76: 545-549, 1972
49. Marshall HH: The effect of punishment on children: a review of the literature and suggested hypothesis. J Genet Psychol 106:23-33, 1965
50. Smolev SR: Use of operant techniques for the modification of self-injurious behavior. Am J Ment Defic 76:295-305, 1971
51. Favell JE, Azrin NH, Baumeister AA, et al: The treatment of self-injurious behavior: Association for Advancement of Behavior Therapy Task Force Report. Behav Res Ther 13:529-554, 1982
52. Lippman RS: Psychotropic drugs and the mentally retarded: what we know and what we need to know, in The Use of Medications in Controlling the Behavior of the Mentally Retarded. Young R, Kroll J (eds), University of Minnesota, 1981, pp. 34-61
53. Sprague RL, Baxley GB: Drugs for behavior management with comment on some legal aspects. Ment Retard Develop Disabil 10:92-129, 1978
54. Tardiff K; A survey of drugs used in the management of assaultive patients. Bull Am Acad Psychiatry Law 11:215-222, 1983
55. Menolascino FJ: Emotional disturbance and mental retardation. Am J Ment Defic 70:248-256, 1965
56. Phillips I, Williams N: Psychopathology and mental retardation: 1. psychopathology. Am J Psychiatry, 132:1265-1271, 1975
57. Wyatt v. Stickney, 344 F. Supp. 387, 1972
58. Welsch v. Dirkswager, 4-72 CIV. 451 (order entered Dec. 1977), amending order in Welsch v. Likens, 373 F. Supp. 487 (D. Minn.) 1974
59. Welsch v. Likens, 550 F. 2d 1122 (8th Cir.), 1974
60. Aman M: Psychoactive drugs in mental retardation, in Treatment Issues and Innovations in Mental Retardation. Matson JL, Andrasik F (eds), New York, Plenum, 1980
61. Breuning SE, Ferguson DG, Cullari S: Analysis of single-double blind procedures, maintenance of placebo effects, and drug-induced dyskinesia with mentally retarded persons. Appl Res Ment Retard 1:175-192, 1980
62. Matson JL, Barrett RP: Psychopathology in the Mentally Retarded. New York, Grune and Stratton, 1982
63. Wysocki T, Fuqua RW: Methodological issues in the evaluation of drug effects, in Drugs and Mental Retardation. Breuning SE, Poling AD (eds), Springfield, Il, Thomas, 1982, pp. 138-167
64. Marholin II, D, Touchette PE, Stewart RM: Withdrawal of chronic chlorpromazine medication: an experimental analysis. J Appl Behav Anal 12:159-171, 1979
65. Breuning SE: An applied dose-response curve of thioridazine with the mentally retarded: aggressive, self-stimulatory, intellectual, and workshop behaviors—a preliminary report. Psychopharmacol Bull 18:57-59, 1982
66. Breuning SE, O'Neill MJ, Ferguson DG: Comparison of psychotropic drug, response cost, and psychotropic drug plus response cost procedures for controlling institutionalized retarded persons. J Appl Res in Ment Retard 1982
67. Hollis JH, St. Omer VV: Direct measurement of psychopharmacologic response: effects of chlorpromazine on motor behavior of retarded children. Am J Ment Defic 76:397-407, 1972
68. McConahey DL, Thompson T, Zimmerman R: A token system for retarded women: behavior therapy, drug administration, and their combination, in Behavior Modification of the Mentally Retarded, 2nd edition. Thompson T, Grabowski J (eds), New York, Oxford University Press, 1977, pp. 167-234

69. Lipman RS, DiMascio A, Reatig N, et al: Psychotropic drugs and mentally retarded children, in Psychopharmacology: A Generation of Progress.Lipton MA, DiMascio A, Killman KF (eds), New York, Raven Press, 1978, pp. 1437-1449

70. Ferguson DG, Breuning SE: Antipsychotic and antianxiety drugs, in Drugs and Mental Retardation.Breuning SE, Poling AD (eds), Springfield, Il, Thomas, 1982, pp. 168-214

71. Zimmerman RL, Kollmorgan R: Adverse impacts of clinical drug withdrawal trials, in The Use of Medications in Controlling the Behavior of the Mentally Retarded. Young R, Kroll J (eds), University of Minnesota, 1981, pp. 234-243

72. Callahan EJ, Alevizos PN, Teigen JP, et al: Behavioral effects of reducing the daily frequency of phenothiazine administration. Arch Gen Psychiatry, 32:1285-1290, 1975

73. Bloom M, Fischer J: Evaluating Practice: Guidelines for the Accountable Professional. Englewood Cliffs, New Jersey, Prentice-Hall, 1982