

Changing the Approach:
Ending the Use of Restraints in Psychiatric Care of Children

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Throughout history, restraints have been utilized for various reasons in psychiatric care. Children with psychological issues have been the most vulnerable to this treatment in hospitals as well as schools. The process of using these measures is not usually a quiet occurrence. The child, for whatever the reason necessitating a restraint, will typically fight, cry, scream, or threaten. Staff, even under the best of circumstances, are busy attempting to direct the child and communicate to each other, as well as calm other patients. The experience of incorporating a take-down restraint of a child can be described as “analogous to a cardiac arrest in a CCU....the process constitutes an acute psychiatric emergency and is a highly emotional and volatile event for patients and staff. Although some discussion may ensue between patients and staff members, the actual take down often is chaotic, with staff members urging the child to calm down, and the child responding in crude terms, crying, shouting, or struggling. ” (Mohr & Anderson, 2001, p. 2). It is a whirlwind of emotions and activity perceived very uniquely by all involved. During a restraint, children may feel angry, resentful, trapped, paranoid, or scared. Staff experience feelings of indifference or exhilaration yet afterward are left emotionally and physically drained (Smith & Bowman, 2009). Physiological reactions occur as well. The child automatically goes into a fight or flight mode with increases in pulse, blood pressure, and cortisol. Harm or injury can occur to patients as well as staff. The need for change is evident. The present trend is to alter the previous methods of restraint and incorporate alternative approaches to safely care for psychologically disturbed children.

There are two main categories of restraints, mechanical and physical, used in psychiatric care. A mechanical restraint is a device made of fabric used to hinder a patient's movement, such as a safety vest, hand and wrist straps, mittens, or a stretcher equipped with belts (<http://medical->

dictionary.thefreedictionary.com/mechanical+restraint). A physical restraint restricts the patient's movements without a device or consent of the patient. A physical hold or a take-down (act of bringing a resident being restrained to a sitting or horizontal position) are the two main types of physical restraints performed by staff.

The first state-run mental hospital in the United States was not established until 1822. Restraints were utilized at that time and "rather than seeing restraints as evidence of mistreatment, American physicians believed that restraints were a valuable tool to keep patients safe" (Scott, 2011, para. 1). In the sixties and seventies, the idea that these forms of treatment were safe and effective when used as an active part of the treatment program was embraced. However, in the nineties, criteria for the use of restraints changed to include the prevention of serious disruption to the unit or refusal to adhere to staff requests (such as taking medication, moving to another area).

The catalyst for a change in this type of thinking and treatment was created by an article in 1998. The *Hartford Courant* published "Deadly Restraint" in which they presented one hundred and forty two deaths in ten years related to the use of restraints. They reported the shortage of staff, lack of training, and misuse of treatments that led to these deaths (Megan, Blint, & Weiss, 1998). Subsequently, the U.S. Health Care Financing Administration issued specific guidelines for restraint use in psychiatric settings as a condition for participation in federal reimbursement programs. In 2000, the Children's Health Act came into play in order to conduct a national study on environmental influences on children's health and development. In 2003, SAMHSA (Substance Abuse and Mental Health Services Administration) issued to eliminate restraints and seclusions in behavioral health. The National Action Plan was put into place in order to achieve this (Huang, 2011).

The findings of the studies conducted revealed that guidelines for the use of restraints were vague and extremely subjective. There were considerable discrepancies between nurses and staff as to when was it was appropriate to restrain a child. Usually, nurses were not involved in the decision-making to employ these actions and judgment was left for staff to determine. Unfortunately, many of the staff were untrained and misused these interventions incorporating them on children for noncompliant behavior, staff convenience, or damaging property. Children viewed these restraints as a punishment or power struggle between them and staff. As a result of these approaches, they felt angry, afraid, vengeful, or confused. Most of the children remained in a state of hypervigilance and tended to overreact or misinterpret the behavior of others. (Mohr & Anderson, 2001) Injuries to staff as well as children were inflicted due to poor techniques and lack of monitoring. Teaching was ineffective and the behaviors of these children remained unchanged or worsened.

Currently, restraints are no longer viewed as a therapeutic intervention but as a last resort in order to maintain safety on the unit. Studies continue to be implemented on new approaches as others have become incorporated in hospitals. The role of the nurse has changed considerably in accountability, teaching, and monitoring. Nursing care has become patient-centered where each child is treated as an individual instead of one intervention applied for all. Many of these children have developmental disabilities or have experienced severe trauma and react differently to situations. The goal for care in these children is to aid them in building skills to effectively cope with their emotions as well as keeping them safe.

Changes in approach to care started with the admission process. Each child is assessed by a nurse as well as a psychiatrist. A personalized safety plan is incorporated as a first step to prevent a crisis and a framework for others to follow. Triggers are documented in order for staff

to recognize situations that the child would need support. A trigger is anything that could generate feelings of agitation, stress, anger, depression, or sorrow. 'Taking space' is a method used in which children walk away from triggers in order to gather their thoughts and emotions. Most of the children have learned to cope with their situations using unhealthy, inappropriate, or unsafe strategies. Healthy coping strategies such as deep breathing or self-calming techniques are taught and practiced. These skills are as individual as the children and can be as simple as listening to music, reading a book, or playing a game. "Coping refers to what a person does in order to avoid, remove, minimize, or 'get through' a stressful situation. Coping is defined as the process of making adaptations to meet personal needs and to respond to the demands of the environment" (Children Coping Skills, 2012, para. 1). In this way, these children will have obtained tools to work and take with them in order to manage their emotions without compromising safety.

In order to create a sense of belonging, most psychiatric hospitals have incorporated the idea of coaches for patients individually to instruct them in their care. At the beginning of the shift, staff are assigned patients to coach. Their responsibilities are to encourage coping skills, offer verbal support, and teach appropriate responses. Goals groups, where patients get together and identify a goal to work on, provide a positive focus for that shift. In times of difficulty, comfort rooms can be utilized. These are areas on a unit where a patient can go as a sanctuary to experience their feelings of anger or anxiety within acceptable boundaries. This area is a soft room with calming colors, encouraging messages, and soothing pictures. (Silvak, 2012). These approaches guide staff and patients with clear expectations, safe alternatives, and reassured support.

Cognitive-behavioral techniques are taught to staff as well as nurses to be utilized in all activities and functions of the unit. One form of psychotherapy that has had much success is dialectical behavior therapy which was derived from Buddhist meditative practice. It combines cognitive-behavioral techniques with reality-testing and consists of concepts of mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness. Mindfulness is the core for all the other elements. Staff incorporate activities where children are aware of their emotions and senses as well as their environment and others in the here and now. Distress tolerance is learning to accept oneself and their current circumstances instead of hiding or being overwhelmed by them. Coping skills are learned in order to deal with life situations. Emotional regulation is understanding how to self-regulate emotions. Interpersonal effectiveness focusses on assertiveness and problem-solving activities. Incorporating these techniques allows the children to not only learn but acquire skills to change their behaviors and deal with challenging emotions. ("About DBT," 2011).

Unfortunately, even with the utilization of current preventative measures, aggressive behaviors still occur. When a child dysregulates and there is imminent risk of harm to the patient or others, physically restraining them is an option still used. It is a last resort intervention. In order to maintain safety, the nurse must assess the patient within the first five minutes of the initiation of the restraint and intervene if necessary. The physician must be notified and also assess the child within the hour. Physical safety is a priority and these changes have been incorporated due to the history of injuries and deaths.

Debriefing a child after a restraint is an approach that has been included as a learning tool. When the child regains self-control, the nurse will aid him or her in exploring thoughts, feelings, misperceptions, and triggers prior to the event. This is an attempt to connect behavior

to emotions. In this way, the child is taught to identify and label feelings as well as adopt more socially acceptable means of expressing anger. (Dunlap, Ostry, & Fox, 2011).

Prone restraints, in which the patient is face-down, are the number one cause of injuries. “Prone restraints are blamed for the deaths of at least forty-eight juveniles from 1998 through August 2006 nationwide” (Thomas, 2011, p. 2). In Connecticut, The Department of Developmental Services outlawed these type of restraints in 2007. In most facilities this practice has been abolished. The use of mechanical restraints has either been completely eliminated or considerably reduced. Slowly, the practice of restraint use is changing and alternative practices are being incorporated in the care of these children.

The future vision for most institutions is to be able to completely do away with the practice of restraining dysregulated children. With the dangers of restraining recognized in numerous studies, a national standard needs to be established for continuity and a solution to the problem. In this way, more aggressive actions could take place for alternative solutions, continued studies and staff training. State and governmental funding could be reduced if these standards are not met. Adequate staffing as well as trainings in alternative methods are essential in reduction or elimination of older practices. In order for the vision of eradicating the use of restraints in children to become a reality, action needs to be taken for this change to occur.

New ideas can be challenging for staff to accept and incorporate in everyday practice on the unit. Successful and innovative approaches can be time-consuming. Higher staff to patient ratios are necessary to incorporate these practices and continue to retain safety with the other children on the unit. Increased training will need to take place. The requirements to achieve success with alternative approaches may be challenging to both staff and management. It is more costly to integrate increased trainings and staff. However, costs of restraining children and

injury to staff requiring worker's compensation can be staggering. One study concluded that the difference in one facility where these alternative methods were enforced were substantial. "The amount of compensation paid decreased by 98 percent (from \$29,355 to \$597), and the amount of medical costs paid decreased by 98 percent (from \$6,798 to \$157). The FY 2003 data showed that the adolescent inpatient service's aggregate use of restraint decreased from 3,991 episodes to 373 episodes (91 percent), which was associated with a reduction in the cost of restraint from \$1,446,740 to \$117,036 (a 92 percent reduction)" (Lebel & Goldstein, 2005, para. 8). Success with decreased hospitalization time and decreased re-hospitalizations were shown. "At six months post-discharge, 32 percent fewer adolescents were re-hospitalized in FY 2003 (two of 25 adolescents) than in FY 2002 (three of 12 adolescents). Similarly, at 12 months post-discharge, 14 percent fewer adolescents were re-hospitalized in FY 2003 (five of 35 adolescents) than in FY 2002 (three of 18 adolescents)"(Lebel & Goldstein, 2005, p. 7). These figures prove that not only were there less injuries with incorporation of alternative approaches but children were learning and able to achieve skills for success.

The use of restraints in the care of children in psychiatric facilities is in the process of transformation. Older methods have proven to be counter-therapeutic, injurious, and unsuccessful. Newer approaches will continue to be studied and included in the care of these children. As facilities modify expectations and policies to accommodate these changes, less injuries will result. Overall health and wellness for these children will enhance with improved outcomes and increased success. With persistence and a desire for change, these visions can be a reality. Hopefully, someday the emotional and physical trauma of restraints will be interventions of the past and no longer necessary in psychiatric units.

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