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DEATHS FROM RESTRAINTS IN PSYCHIATRIC FACILITIES

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

SPECIAL HEARING

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CONTENTS

DEATHS FROM RESTRAINTS IN PSYCHIATRIC FACILITIES

TUESDAY, APRIL 13, 1999

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:30 a.m., in room SD–192, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.

Present: Senators Specter and Harkin.

CONGRESSIONAL WITNESSES

STATEMENTS OF:

HON. JOSEPH I. LIEBERMAN, U.S. SENATOR FROM CONNECTICUT

HON. CHRISTOPEHR J. DODD, U.S. SENATOR FROM CONNECTICUT

OPENING STATEMENT OF SENATOR SPECTER

Senator SPECTER. We come to order for this hearing of the Appropriations Subcommittee on Labor, Health and Human Services and Education, and Related Agencies. We will begin now that it is 9:30 a.m., the convening time. After this hearing was scheduled, the President set a briefing for members of Congress, so we are going to have to conclude this hearing promptly at 10:30 a.m.

While the openings have never been long at the allocation of time at 5 minutes, we are going to try to do them in 4. I am sorry about the time limitations, but I know you will understand that there are so many issues and Kosovo takes second place to nothing.

This hearing has been scheduled in response to grave concern about an alarming number of deaths resulting from physical restraints in psychiatric facilities. It is impossible to say how many there are because there is no requirement for reporting of deaths from physical restraints, in a field which is largely left unregulated.

It is surprising, because patients in nursing homes are protected by federal legislation from the 1987 Omnibus Budget Reconciliation Act, but no similar provisions apply to people in psychiatric institutions.

The federal government has a very vital role in this area, considering that some $14 billion a year is provided by the federal government for funding of psychiatric care. The kinds of restraints which are used are chemical, physical. While they are obviously

necessary in some cases, there have been reports that they have been used for convenience, coercion or retaliation.

These issues have come to the public floor as the result of an illuminating series in the Hartford Courant. So this hearing is going to be focusing on just what kind of restraints are used and to what extent HCFA from the Department of Health and Human Services ought to be involved.

We are joined by two very distinguished members of the U.S. Senate, the distinguished senior senator, Senator Dodd, elected in 1980, a colleague of mine from that election. We have worked very closely on juvenile matters and health matters over the years. We welcome him here.

Senator DODD. Thank you, sir.

Senator SPECTER. And his distinguished colleague, Senator Joseph Lieberman, elected in 1988, ranking member of the Governmental Affairs Committee.

We welcome you here, gentlemen. As I had said a moment ago, because of the President's briefing, it will require us terminating at 10:30 a.m. I am going to submit my longer opening statement for the record. And to the extent we can confine statements to 4 minutes, it would be appreciated. But you men have presided at enough of these similar hearings to know precisely what is involved.

Senator SPECTER. Senator Dodd, welcome, and the floor is yours.

Senator DODD. Thank you, Mr. Chairman. But I would like to defer to my colleague, if I may, who is——

Senator LIEBERMAN. No. You go ahead.

Senator DODD. Are you sure? Joe has done a tremendous amount of work on this, and I appreciate your—I try to remind him all the time I am his senior senator, but he has done so much work on this, I really wanted to give him a chance to go ahead.

Why do you not do that?

Senator SPECTER. Senator Lieberman, the floor is yours. I note that notwithstanding seniority and chronology, your bill was introduced slightly ahead.

Senator DODD. I want the record to show that.

Senator LIEBERMAN. No; I am grateful to my colleague. And it is true, he has reminded me so effectively that he is my senior colleague, I automatically deferred to him. But I appreciate his graciousness. I will try to respond by abbreviating my statement and submitting a larger one for the record.

Senator SPECTER. Thank you very much.

SUMMARY STATEMENT OF SENATOR LIEBERMAN

Senator LIEBERMAN. Mr. Chairman, I want to thank you for holding this hearing on the deadly use of restraints in mental health facilities and giving Senator Dodd and me the opportunity to testify.

As you referenced, last October all of us, and I mention myself here, read with increasing horror and shame a brilliantly investigating and written series in the Hartford Courant, describing 142 deaths that were caused by restraint and seclusion in mental health facilities in our country over the last 10 years.

In many ways, it was a trip back into medieval times, to a world that, except for this journalistic series, would, for me at least, have been well beyond the limits of my knowledge, a kind of venture into an existence that otherwise would have been invisible to most of us. Although the federal government funded much of the care of these patients, these victims enjoyed almost no federal protections, certainly not relevant to what was done to them. Even basic information about the number and circumstances of their deaths was difficult for their loved ones to obtain.

So I come to this hearing today with a sense of anger over the treatment of some of the most vulnerable people in our society and with a determination to work with you, Mr. Chairman, with Senator Dodd and others, to prevent future deaths and injuries from the improper, I may say so, at times barbaric use of restraints.

I also come with a sense of urgency. Just last Friday I learned of yet another young boy who died in a mental health facility in Chesterfield, Virginia, after the apparently improper use of restraints and seclusion. The facts certainly seem to warrant the conclusion that restraints and seclusion are cruelly over used in America's mental health institutions today. They are used inhumanly, and they are too often used with fatal results.

Let me briefly share some of the major conclusions of the Hartford Courant articles. Deaths were reported in 30 states, including, as you know, Mr. Chairman, Pennsylvania. Thirty-three percent of the victims were suffocated. More than 26 percent of those killed were children under 17, a rate that is nearly twice the proportion of that age category in mental health institutions.

Of course, aggregate statistics do not adequately convey the tragedies experienced by the families of these people across this country. The victims' stories will and would better describe the agonies of their loved ones deaths. Shortly you will hear from Jean Allen, who will describe the parental nightmare she experienced, the death by suffocation of her 16-year-old son Tristan Sovern. As a parent, I extend my sympathy to her and to other parents whose children have died merciless deaths in restraints. As a senator, I express my commitment to work with my colleagues to prevent further such tragedies.

Mr. Chairman, I applaud your efforts to make sure that the mental health care funded by your committee does not result in injury or death. You have acted more quickly than any other committee of Congress to address this national shame.

Now the legislation that Senator Dodd and I have introduced would extend existing nursing home standards on the use of restraints to mental health patients and add a reporting requirement for injuries and death. Our Connecticut colleague representative, Rosa Deloro, and others have introduced companion legislation in the House.

Our bill explicitly forbids the use of restraints unless approved in writing by a physician, except under emergency circumstances. In other words, restraints are not to be used for discipline or for convenience. The same standard in effect in nursing homes since 1987 has reduced the use of restraints by over one-third.

Our bill also requires that facilities report deaths and serious injuries to mental health patients under the care of those facilities,

so that the cause of death or injury can be analyzed, preventive steps deployed, and the public alerted. With mandatory requirements under a state law in your state, Mr. Chairman, as you know, Pennsylvania is already producing dramatic reductions in the use of restraints and seclusions in mental health facilities.

I am encouraged by the response to the legislation. In my printed statement, I will indicate the number of organizations that I am proud to say are supporting it. Let me conclude by going back to the beginning.

PREPARED STATEMENT

I personally, and those of us in Connecticut and around the country, owe the Hartford Courant a debt for breaking the walls of secrecy that concealed 142 deaths caused by the deadly use of restraints. Your hearing today is the beginning of action by Congress that will tear down that wall and erect in its place a better system of protection for America's mental health patients.

I thank you. And again, I thank my colleague for his courtesy.

Senator SPECTER. Thank you very much, Senator Lieberman, for your very insightful statement.

[The statement follows:]

PREPARED STATEMENT OF SENATOR JOSEPH I. LIEBERMAN

Mr. Chairman, Senator Harkin, members of the Committee. Thank you for holding this hearing on deaths from restraints in mental health facilities.

In October, I read with horror, a powerful, brilliantly investigated and written series of stories in the Hartford Courant detailing 142 deaths from restraint and seclusion in mental health facilities. These deaths stretched over a decade, across the country, and to patients of all ages.

Although their care was federally funded, few federal protections were available to the victims and even basic information about the number of victims and the circumstances of their death was difficult to obtain.

I come to this hearing today, months later but still horrified, still outraged, and determined to do what I can to prevent deaths and injuries.

I also come with a sense of urgency having read just Friday that another teenage boy has died in a mental health facility, this time in Chesterfield, Virginia, after the use of restraints and seclusion.

I strongly urge this Subcommittee to protect mental health patients from the deadly use of restraints.

Restraints and seclusion are being used too much, they are being used inhumanely, brutally, and sometimes fatally. This practice is medieval in its application.

Here are some of the findings of the Courant articles: deaths reported in 30 states including both Pennsylvania and Iowa; 33 percent of the victims were suffocated; and more then 26 percent of those killed were children under 17.

But aggregate statistics can not convey the tragedy of restraints. Let me read some of the names and circumstances of deaths of victims that were killed during the months leading up to the death of 12-year old Andrew McClain in Connecticut.

Robert Rollins, age 12, suffocated after a dispute over his missing teddy bear.

Melissa Neyman, 19, suffocated when staffers strapped her to her bed at 10 p.m. and didn't check on her until the next morning. By then she had been dead 6 hours—entangled in her own restraints.

Edith Campos, 15, suffocated. Edith was looking at a family photograph when a male aide instructed her to hand over the "unauthorized" personal item.

Dustin Phelps, 14. Dustin died when the owner of the home wrapped him in a blanket and a mattress and tied it together with straps, investigators said. He was left in the mattress for four hours.

You shortly will hear from Jean Allan who can describe the death by suffocation of her 16-year old son, Tristan Sovern.

I am appalled by these deaths, as I am sure this Subcommittee is.

As a parent, I wish to extend my sympathy to Jean Allan and other parents whose children died in restraints.

As a Senator, I am outraged and want to work with my colleagues to prevent these deaths. One of the basic purposes of government is to protect those who can't defend themselves.

Chairman Specter and Ranking Member Harkin, I applaud your efforts to make sure that the mental health care funded by your Committee is not deadly or injurious. Federal funding sources including Medicare, Medicaid, and SAMHSA comprised almost 40 percent of the $36 billion that flowed into mental health organizations in 1994. You have acted more quickly than any other Committee of Congress to address this national shame.

I have introduced legislation with Senator Dodd that would to extend existing nursing home standards on the use of restraints to mental health patients and add a reporting requirement for deaths and serious injuries to mental health patients. Reps. Degette, Stark, and DeLauro have introduced restraint legislation in the House.

Our bill forbids the use of restraints unless approved in writing by a physician, except under emergency circumstances.

This same standard has reduced the use of restraints in nursing homes by over a third this decade. Our bill would extend this success to the entire nation's mental health community.

The reporting requirement in our bill mandates that facilities report deaths and serious injuries to mental health patients under their care so that the cause of the tragedy can be analyzed, preventative steps developed, and the public alerted. With mandatory reporting, Pennsylvania is producing dramatic reductions in the use of restraints and seclusion in their state mental hospitals.

I am encouraged by the response to the legislation.

The bill is supported by the National Alliance for the Mentally Ill—two of whose Connecticut affiliate presidents, Karen Hutchin of Granby, CT and Jeanne Landry-Harpin of Woodbridge, CT—played a critical role in helping the Hartford Courant investigate and organize its series last year.

It also is supported by the Joint Commission on Accreditation of Healthcare Organizations, the association which sets standards for the health care industry. They "support the mandatory reporting and disclosure of deaths related to the use of restraints".

Other supporters include the National Mental Health Association, the National Association of Protection and Advocacy Systems, the Bazelon Center for Mental Health Law.

The wall covering 142 deaths was broken by the Hartford Courant. Your hearing today is the beginning of action by Congress that will tear the wall down and build in its place a system of protection for America's mental health patients.

I applaud your action and thank you for your time.

SUMMARY STATEMENT OF SENATOR DODD

Senator SPECTER. Senator Dodd.

Senator DODD. Thank you very much, Mr. Chairman. And I am very pleased to be sharing this witness table with my colleague from Connecticut. We have introduced two bills and are co-sponsoring each other's because they involve different committees of jurisdiction, so avoiding the consequential referrals. The bill that Joe has talked about I think goes to finance, or at least part of it does anyway, because it touches on HCFA, and the legislation that we both introduced that goes specifically to the Labor Committee, where SAMSA legislation has to be reauthorized this year.

And obviously, a critical piece of that obviously comes to you, because we will be talking about resources that will be needed if major parts of our legislation are going to be funded. So I am deeply appreciative to you and to Senator Harkin, with whom I have the pleasure of serving on the Labor Committee.

And as you pointed out, Mr. Chairman, I have had the pleasure for the past 18 years of working with you on countless issues involving children. And it seems rather natural to be appearing be-

fore you today on an issue, as Senator Lieberman has pointed out, where 26 percent of these deaths that we are talking about occurred to juveniles, a percentage vastly in excess of the percentages in the population of mental health patients.

I note here, just looking at some of the notes here prepared by various groups and organizations, this one here, as we talk about 142 deaths that the Hartford Courant included in its series of articles, it has been pointed out that there have been 5 additional deaths in the last 5 months. And just noting the ages of 17, 15, 16 and 9, 4 out of the 5, one an adult of 36, just to dramatize the point that this is particularly an issue that affects all people, but it seems particularly hard to understand how a 9-year-old could die as a result of excessive restraint.

It was on March 22, 1998, just about a year ago, Mr. Chairman, that a 90-pound, 4 foot, 6 inch tall 11-year-old boy in Portland, Connecticut, had his chest crushed as a result of restraints in a mental health facility in the State of Connecticut. Andrew McClain is really what provoked in many ways the series of articles prepared and written by the Hartford Courant.

And I would like to ask, and you may have already done this before I walked in, but maybe as part of the record those articles be included, since they were so important in causing Senator Lieberman and I and you made note yourself and others to really decide this is an issue we ought to look into. And particular commendation, I think, should go to Eric Weiss, who is the principal author of these articles, but were supported by Dave Altimari, Dwight Blint and Kathleen Neegan, who all put those articles together.

Senator SPECTER. Without objection, they will be made a part of the record.

Senator DODD. Thank you, Mr. Chairman.

As a result of that, those series of articles, your interest and the interest of others, we have a wonderful chance in this first session, I think, of this Congress to be able to do something about this issue. We have, I said, Tom, before you walked in, the SAMSA legislation up in our committee, the Chairman's interest in this. We can bring these issues together and the work with HCFA.

Let me just briefly, we do three things in our bill, Mr. Chairman, as I am sure you are aware. First, we set standards for restraint and seclusion use, as Senator Lieberman has already pointed out here. Again, the only reason—no longer can reasons be used of discipline, punishment or convenience be tolerated in the area of physical restraints or seclusion.

We also require a physician's written order specifying the length and circumstances under which restraints may be applied. This is—again, we are applying the standards that have been used in nursing homes, I think rather effectively, by modifying the legislation that would allow for those standards now to be used in mental health facilities.

Second, Mr. Chairman, we have discovered—and again, both you and Senator Harkin, I am preaching to the choir on this issue, but the least trained people in the entire health care fields are people in mental health. The lowest paid, least well trained are in mental

health. It is just an amazing statistic, but it happens to be the case.

And what we try to do with our legislation is to see if we cannot help out here, because these are good people in places. They need to be trained and understand what needs to be done. And we do not want to be suggesting, I do not want to be, that people who work in these facilities are criminals in some way. This requires the kind of training and backing that is necessary.

Only three States, California, Colorado, and Kansas, license aides in psychiatric facilities. Out of 50 states, only 3 do. And while individual States or facilities may set their own standards, and we respect that, there is no uniform minimum training stated for mental health care workers. Our legislation will help ensure that adequate staffing levels and appropriate training for staff facilities will serve the mentally ill.

Specifically, the legislation requires the Secretary of Health and Human Services to set regulations requiring mental health providers to adequately train their staff in the correct application of restraints and their alternatives to ensure that appropriate staffing levels are maintained.

A staff person, I might point out, with 23 years of experience, Mr. Chairman, was quoted in the Hartford Courant series, she said, "Every time we've had a downsize in staff, we've had an increase in restraints and seclusion." So there is a direct correlation.

Third and last, Mr. Chairman, we will ensure that providers who violate the rights of the mentally ill will be held accountable. And this underscores Senator Lieberman's comments of the abhorrence with which we read these stories and find out what happens to these people, particularly again on children.

My bill, this bill rather, will amend the protection in advocacy for mental ill individuals, so that the state advocacy systems are specifically granted the authority to investigate and prosecute deaths and serious injuries resulting from improper restraint and seclusion use. It will also require mental health care providers to notify their state's protection and advocacy organization of all the deaths that occur in their facility, at their facilities. It is incredible to me in 1999 that that has not been required, that only three states have any standards in this area at all.

And last, we grant the Secretary of Health and Human Services the authority to end any federal funding for mental health care providers that violate the protections that this bill would establish. We think that alone may have the greatest impact in getting the kind of compliance that is necessary.

Again, Mr. Chairman, we thank you immensely for your interest in this, Senator Harkin's interest, confident in this session of Congress we can get some good work down in any area that cries out for attention.

PREPARED STATEMENT

Senator SPECTER. Thank you very much, Senator Dodd, for that important statement. And thank the two of you gentlemen for your leadership. This subcommittee will be picking it up, and we will obviously have the important funding responsibilities on this enormously important matter.

Thank you very much.
Senator DODD. Thank you.
Senator LIEBERMAN. Thank you.
[The statement follows:]

PREPARED STATEMENT OF SENATOR CHRISTOPHER J. DODD

I want to begin this morning with a brief story that may illustrate why we are here. On March 22, 1998, in Portland, Connecticut, 11 year old Andrew McClain—4 feet 6 inches tall and weighing 90 pounds—was held down by two staff members of a psychiatric hospital because of a disagreement over where he would sit for breakfast. His chest was crushed and he died as a result. The death of Andrew, like those of more than 140 mental patients around the country cited in a Hartford Courant series, was tragic and preventable.

That is why we are here today—to help make sure that no family ever has to bury another Andrew McClain. Thank you Senators Specter and Harkin for convening this morning's hearing and for examining the national tragedy that these deaths represent. As Senator Lieberman mentioned, the bills that we've introduced recently differ in various respects. But, taken together, they share a common core: they create tough new limits on the use of potentially lethal restraints—be they physical or chemical in nature; they set rules for training mental health workers; and they increase the likelihood that a wrongful death of a mental health patient will be investigated and prosecuted—not ignored.

The legislation I introduced contains these core provisions. Let me go into them with a bit more detail.

First, we will set standards for restraint and seclusion use

Physical and chemical restraints may only be used when a patient poses an imminent risk of physical harm to himself or others. We also require a physician's written order specifying the length and circumstances under which restraints may be applied. No longer will the use of restraints for reasons of discipline, punishment, or convenience be tolerated.

As Senator Lieberman mentioned, we will extend to the mental health population an existing standard enacted as part of the 1997 Omnibus Budget and Reconciliation Act that has already proven effective in reducing the use of restraints in nursing homes.

Second, we will ensure adequate staff training and staff levels

Mental health aides are consistently the least-trained and lowest-paid workers in the health care field. Only three States—California, Colorado, and Kansas—license aides in psychiatric facilities. While individual States or facilities may set their own standards, there are no uniform or minimum training standards for mental health care workers.

My bill will help ensure adequate staffing levels and appropriate training for staff of facilities that serve the mentally ill. Specifically, my bill requires the Secretary of Health and Human Services to set regulations requiring mental health providers to adequately train their staff in the correct application of restraints and their alternatives and to ensure that appropriate staffing levels are maintained.

As a staff person with 23 years of experience was quoted in the Courant series, "Every time we've had a downsizing of staff, we've had an increase in restraints and seclusion." This provision will ensure that restraint use is not as result of staff shortages or inadequate training.

Third, we will ensure that providers who violate the rights of the mentally ill will be held accountable

My bill will amend the Protection and Advocacy for Mentally Ill Individuals Act (PAMII), so that State advocacy systems are specifically granted the authority to investigate and prosecute deaths and serious injuries resulting from improper restraint and seclusion use.

My legislation will also require mental health care providers to notify their State's Protection and Advocacy Organization of all deaths that occur at their facilities.

My bill will also grant the Secretary of Health and Human Services the authority to end any Federal funding for mental health care providers that violate the protections the bill establishes.

As the Courant's series mentioned, we regulate the size of eggs, how our pets may be groomed, how manicurists are trained, yet we have not established a standard of care for some of our most vulnerable citizens. The legislation Senator Lieberman

and I have introduced offers a significant step toward protecting those who may not be able to protect themselves.

It is regrettable that it took the deaths of so many innocent victims to stir Congress to act. I can think of no higher priority for this Congress than the enactment of this important legislation. Such legislation is an attempt to carve something of value and meaning out of the tragedy of more than 100 restraint related deaths.

REMARKS OF SENATOR TOM HARKIN

Senator SPECTER. Before calling on the ranking member, may I ask the next panels to come up?

Senator HARKIN. I just want to thank both Senator Lieberman and Senator Dodd. And please also take back our gratitude to the Hartford Courant for doing a great series of articles. This never would have come to light if they had not done an extensive investigative reporting on it. They deserve some prize for that. I do not know what they give out, but they deserve a prize.

Senator DODD. Well, the Hartford Courant won a Pulitzer today but on another subject matter.

Senator LIEBERMAN. We are going to give them the Harkin prize.

Senator HARKIN. Whatever it is. Something more meaningful than that.

Senator SPECTER. Now before calling on our distinguished ranking member, let me ask the two panels to come simultaneously, Dr. Allen, Dr. Mohr, Mr. Rogers, Dr. O'Leary, and Mr. Harmon, so we can expedite the hearing.

Now it is my pleasure to call on the distinguished ranking member, Senator Harkin.

Senator HARKIN. Thank you very much, Mr. Chairman. And thank you for calling this most important hearing.

You know, as often as we are involved in these issues, sometimes things just sort of slip by. You know, we have so many things on our plate to pay attention to. And I just must tell you, as the author of the Americans with Disabilities Act, I take a particular interest in this issue. And I am amazed at how much I am now learning that I did not know about it before. And that is an indictment of myself for not being more cognizant of this issue. And again, I am really grateful to the Hartford Courant for the series that they have done on this.

When I think about this, I think of young Chris Campbell from the State of Iowa, my home state, 13 years old, weighed 90 pounds. In the last 24 hours of his life, he was physically restrained 4 times by staff. During the fourth time, he died.

Again, he is an example of one of the major findings by the Hartford Courant that younger people with mental disabilities are the group that is most vulnerable to abuse and death caused by the inappropriate use of restraints.

I especially want to thank Jean Allen and Joseph Rogers for coming forward today to tell their personal stories. Mrs. Allen, I was sorry to learn that your adopted son, Tristan, died while being restrained by staff. And Mr. Rogers, I know that your past experience of being placed in restraints will be enlightening to all of us. And I commend both of you for the courage that you have to come forward.

So again, Mr. Chairman, this is an issue that, again, sitting here, I do not know exactly what we have to do. But when I found out

that only three states have licensing and standard requirements, something is wrong out there. And I think we are going to have to take a really serious legislative look at what we need to do in this area. And I hope through this hearing, Mr. Chairman, that we will get a better idea of exactly what we ought to be doing legislatively on this thing.

Again, I thank you for bringing us together for this very, very important issue.

Senator SPECTER. Thank you very much, Senator Harkin.

NONDEPARTMENTAL WITNESSES

STATEMENT OF CATHERINE JEAN ALLEN, Ph.D., GREENSBORO, NC

Senator SPECTER. We now turn to our first witness, Dr. Jean Allen, who combines a professional standing with this issue. A Ph.D., in human development, family studies from the University of North Carolina, Greensboro, and tragically lost her 16-year-old son, Tristan Sovern, last year when 7 staff members of a private psychiatric facility restrained him face down, wrapped a bed sheet around his head, resulting in his death, the official cause ruled suffocation, and is a very poignant and striking example of the excessive use of restraints resulting in a death and a great tragedy.

Thank you for joining us, Dr. Allen, and we look forward to your testimony.

Dr. ALLEN. Thank you, sir.

I speak with you as the mother of a 16-year-old who died needlessly. His picture is up here. He is the child on the top row, far right. A child who should have been finishing his junior year in high school and looking forward to fulfilling his dream of earning his diploma as part of the class of 2000.

Our son was hospitalized for a severe depressive episode. On the morning of his sixth day, my husband and I attended his discharge planning meeting. At 10:30 p.m. that night, he was dead. In the days and weeks that followed, the gruesome nightmare of his death began to unfold. There was a restraint and a seclusion, the second one in 2 days. Mouth coverings were used both times. In the second occasion, not one, but two, a large towel plus a bedsheet.

Seven staffers took part in the take-down, meaning that Tristan was brought down to the floor face down, arms crossed across his chest, staffers at both of his sides, his feet, his hips and at his head.

He went through a similar ordeal the night before when, after becoming agitated, he asked to leave a therapy session. And as he got up to leave and brushed by a staff person, he was taken down right outside the door to the therapy room and placed in seclusion in restraints. It is not clear exactly how long he was in restraints that night. It may have been longer than 3 hours. We were never notified of this intervention.

We learned from the staff that Tristan's body went limp during that last restraint. When that happened, no one removed the mouth coverings nor checked to see if his airway was blocked. He was carried face down, down a long hallway to a seclusion room, placed on a bed face down, and his feet were strapped to the foot of the bed. No one removed the mouth coverings. Still no one assessed his breathing status.

Someone finally thought to call his name. He did not respond. The mouth coverings were still held in place. The ankle straps were unbuckled, his body was turned over, and the mouth cov-

erings were finally removed. CPR was unsuccessful, and Tristan was dead. The official cause of death, asphyxiation.

Hospital reps cited this death as an unfortunate incident. They stood by their actions, stating the facilities policies and procedures had been followed. In the multiple investigations that ensued, several staffers stated that this type of restraint with mouth coverings was used approximately 85 to 90 percent of the time, especially during interventions with adolescents.

When asked to produce the manual that outlined the use of mouth coverings, the facility could not. Later, facility reps stated that the unwritten policy had "just evolved over the course of the last five years." Staffers reported that they were never specifically trained when or how or how not to use mouth coverings, nor were the risks of using such a procedure covered during staff trainings. As a part of their damage control, the facility bought several one-page newspaper advertisements, one of which declared "a lack of national standards." And they capitalized on their JACHO accreditation with commendation.

Something is very wrong with this picture. And children, adolescents and adults are paying with their lives. It is crystal clear that these tragedies have been allowed to occur in part because there are no national standards preventing this type of abusive restraint and seclusion. It is equally clear that the current accreditation and monitoring process is woefully inadequate. Requirements for staff training must be established. Accountability must be mandatory. And enforcement must have teeth.

Facilities must document the specific details of every intervention. Data should be verified by patients, patients' families, or other involved persons. All patient deaths and serious injuries should be reported and thoroughly investigated. We must have in place an independent, empowered system of advocacy for these vulnerable patients.

Too many emotionally vulnerable and behaviorally disordered children and adults have already died. But of those healthy, normally developing children and adolescents who find the circumstances of their lives too difficult to handle and who begin to act out, who go into depressions, and whose families seek out professional help? What of those who go through this type of therapy and live through it?

As a last effort, when all other alternatives have failed, proper, controlled restraint in certain emergency situations may protect an individual, but being manhandled and treated with disrespect and inhumanity leaves individuals scarred.

Internalized feelings of anger, rage, abandonment and worthlessness are added to their already compromised coping mechanisms, making them even more vulnerable and emotionally broken. We must seriously examine the benefits of routine physical intervention against the high cost that patients are paying.

PREPARED STATEMENT

Today I urge the members of the 106th Congress to stand up and let your voices be heard for the rights of those who have no voice. Stand up and speak out for the children of the United States and their families. The Patient Freedom from Restraint Bills are a first

step to making the United States a leader in the human rights mission. How can we demand adherence to human rights standards of other countries, if we do not take a stand for human rights here in America? Our children are depending on us.

Thank you.

Senator SPECTER. Thank you. Thank you very much, Dr. Allen, for sharing with us this tragedy and for your very thoughtful recommendations.

[The statement follows:]

PREPARED STATEMENT OF CATHERINE JEAN ALLEN

As I appear before you today, I speak with you first as a mother of a child who died needlessly. A child who should have been finishing his junior year at a local high school now and looking forward to fulfilling his dream of earning his diploma as a part of the class of 2000. I also speak with you from a professional stance as I hold a Ph.D., in Child Development and Family Studies.

On the morning of March 4, 1998, my husband and I attended a discharge planning meeting at a private psychiatric facility where our son, Tristan, had been for the previous 6 days. He was hospitalized for a severe depressive episode and he, his therapist, and we felt he needed constant, close supervision while his medications could be assessed and changed if needed. At 10:30 that night, Tristan was dead.

Within 24 hours the coroner reported to us that there was no physiological reason for our son's death. Our initial thoughts that perhaps he had had some unexplainable heart attack or brain aneurism were erased. Within the days and weeks that followed the gruesome nightmare of the circumstances of our son's death began to unfold.

First, there had been a restraint and a seclusion, the second one in two days. Mouth coverings had been used both times to prevent biting. On the second occasion—not one, but two: a large towel, plus a bed sheet. On the evening Tristan died, seven staffers had taken part in the take-down, meaning that Tristan had been brought down to the floor face down, with arms crossed across his chest; staffers at both of his sides, his feet, his hips, and at his head.

None of us can really know how frightened and panicked he must have been, because he had been through a similar ordeal the night before. After becoming agitated, he had asked to leave a therapy session, and as he got up to leave and brushed by a staff person, he was taken down outside the door to the therapy room and placed in seclusion in restraints. It is not clear exactly how long he was kept in restraints that previous night. Nursing notes were vague indicating that he was restrained and put in seclusion during evening group therapy which usually occurred around 7:30 PM. The 11:00 PM nursing note indicated that he was no longer pulling at the restraints around his wrists. This was Tristan's "therapy" because he asked to leave a session. We were never notified of this intervention. I ask you to consider what it accomplished, other than instilling fear, anger, distrust, and rage?

We learned from the staff that Tristan went limp during the restraint which took place in his hospital room on the evening of March 4. When that happened, no one removed the mouth coverings, nor checked to see if his airway was blocked.

He was carried face-down, down a long hallway to a seclusion room, placed on a bed face-down, and had his feet strapped to the foot of the bed. No one removed the mouth coverings; still no one assessed his breathing status.

Someone finally thought to call his name; he did not respond. The mouth coverings were still held in place.

The ankle straps were unbuckled, his body was turned over, and the mouth coverings were finally removed. CPR was unsuccessful. Tristan was dead.

Official cause of death—asphyxiation.

The reason for the episode: another adolescent on the unit reported to a staff member that Tristan had something with which he was going to hurt himself. The small end of what appeared to be a key chain was found on the top of his dresser later. It was not in his possession or even near him at the time of the takedown.

Hospital representatives cited Tristan's death as an unfortunate incident. They stood by their actions stating that the facility's policies and procedures had been followed. In the investigations that ensued by the state of North Carolina Facility Services Division, the Joint Commission on Accreditation of Healthcare Organizations, the Department of Health and Human Services Health Care Financing Administration, and the police, some staffers stated that this type of restraint with

mouth coverings was used approximately 85–90 percent of the time, especially with adolescents who were being placed in therapeutic holds and/or transported to the seclusion/restraint room.

When asked to produce the portion of the Policies and Procedures Manual, that outlined the use of mouth coverings during holds and restraints the facility could not. Later facility spokespersons stated that the procedure had "just evolved over the course of the last 5 years." As a part of their damage control, the facility bought several one-page advertisements in the local newspaper, one of which declared that "there are no national standards . . ." The advertisement also touted that the facility "was accredited with commendation—the highest award possible—virtually the entire decade." It further stated that on their last JACHO evaluation, the hospital had received a 96 out of a possible 100 points. How could this be?

A procedure for using a mouth covering during holds and restraints to alter a patient's behavior did not exist in a written policy manual. Staffers reported that they were never specifically trained when or how to use or not to use mouth coverings. This fact was corroborated by the Director of Nurses who also stated that the risks of using such a procedure were not covered during staff training. CPR certifications were out of date. According to news reports, one staffer who was a part of the restraint team, had twice been convicted of assault charges.

Something is very wrong with this picture; and children, adolescents, and adults are paying with their lives. It is crystal clear that these tragedies have been allowed to occur simply because there are no national standards preventing this type of abusive restraint and seclusion practice. It is equally clear that the current accreditation and monitoring process is woefully inadequate. Requirements for staff training must be established, accountability must be mandatory, and enforcement must have teeth! We must have in place an independent, empowered system of advocacy for these vulnerable patients.

This system must be federally mandated to receive reports of deaths and injuries occurring in all facilities so that appropriate investigations and corrective action can be instituted. There also must be adequate funds devoted to this effort to ensure that we eliminate these practices. The current nationwide protection and advocacy system is the appropriate vehicle for this task.

I believe that restraints should only be used as a last resort—only to insure the immediate safety of the patient or others. Restraints should be used only under a physician's written order, and in the least restrictive manner possible. Facilities must document the specific details of every intervention, but also be required to provide evidence of treatment planning to reduce the need for the use of restraint and seclusion in the future. These data should be verified by patients, patients' families, or other involved persons. This information should be made available to the protection and advocacy agency in each state, so that the agency can investigate and correct systemic abuses. Also, stricter, universal guidelines for the training of staff must be established.

Finally, accountability must be mandatory. Evaluators must take an active role in the assessment process which leads to accreditation of facilities that care for people with mental illness, emotional and behavioral disorders, chemical dependencies, and/or developmental disabilities. Evaluations must be rigorous, frequent, thorough, and unannounced.

Patients and their families should not have to be fearful of neglect and abuse in the name of therapeutic intervention. Inhumane treatment and disrespect for patients as human beings can no longer be allowed to be masked under the guise of a facility's offer of "compassionate, quality, state of the art care."

Too many emotionally vulnerable and behaviorally disordered children and adults have already died. But what of those healthy, normally developing children and adolescents who find the circumstances of their lives too difficult to handle and who begin to act out, who go into depressions, who struggle with chemical dependencies and whose families seek out professional help at some public or private facility, clinic, hospital, or treatment center?

We have begun to identify those who have not survived restraint and seclusion: Tristan Sovern, age 16; Andrew McClain, 11; Mark Draheim, 14; Edith Campos, 15; and Timithy Thomas, 9; and all the others identified by the staff of the Hartford Courant in their investigative probe of last October. But what of those who go through this type of "therapy" and live through it? As a last effort, proper, controlled restraint in certain circumstances may protect individuals, but being manhandled and treated with disrespect and inhumanity will leave these people scarred. Internalized feelings of anger, rage, abandonment, and worthlessness are added to their already compromised mechanisms making them even more vulnerable and emotionally broken. We must seriously examine the benefits of this type of routine physical intervention against the high costs that patients are paying.

A young girl wrote to me after Tristan's death. She had been hospitalized at the same facility as my son. She was 15, an A/B student, an athlete, who found herself, even with the support of her family, having severe difficulties navigating the road of adolescence. She was involuntarily hospitalized after going in for a therapy session. She was placed in the seclusion room and spent the night huddled on the floor in the dark wondering if her parents still loved her and if they would ever come to get her out of this place.

She told me that I must never give up on speaking out for the rights of children like Tristan, and like herself, for all the children. She wrote that I was the only voice some of them had, perhaps their only hope.

Today I urge all of the members of the 106th Congress to stand up and let their voices be heard for the rights of those who have no voice. Stand up and speak out for the children of the United States and their families. The Patient Freedom From Restraint Bills are a first step to making the United States a leader in the human rights mission. How we can demand adherence to human rights standards of other countries if we do not take a stand for human rights here in America? Our children are depending on us.

STATEMENT OF WANDA MOHR, Ph.D., ASSISTANT PROFESSOR OF NURSING, UNIVERSITY OF PENNSYLVANIA

Senator SPECTER. We now turn to Dr. Wanda Mohr, professor and course director of psychiatric mental health nursing at the University of Pennsylvania School of Nursing. Dr. Mohr is national co-chairperson for research and education for the Association of Child and Adolescent Psychiatric Nursing.

Welcome, Dr. Mohr.

Dr. MOHR. Thank you.

Senator SPECTER. Thank you for joining us, and the floor is yours.

Dr. MOHR. Thank you.

As a nurse, I am here to tell you that restraints and seclusion are the most draconian methods of patient control. I have seen them used, and I have broken up situations that could have turned potentially tragic.

Imagine what it must be like to be 12 years old, alone, frightened by voices in your head, not understanding what is happening, and having 6 to 8 big people surround you, yell at you to calm down.

When you try to run away or defend yourself against these monsters gathered around you, they lunge at you and pin you to the floor. You cannot breathe, and you tell them. But they pay no attention. After all, you are crazy. They dismiss your complaints by saying that you are being manipulative. And then things begin to go black.

At worse, you die calling for your mommy and for help that never comes. At best, they carry your little body to a bare room, strap you to a bed spread-eagle, pull down your pants, inject you with drugs, and leave you alone with the horror for hours at a time. This scenario plays itself out repeatedly in psychiatric hospitals across this country.

I am an active member of the National Alliance for the Mentally Ill, the nation's largest grassroots voice on mental illness. On March 25, NAMI released a summary of reports of abuse received since the October Courant series. Over 5 months, five new deaths have occurred, four were youths under the age of 8. One was a 9-year-old boy. And those are only the ones that we know about. Five deaths in 5 months.

As you consider this proposed legislation, please think about how many more may die unless you act. I am someone who has had a

family member with severe and persistent mental illness. I am a consumer myself, and I have years of clinical and now academic nursing experience. From all of these perspectives, I feel competent to talk about some reasons why restraint situations go out of control and to give my opinion as to what can be done.

No. 1, seclusion and restraints are psychiatric conventions, rather than interventions that are based on foundations of research. The use of any therapeutic intervention, such as medication or surgery, in health care should be based on solid scientific data. This does not happen with restraints.

Lack of meaningful oversight. Hospital accreditation and inspection is little more than a check of appropriate paperwork. I have been through many such inspections. And frankly, the representation of reality by an adequately completed form is problematic. There is absolutely no evidence that what was written actually happened.

Lack of staff education and training. The level of employee dealing directly with the most vulnerable patients are the ones with the least amount of education. There is a pervasive attitude in this field that anyone can take care of psychiatric patients, especially in the case of children. We have special standards for staff members working in critical care or emergency units, but not in psychiatric settings.

As much as critical care units, the acute care units of psychiatric hospitals are equally complex and require special training and education, especially today when the patients that we are seeing are the sickest of the sick.

I have made a number of recommendations in my written testimony. And in the interest of time, what I would like to do is to ask you to enter them into the record.

Senator SPECTER. They will be fully made a part of the record, without objection.

PREPARED STATEMENT

Dr. MOHR. OK. So in the interest of time, I will defer to Mr. Rogers, because my recommendations are all those that are in the legislation. And I thank you very much and offer myself to any questions that you might have.

Senator SPECTER. Thank you. Thank you very much, Dr. Mohr.

[The statement follows:]

PREPARED STATEMENT OF WANDA K. MOHR

As a nurse I am here today to tell you that restraint and seclusion are the most draconian methods of patient control in mental health settings. I've seen them used, and I've broken up situations that could have turned into potential tragedies.

Imagine for a moment, if you will, what it must be like to be 12 years old, alone, frightened by voices in your head, not able to understand what is happening, and having six to eight big people surround you and yell at you to "calm down." When you try to run away or defend yourself against the monsters gathered around you, they lunge at you and pin you to the floor.

In the worst-case scenario you can't breathe and you tell them. But they pay no attention—after all, you're crazy. They dismiss your complaints by telling each other that you're being manipulative. And then things begin to go black.

In the worst-case scenario, you die, calling for your mommy and for help that never comes. In the best-case scenario, they carry your little body to a bare room, strap you to a bed, spread-eagle, pull down your pants, inject you with drugs, and

leave you alone with the horror—for hours at a time. This scene is replayed over and over again in psychiatric hospitals across this county.

I am an active member of the National Alliance for the Mentally Ill, the nation's largest, grassroots voice on mental illness. As someone who had a family member with severe and persistent mental illness, and being a consumer myself as well as someone who has years of clinical and now academic nursing experience, I feel uniquely situated to speak to the issue of restraint.

Last year, NAMI members in Connecticut played a critical role in getting the Hartford Courant to investigate the use of restraint in psychiatric facilities—which led to publication of the series that documented 142 actual deaths around the country over a decade and that commissioned a Harvard University report that estimated between 50 and 150 deaths annually as a result of restraint.

On March 25th, NAMI released a summary of reports of abuse received since the Hartford Courant series was published in October. Over 5 months, five new deaths occurred. Four were youths under the age of 18. One was a 9-year-old boy. And those are only the ones we know about.

Five deaths in 5 months.

As you consider the issue, please think about how many more may die.

Unless Congress acts.

I am here today to speak to how and why restraint situations go out of control and to give my opinion about what can be done to alleviate this problem. In the interest of brevity I have bulleted my list so that it can be easily perused by this committee, and I will read some of those. I do ask that my entire testimony as submitted be entered into the congressional record.

SECLUSION AND RESTRAINT ARE PSYCHIATRIC CONVENTIONS RATHER THAN INTERVENTIONS BASED ON A FOUNDATION OF RESEARCH

Therapeutic interventions should promote, maintain, or restore health or at least prevent further illness from occurring. The use of any therapeutic intervention in a clinical setting should be based on solid scientific data. To date we have very scant research concerning the effectiveness or the effects of restraint use on patients and no research on the effectiveness of alternate ways of managing aggressive or violent behavior (Walsh & Randell, 1995). Placing a patient in restraints remains an unquestioned and accepted ritual of practice despite recognition by the psychiatric community that it is governed by consensus rather than research (Rubenstein, 1983; Goren, 1991; Goren & Curtis, 1997).

LACK OF MEANINGFUL OVERSIGHT

Based on my experience as a practitioner, hospital accreditation and inspection is little more than a check of appropriate paperwork. I have been through many such inspections and quite frankly the representation of reality by an adequately completed form is problematic in that there is no evidence that what was written actually happened.

Visits are announced. Knowing weeks in advance of a JCAHO visit, hospital administrators will often assign additional staff and arrange for "charting parties" in which paper work is cleaned up and brought into compliance with standards. This practice was reported and documented repeatedly during the investigation of the abuses conducted by the state of Texas and former Representative Patricia Schroeder's investigation of those abuses (U.S. Government Printing Office, 1992). Reports from my colleagues who still practice in clinical settings raise serious doubt that much has changed with respect to this kind of creative record-keeping.

There are no penalties for non-compliance. At worst, even in the event that accreditation is denied, hospitals do not necessarily suffer ill consequences.

Years ago, we in health care relied on paperwork and asking other professionals about the efficacy of "pain control." We finally woke up to the fact that the patient is the one who should be asked. While it seems commonsensical to ask the patients and families—the experts in their own experiences—for their opinions, inspectors do not independently meet with patients and families to ask about their hospital experience. The mentally ill still have no credibility. This puts the onus of "proof" on the very people who are in a position to alter reality.

NO PROCEDURAL CONSISTENCY

Procedures, standards and regulatory statements on restraint use vary from document to document and from institution to institution. Definitions of assault and violence are loose and articulated in the vaguest of terms and subject to interpretation (Rice, Harris, Varney, & Quinsey, 1989; National Research Council, 1993).

Standards and regulatory documents are based on a number of unspoken assumptions that are not true, and I could be here for many hours outlining and debunking them. But I will focus on a single example—the assumption that staff members are adequately trained and educated in the care of vulnerable individuals and that they can de-escalate potentially explosive situations. In fact, research conducted by nurses reveals that nurses' aides are not cognizant of available alternative techniques to restraint (Neary, Kanski, Janelli, Scherer, & North, 1991). Over 70 percent of these same aides had attended an inservice on the subject one year prior to this study.

Moreover, so far as I know, procedures for seclusion and restraint are developed for the most part without consumer input. Their development is driven by external experts rather than the real experts—the patients.

Standards and regulatory guidelines are written by persons who are not involved in the decision to employ the restraints. Psychiatrists issue guidelines and write orders for the use of seclusion and restraint in the abstract. In general they are rarely involved in observing the incidents that lead up to the necessity for such intervention. They have little day-to-day experience with the cycle leading to the intervention and therefore are not in a position to monitor, nor help to prevent and reduce their use. Therefore, they don't really see this issue as the problem that it is—it simply is not part of their reality.

LACK OF STAFF EDUCATION AND TRAINING

The employees dealing directly with the most vulnerable patients are the ones with the least education. This has been the case throughout history, and there is ample documentary evidence that speaks to this problem (Perrow, 1965; Goffman, 1961; Morrison, 1990).

There are fuzzy requirements for education and training, which seem to be mostly voluntary. One of the first things to be jettisoned when money gets tight are staff-development activities (Braxton, 1995). Because training and on-going education are not universally required, they are considered a luxury more than a necessity.

There is a pervasive attitude that anyone can take care of psychiatric patients, especially in the case of children. We have special standards for nursing staff who work in critical care or emergency areas, but no such standards in psychiatric settings. As much as critical care units, the acute care unit of a psychiatric hospital is a complex milieu with a very difficult population whose brains can feel as though they are "on fire." This is a situation requiring special training and education, especially today when the patients that we are seeing are the sickest of the sick.

There is a lack of developmentally appropriate programming for patients. This was another problem that was explored in the National Medical Enterprises investigation of the early 1990's. Here I would have to reference my own work because almost nothing has been written or researched about this topic by any one else. Children of varying ages are mixed with everyone else receiving the same "interventions" for the same periods of time. Four-year-olds do not have the same capacity for attention as 14-year-olds, yet they go to 50-minute groups. When they act in a developmentally appropriate way, by whining or acting up, they are punished and a cycle of aggression is set up (Goren, Singh, & Best, 1993).

There are too few nurses with too little education. Nurses are costly; thus the actual number of registered nurses is cut to the bare minimum in the interest of profits. Moreover, the education of nurses is in and of itself a problem. The majority of nurses (64 percent) do not have even a baccalaureate degree (U.S. Dept. of Health & Human Services, 1996). Thus, a two-year, associate-degreed registered nurse may have 7 to 10 days of exposure to psychiatric content. A four-year baccalaureate-degreed nurse has considerably more, but even he/she is a generalist. I teach an extremely bright cohort of young people in a baccalaureate program, and believe that I do so quite competently. Yet I do not believe that the time spent with me qualifies them to work with such a complex population.

Staff turnover has been repeatedly correlated in the literature with incidents of violence (Rice, Harris, Varney, Quinsey, 1989). Staff turnover results from poor pay, poor working conditions, and high levels of stress and frustration due to both a very challenging population and the lack of skills needed to work with that population (Braxton, 1995).

A PSYCHIATRIC CULTURE THAT IS IN SERIOUS NEED OF SELF-REFLECTION AND REFORM

Despite much progress in psychiatry and an insistence that psychiatric illness is brain illness, many psychiatric professionals still want to play under a different set of rules than their colleagues in other specialties. A situation in which a restraint takes place is an acute psychiatric emergency that is analogous to any other emer-

gency in medicine, and it should be handled by medical personnel as such. A cardiologist would not dream of relegating the assessment of his/her patient to a staff member after such an event. They would grumble and roll themselves out of bed to do what they are responsible for doing—assess the patient. Yet during this debate psychiatrists have resisted our suggestions that they subscribe to the same standards of practice.

Resistance to advocacy groups is common. My experience has been that with many nurses and psychiatrists there is a general attitude that advocacy groups are a nuisance and that they make life more difficult for both groups.

Resistance to shared decision-making and a participative model of care is also common. Nurses and MD's resist consumer input and the input of their families, even though the families are the repositories of the best information about interventions that may help in treatment. They are reluctant to give up any power to families and patients as the ontological arbiters of what is "normal." Patient's (and their families') experiences are discounted and considered lacking in credibility. Historically we have learned little from Rosenhan's (1973) work in which he observed that psychiatric staff members "keep to themselves, almost as if the disorder that afflicts their charges is somehow catching." (p. 254)

I've made a number of recommendations in my written testimony, but I'd like to highlight just a few today.

—Identify, evaluate, and implement promising practices while we conduct clinical research studies into theory and intervention.

—Back research agendas on this issue. Funds to specifically study restraint use, misuse and best practices must be allocated to agencies such as NIMH (National Institute of Mental Health), NIJ (National Institute of Justice), and NINR (National Institute for Nursing Research).

—Insist on greater physician accountability and involvement.

—Mandate unscheduled oversight by independent agencies/persons that goes beyond exercises in paperwork that is not announced ahead of time.

—Require systematic reporting of restraint/seclusion incidents to an independent agency.

—Mandate reporting of sentinel events such as injury and death.

—Develop consistent standards for restraint use that are patient- and not staff/physician-focused, and include consumers in the development of these standards. Base such standards on the concept that restraints may only be used for emergency safety situations.

—Mandate staff orientation and ongoing education and training that is fully documented. The literature provides considerable support for the idea that significant reductions in institutional violence could be achieved by a staff training program aimed at teaching non-restrictive and non-authoritarian ways of interacting with residents.

—Increase standards for those who can be hired to work with psychiatric patients. For example, nurses should be certified and have advanced training, and aides or mental health technicians should have a high school education and special training and education in the care of psychiatric populations.

—Insist that patients and their families are given free access to members of advocacy groups and that the telephone numbers of advocacy groups be prominently displayed in the living areas of each facility and also given individually to each patient upon admission.

—Provide protection from retaliation to staff members for their advocacy efforts on behalf of patients.

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STATEMENT OF JOSEPH ROGERS, EXECUTIVE DIRECTOR, MENTAL HEALTH ASSOCIATION OF SOUTHEASTERN PENNSYLVANIA, NATIONAL MENTAL HEALTH ASSOCIATION

Senator SPECTER. Thank you for observing the time limit.

We now turn to Mr. Joseph Rogers, executive director of the Mental Health Association of Southeastern Pennsylvania and of the National Mental Health Consumer Self-Help Clearing House. Mr. Rogers brings both professional and personal insights into this issue, having first-hand experience with restraints during his own hospitalization for mental illness.

We appreciate your sharing with us your own private experiences, Mr. Rogers. Thank you for joining us, and the floor is yours.

Mr. ROGERS. Thank you, Senator Specter and Senator Harkin. On behalf of the Mental Health Association, the National Mental Health Association, I really want to congratulate you on having this hearing.

I, too, have extensive remarks that I hope can be entered in the record.

Senator SPECTER. They will be made a part of the record in full.

Mr. ROGERS. But briefly, as an advocate, as well as someone who has survived being put in seclusion in restraints, I am deeply concerned about this deplorable practice. My knowledge of the subject was gained first hand. One of my worst experiences was in a private hospital in Florida. I had been brought into the emergency room from a halfway house on a Friday evening. Although I was fairly subdued, I was taken to a room with thick, opaque glass doors and strapped to a platform in five-point restraints.

These are the kinds of restraints that they use in restraining someone. You get two across the arms around the restraints on the platform, two across on the legs and——

Senator SPECTER. That one is not quite big enough for you, though, is it?

Mr. ROGERS. They get them bigger. They have them big.

There were two each on my wrists and ankles and around and across my chest. No sound penetrated the room, which contained nothing but the platform to which I was strapped. Over the next 2½ days, I was psychotic and hallucinating and in and out of consciousness. I was left alone to lie in my urine and excrement until someone came to clean me up once.

When the regular staff replaced the weekend staff on Monday, they found me filthy and dehydrated. They were shocked and kept saying that I must have done something to warrant such treatment. But I did not know what I had done.

This may sound extreme, but I have heard many similar stories. What can be done to stop the abuses we see every day in the use of restraints? One, we must move away from institutions toward community-based treatment. We must safeguard the rights of people in institutions. The effort to protect people's rights is central to Pennsylvania's move toward the elimination of seclusion and restraints in its state and private mental hospitals.

I would also like to point out that people with developmental disabilities are also put at risk by the use and abuse of restraints.

I understand that the American Psychiatric Association is claiming that the proposed legislation will have a chilling effect on treatment options and safety issues.

Well, there is nothing more chilling than death. And people are dying as a result of this so-called treatment, which in reality indicates a treatment failure. We must document that failure so that we can make needed changes in our system.

Information on the use of restraints is key. One mechanism for disseminating such information might be under the State Mental Health Planning Act, which requires that every state submit a mental health plan to the Federal Substance Abuse and Mental Health Services Administration. That plan could require information on the use of restraints broken down by state and local hospitals, so that a pattern of usage can emerge.

We must involve consumers and family members and the community in helping develop policies and procedures. We are advocating for a national program of self-advocacy training for consumers of mental health services, because we find that consumers make the best advocates on such issues as the abuse of restraints. This program would be implemented through the protection and advocacy agencies with the assistance of the National Mental Health Association.

PREPARED STATEMENT

As I mentioned, we must move away from institution toward community treatment. In the meantime, people who find themselves hospitalized must be assured of a safe place. Toward this end, we would like to see the days when the last available set of restraints is placed under plexiglass saying "obsolete equipment." We hope proposed legislation takes one step towards that day.

Thank you for your attention.

Senator SPECTER. Thank you very much, Mr. Rogers.

[The statement follows:]

PREPARED STATEMENT OF JOSEPH A. ROGERS

Senator Specter, on behalf of the National Mental Health Association as well as the Mental Health Association of Southeastern Pennsylvania, of which I am executive director, I want to thank you for holding this hearing on seclusion and restraints.

I'm here today because I have survived the experience of being put in seclusion and restraints. As an advocate as well as someone who may need acute psychiatric services in the future, I am deeply concerned about this deplorable practice, which has been responsible for numerous deaths as well as many more instances of trauma in those who have experienced it.

I'm here to testify that massive changes in the system are needed in order to protect the lives of people with mental illness.

—First, we must move away from institutions toward community-based treatment. It has been repeatedly demonstrated that people do better in the community, and that the behaviors that get them in trouble, and into restraints, are a product of conditions in the institution. I've been there, and no one should have to be subjected to those kinds of conditions, where people are crammed into a small room to spend their days with little to engage them. This kind of stress definitely has an impact on behavior. So we need to get people out of the institutions.

—Second, we must safeguard the rights of people in institutions. The effort to protect people's rights is central to Pennsylvania's move toward the elimination of seclusion and restraint in its state hospitals, about which I will provide details later in my testimony. It is my understanding that the American Psychiatric Association is opposing the proposed legislation and is claiming that it will have a chilling effect on "treatment options" and "safety issues." Well, there is nothing more chilling than death, and people are dying as a result of this so-called treatment, which in reality indicates a treatment failure. And we must document that failure so that we can make the needed changes in our system.

—Third, we need to involve consumers, family members and the community in helping develop policies and procedures, and in monitoring this situation. And we need your help: we need federal legislation that mandates that information be gathered and disseminated. And we need to make that information public. Then we must ensure that consumer-run self-help organizations, family organizations, and advocacy organizations such as Mental Health Associations and Protection and Advocacy agencies get the information they need and have the necessary access to monitor this very dangerous practice.

That being said, I am testifying in support of the legislation proposed by Senators Joseph Lieberman and Christopher Dodd and by representatives Pete Stark, Diana DeGette and Rosa DeLauro. We consider this legislation a good first step in regulating the use of seclusion and restraints.

At the same time, it is important to note that the legislation does not go far enough. "Far enough" would mean instituting regulations that would either outlaw the use of seclusion and restraints, or make it nearly impossible to employ them.

In Pennsylvania, our top mental health official, Charles G. Curie, has made it a goal to eliminate the use of seclusion and restraints in state mental hospitals. This goal has already been achieved in one state hospital: for the six months before it closed, as part of Pennsylvania's progressive shift toward community-based services, Haverford State Hospital did not employ seclusion and restraints.

My testimony will cover the Pennsylvania model, as well as my own personal experience with seclusion and restraints. I will also suggest ways that the proposed legislation could be made more effective.

My knowledge of this subject was gained firsthand; I have been repeatedly hospitalized for mental illness and have experienced seclusion and restraints a number of times.

One of my worst experiences was in a private hospital in Florida. I had been brought to the emergency room by ambulance from a halfway house on Friday evening. Although I was fairly subdued, I was immediately taken to a room with thick, opaque glass doors and strapped to a sort of platform in five-point restraints: two each on my wrists and ankles and one across my chest. No sound penetrated the room and, since it contained nothing but the platform to which I was strapped, there was a nearly complete sense of sensory deprivation.

Over the next two-and-a-half days I was psychotic and hallucinating, and passed in and out of consciousness. I remember being given some shots. I don't remember getting anything to eat or drink, although I suppose I must have. I was left alone to lie in my own urine and excrement, until someone came to clean me up, once. Most of the time, I was ignored.

When the regular staff replaced the weekend staff on Monday morning, they found me filthy and dehydrated. They were shocked, and kept asking, "What did you do? You must have done something." I had no answer; I did not know what I had done.

This may sound extreme, but I have heard many similar stories.

Obviously, no one's definition of "best practices" would include my experience in Florida. But, unless restraints are outlawed, there will always be the possibility that inexperienced staff will over-react and violate procedures.

For example, a couple of years ago, when I was left in restraints overnight at a respected private psychiatric hospital in Philadelphia, I was told later that this was "against hospital procedures." Unfortunately, because of chronic staff shortages and other administrative shortfalls, not to mention staff who are punitive or frightened, it seems to be a given that procedures will be violated on a regular basis. "Best practices" may dictate the use of restraints only in extreme cases of risk to the patient or others; but this is not what happens.

In fact, many consumers of mental health services steer clear of going to emergency rooms to seek psychiatric help because of the risk that, if they seem agitated, they may wind up in seclusion and restraints.

Unless any policy statement outlaws restraints or at least makes it nearly impossible to employ them, there is going to be abuse. If you have an inexperienced nurse at midnight who is terrified of the patients, policies tend to go right out the window. By the same token, if you don't have a room equipped with a table to strap people onto, that's the best guarantee that people won't be restrained against policy.

It's also vital to make sure that chemical restraints are not substituted for tables and straps. When I have been heavily medicated to make me "calm down," I have found that the effects can last for weeks.

Educating staff in the use of alternatives to restraints is more important than creating policy to govern the use of restraints, since policy is so often violated.

For the reasons described above and the ones that follow, I fully support the decision of Pennsylvania's top mental health official, Charles G. Curie, to establish the goal of eliminating seclusion and restraints in state hospitals.

First, seclusion and restraint are not treatments; they are treatment failures.

Second, seclusion and restraint are high-risk techniques that may result—and have resulted—in injury or death to the patient, both while the patient is being subdued and afterward. In addition, staff injuries decline in frequency and severity when the need for physical interventions with patients is eliminated.

Third, a high percentage of state hospital patients are trauma survivors, and seclusion and restraint are themselves traumatic, for both patients and staff. Hospitals cannot cause trauma and effectively care for people.

Fourth, the use of seclusion and restraint fosters an atmosphere of staff control over patients rather than the desired treatment partnership.

In 1995, when Mr. Curie assumed his duties as Deputy Secretary for Mental Health in Pennsylvania, he found that there was a relatively high usage of seclusion and restraint in some state hospitals.

With the support of others in the department, he took the first step of redefining the use of seclusion and restraint as a treatment failure, only to be used as a safety measure of last resort, when all other types of intervention have failed. This resulted in clinicians using alternative interventions, and led to a significant reduction in seclusion and restraint in most state hospitals.

The Office of Mental Health thus created an environment in which all staff expect to see a reduction in the use of seclusion and restraint and the risks associated with their use.

This shift in attitude has been accompanied by dramatic changes in policy and procedure, Mr. Curie has reported. For example, the department's Bureau of Hospital Operations has developed a system-wide monitoring tool that measures and compares the incidence and duration of seclusion and restraint in all hospitals. Increased emphasis has also been put on staff training on clinical alternatives to the use of seclusion and restraint, as well as ongoing reinforcement by management of reducing usage at each hospital. Consequently, Pennsylvania has continued to see a substantial reduction in the incidence and duration of use of these techniques.

As Mr. Curie recently said:

"Pennsylvania's experience proves that the use of seclusion and restraint can be eliminated or greatly reduced when there is a treatment environment that focuses on the strengths of the individuals being served; that protects patients' dignity, comfort, and privacy; that promotes constructive interaction and partnership between staff and patients; that eliminates arbitrary ward rules developed for staff convenience; that fosters patients' ability to make choices and have a greater under-

standing of their own behavior; and that involves management and staff in planning how to reduce the incidence of seclusion and restraint.

"The options available today make the elimination of seclusion and restraint an extremely realistic goal. One such option is use of a new generation of antipsychotic medications, which are more effective in reducing the symptoms that lead to aggressive behavior. Clearly, medication should be administered only in the context of a treatment plan in order to relieve symptoms, and not as a chemical restraint.

"Clinicians also have a better understanding of the use of verbal de-escalation techniques to avert physical confrontation. In addition, providing more hours of active treatment and more structure and activity for patients during the day would leave less time for conflicts to erupt between patients and staff."

The Pennsylvania Office of Mental Health and Substance Abuse Services has instituted a standardized, universal risk assessment procedure to help identify people who may exhibit behaviors that could put them at risk of seclusion and restraints, and to target those risks through treatment planning. The objective is to help people learn to manage their anger instead of waiting until a crisis erupts.

After any sort of seclusion or restraint is used—and that is only in the most extreme cases—Pennsylvania policy requires a debriefing so that patients and staff can talk about the incident, figure out what may be learned from it, and use those lessons in the treatment planning process in order to avoid similar incidents. This also allows both staff and patients an opportunity to deal with the trauma associated with their use.

The Office of Mental Health and Substance Abuse Services is establishing a baseline and using that to measure the incidence of seclusion and restraint periodically in each state hospital. And the state plans to share that and other such information publicly. Any licensed entity that provides mental health care—especially those that are publicly funded—must be accountable to the public. That includes accountability about seclusion and restraint.

The legislation that has been proposed in the Senate would keep confidential any investigations and analyses developed in the wake of a death, whereas the legislation proposed in the House would make this information public. In this regard, the House legislation is superior. The only way things can change is if there accountability to the public, and if state Protection and Advocacy agencies as well as citizen advocacy organizations know and can comment on policies, on how those policies are being implemented or are not being implemented, and on whether the incidence of restraint use is reported on a regular basis.

One mechanism might be under Public Law 99–660, the State Mental Health Planning Act, which requires that every state submit a mental health plan to the Substance Abuse and Mental Health Services Administration. The plan could require information on the utilization of restraints. This information should be broken down by state hospital, so that a pattern of utilization can emerge. The advocacy community can then focus their attention in particular on institutions with a high usage of restraints.

As I mentioned above, the effort to eliminate seclusion and restraints has already been successful in at least one state hospital: for six months before Haverford State Hospital closed, there was no use of seclusion and restraints and there was a decrease in the use of medication.

Aidan Altenor initiated the effort to end seclusion and restraints when he was Haverford's superintendent; he credits Deputy Secretary Curie with providing the impetus. He has since been working toward the same goal at Norristown State Hospital, where he now serves as superintendent.

Mr. Altenor described methods, which were successful at Haverford, that can lead to eliminating restraints.

First, as mentioned above, the use of restraints must be re-defined as a treatment failure. As Dr. Altenor said, "This is not a clinical intervention; this is tying you to a bed."

Second, a one-hour limit must be set on the period for which a physician can write a restraint order; the patient must then be reassessed. In Haverford's past, there was no such time limit. Dr. Altenor noted that, at Norristown State Hospital, the nursing staff plays a critical role in determining whether someone needs to remain in restraints for the full time period for which the order was written. That is, a nurse may determine that someone may be released from restraints in 10 or 15 minutes, although the order was for an hour.

Third, when someone exhibits behavior that the staff may consider cause for using seclusion and restraints, staff must attempt to determine what someone is trying to communicate and must ask how the person's treatment plan can be revised to be more responsive to that person's needs.

Fourth, the staff must review with the patient any incident that has led to seclusion and restraints, and must ask what to do if there is a similar incident in the future. This is common sense, it involves listening to the consumer and saying, 'Oh, that's what you want us to do; we can do that.' Often, this is something as simple as going for a walk. Dr. Altenor said that this approach has played a significant role in eliminating the use of restraints for many people.

Dr. Altenor added that when clinicians suspend judgment about what they believe to be the most appropriate clinical intervention and go with what the consumer wants, everyone ends up winning. With patients who are not able to provide straightforward feedback, clinicians must apply critical acumen to translate their messages so that they can respond with more supportive interventions.

It is also extremely important to hold training sessions where all points of view are represented.

At Haverford State Hospital, panel discussions among consumers, family members and professionals were presented. Besides personal testimony, the sessions also included data on what happens when people are in restraints, such as the increased risk of injury to both staff and patients. Prevention was also stressed.

Dr. Altenor said that the most compelling aspect of the sessions was the consumers' stories about how it felt to be in restraints. Many people said that they felt violated, and at the mercy of whoever was walking around in the room. They felt they were being punished for aspects of their illness over which they had no control, adding insult to injury. He said that hearing the consumers' perspective was an eye-opener.

Clearly, the consumer perspective is the most important one. We are advocating for a national program of self-advocacy training for consumers of mental health services, because we find that consumers make the best advocates on such issues as the abuse of restraints. This program would be implemented through Protection and Advocacy agencies with the assistance of the National Mental Health Association.

We would also like to see a requirement for the establishment of consumer/family/volunteer monitoring teams at psychiatric facilities. These teams would serve as a vital ombudsman when situations arise in which restraints may be applied. In Pennsylvania as in many other states, we already have peer advocates working in state hospitals, as well as peer-run drop-in centers in hospitals.

And, as I mentioned at the beginning of my testimony, we must move away from institutions toward community-based treatment.

I would like to talk about two of the individuals whose stories are told in an *amici curiae* brief filed with the U.S. Supreme Court by the National Mental Health Consumers' Self-Help Clearinghouse, of which I am also executive director, and other consumers and consumer organizations. The brief was filed in the *Olmstead* case, which is a challenge to the community integration mandate of the Americans with Disabilities Act.

Both of these individuals—Margaret Donahue and James Price—spent a lot of time in seclusion and restraints when they were residing in state hospitals. As James Price described the conditions: "It was hard living there. I had to stay in a day room and wasn't able to get out. We had a dormitory with eight to ten people. I got in trouble there a lot. They would put me in seclusion and restraints and give me needles."

For the last eight years, however, he has lived in his own apartment in Philadelphia, and he enjoys his freedom. He does volunteer work, goes to the movies, and has his eight-year-old niece over to stay.

Margaret Donahue also spent most of her life in institutions. She now lives in Willow Grove, Pennsylvania, in a house she shares with two other women, both of whom were also patients at the state hospital. The house is a "supported living" residence, with round-the-clock staffing.

In the hospital, she reported, she spent a lot of her time in restraints because of fighting and banging her head. In the community, she has none of those problems. She entertains visitors, and sometimes goes to church. She also does her own housework, and has a part-time job cleaning houses. In her words, "It's better living in my house [than in the hospital]. You can't live in the hospital all your life."

No, you can't. But those people who do find themselves hospitalized must be assured of a safe place. Toward this end, we would like to see the day when the last available set of restraints is displayed in a Plexiglas case, under a sign saying "obsolete equipment." We hope the proposed legislation takes us one step closer to that day.

Thank you for your attention.

STATEMENT OF DENNIS O'LEARY, M.D., PRESIDENT, JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS

Senator SPECTER. We now turn to Dr. Dennis O'Leary, President of the Joint Commission on Accreditation of Health Care Organizations. Dr. O'Leary has served as dean of the Clinical Affairs Unit at George Washington University Medical Center and Vice President of the George Washington University Health Plan.

Thank you for joining us, Dr. O'Leary. We look forward hearing from you.

Dr. O'LEARY. Thank you, Senator Specter.

On behalf of the Joint Commission on Accreditation of Health Care Organizations, I would like to thank you and the other members of the subcommittee for holding these hearings to address the very serious problem surrounding the improper use of physical restraints on patients in psychiatric facilities. We appear here today as a very committed part of the solution to eliminating the occurrence of these tragic events.

Over the past half century, the Joint Commission has made significant contributions to protecting patient rights, enhancing patient safety and reducing restraint use in the nearly 20,000 health care organizations it accredits. Long-standing Joint Commission accreditation standards cover the full range of issues relating to the use of restraints.

These include clinical justification for use, staff training and strategies for limiting the use of restraints. Application of these standards has reduced the use of restraints in accredited organizations.

In 1995, patient safety became a pivotal focus of the Joint Commission's oversight efforts. During that year, we began an intense effort to evaluate restraint-related deaths in accredited organizations as part of a broader initiative to gain knowledge about serious adverse occurrences in the care of patients. This initiative took its origins in the midst of an apparent outbreak of widely publicized, unanticipated serious injuries and deaths.

The existence of these serious occurrences, which we call sentinel events, was a clarion call to the Joint Commission and others that far greater efforts needed to be made to improve the safety and quality of health care.

In this process, the Joint Commission has become the nation's leader in facilitating the identification of sentinel events and working with organizations to reduce the risk of future occurrences and in sharing lessons learned. Today the Joint Commission requires accredited organizations to identify all sentinel events and address their underlying causes. Failure to do so places the organization for risk of loss of its accreditation.

The Joint Commission believes that asking organizations to identify and report unexpected deaths and injuries is the first step in the process of reducing in the incidences of sentinel events. No entity charged with oversight responsibilities can take appropriate action without this kind of information. That reporting responsibility for restraint-related deaths must lie on the organizations where care is being provided.

But if mandatory reporting of restraint-related deaths is a necessity, we must recognize that it will not, by itself, be sufficient in reaching the goal of eliminating these tragic events.

The Joint Commission's board of commissioners has taken the position that the most effective way to reach this goal is to mandate the reporting of restraint-related deaths as part of an oversight framework that also facilitates a no-holds-barred internal self-evaluation process. However, to achieve this objective, these root cause analyses must be protected from public disclosure by federal legislation.

We must emphasize that the creation and sharing of these highly sensitive documents with monitoring agencies will be resisted unless they are afforded a peer review-like protection similar to what the states now have in place for hospital internal quality review.

Early this year, our board of commissioners appointed a new high-level restraint use task force, which will conduct a thorough reevaluation of the Joint Commission's current restraint standards, on-site evaluation process and other means for accessing information about restraint use. That task force is expected to make its final recommendations to the board by the end of this year.

The task force has launched its efforts by initiating a series of public hearings across the country. These hearings are designed to elicit input from the public and other interested parties regarding the current oversight process and what can be done to make it more searching and meaningful.

We are also seeking dialogue with the health professional communities, because we believe that more than just the accreditation process must change. There must also be a significant reevaluation of what are considered acceptable practices and behaviors in providing psychiatric and psychological care.

The reduction of restraint-related deaths and other sentinel events is one of the most important issues facing us today. Again, we applaud the subcommittee's leadership on this issue.

PREPARED STATEMENT

We support and welcome the opportunity to bring together the strength of the public and private sectors to address these issues. And we look forward to working with you in doing whatever is necessary to prevent other deaths from occurring.

Thank you.

Senator SPECTER. Thank you very much, Dr. O'Leary.

[The statement follows:]

PREPARED STATEMENT OF DENNIS O'LEARY

On behalf of the Joint Commission on Accreditation of Healthcare Organizations, I would like to thank Chairman Specter and the other members of the Subcommittee for holding these hearings to address the very serious problems surrounding the improper use of physical restraints on patients undergoing psychiatric or psychological treatment, and I am very pleased to provide our recommendations for appropriate action. We appear here today as a very committed part of the solution to eliminating the occurrence of these tragic events.

There should be zero tolerance for the types of deaths we have all read about in the Hartford Courant series. Many of the 142 patients who died in relation to the use of restraints were children and adolescents. Ms. Allen's testimony about her son is especially heart wrenching and is nothing less than a call to action for all in the

health care system who have not already taken serious steps to change the status quo.

The Joint Commission views this hearing as a major opportunity to begin to build consensus on effective safeguards for reducing the likelihood of restraint-related deaths. This will be a daunting task, for there are few things in health care as challenging as the appropriate management of restraint use. The issues to be dealt with go to the very heart of patient rights, patient safety, and the safety of health care workers. Significant opportunities exist in improving staff training, identifying and sharing best practices, and developing and using effective alternatives to restraints. But the most immediate need is the design of an oversight framework which establishes clear accountabilities, and facilitates learning from each tragedy that occurs without driving the reporting of such incidents underground.

Over the course of its long history, the Joint Commission has made significant contributions to protecting patient rights, enhancing patient safety, and reducing restraint use in the nearly 20,000 health care organizations it accredits. We have had extensive patient rights standards for many years that set clear expectations regarding personal interactions with patients, specify the information patients must be given about their rights, and describe the physical, social, and cultural environments necessary to the effective support of patient care. Joint Commission standards have, as well, delineated requirements for patient safety, while protecting the dignity with which patients are being treated. Professionals in the behavioral health care field can attest to the Joint Commission's pioneering efforts in these areas over the past several decades.

Joint Commission accreditation standards have also had a positive effect on identifying and addressing inappropriate use of restraints. While the organizations we accredit have long evidenced difficulty in fully meeting these standards, their performance has progressively improved in recent years and most behavioral health care professionals would be quick to acknowledge their impact in reducing inappropriate restraint use.

Because of their high visibility and importance, the restraint standards are frequently reviewed and updated in collaboration with expert professionals, advocacy groups and other stakeholders. These standards cover a range of important issues, including clinical justification for use of restraints, staff orientation, and education, and strategies for limiting the use of restraints—and are more comprehensive than comparable standards used by other accreditors, the states or the Health Care Financing Administration (HCFA).

In 1995, patient safety assumed an increasingly prominent role in the Joint Commission's agenda. During that year, we began an intense effort to evaluate and monitor restraint-related deaths in accredited health care organizations as apart of a broader initiative to gain awareness and knowledge about and resolve serious adverse occurrences in the care of patients. This initiative took its origins in the midst of an apparent "outbreak" of widely publicized unanticipated serious injuries and deaths. The importance of this effort to the Joint Commission lay, and continues to lie, in the fact that our accreditation process is fundamentally designed to reduce risk to patients. The existence of these serious occurrences—which we call "sentinel events"—was a clarion call to the Joint Commission and others that more needs to be done to improve the safety and quality of health care.

Since 1995, the Joint Commission has become the nation's leader in facilitating the identification of sentinel events, in working with specific organizations to reduce the risk of future occurrences and in sharing "lessons learned" with other accredited organizations. This has been both an enlightening and sobering experience. The risk of errors is high—an inevitable correlate of the intense human effort involved in patient care, the growing complexity of care, the expectation that care be provided with fewer resources, and other risk enhancing factors—and it appears that a significant number of errors and even sentinel events, are not reported within organizations. There is much to be done.

Today the Joint Commission requires accredited organizations to identify all sentinel events and address their underlying causes. Current policy also encourages the voluntary reporting of sentinel events to the Joint Commission, and where the Joint Commission becomes aware of a sentinel event—either self-reported (80 percent) or through other sources such as the media (20 percent)—the organization is required to perform and make available to the Joint Commission an in-depth analysis of the underlying causes and an appropriate action plan. Failure to do so places the organization at risk for loss of its accreditation. It is the Joint Commission's experience with the sentinel event reporting program that provides us with the unique perspective we wish to share with you today, toward the end of eliminating the types of tragedies that bring us here today.

The most immediate and obvious issue is that the litigious atmosphere in which health care is provided in this country constrains the willingness of accredited organizations to self-report sentinel events and, in a very real sense, to run the risk of self-indictment through sharing their sentinel event analysis with a private sector accrediting body. With these concerns in mind, the Joint Commission sought federal legislation last year to protect these analyses. We were particularly pleased to have our legislative initiative supported by the Leadership of the House of Representives and subsequently passed by the House in last year's Patient Protection Act.

But even stronger medicine is needed to bring these tragic occurrences to the surface and deal with them. Our understanding of the complexities and sensitivities attending effective reporting programs leads us to be very supportive of the mandatory reporting provisions for restraint-related deaths contained in Senators Lieberman and Dodd's Freedom from Restrain Act of 1999 (S.736) which incorporates and expands upon the important strategic concepts in the Patient Protection Act respecting sentinel event reporting. We believe S. 736 would provide the groundwork for a public/private sector partnership that could strengthen the value of voluntary accreditation in promoting patient safety and extend the most successful aspects of the sentinel event program to non-accredited health care organizations participating in Medicare and Medicaid.

REPORTING

Reporting unexpected deaths and injuries is the first step in the process of reducing the incidence of sentinel events. Obviously, no entity charged with oversight responsibilities can act without information. Reporting should be the responsibility of the organizations experiencing the sentinel events, and reporting should be encouraged and rewarded. Creating inventories of serious medical events should not fall by default to investigative reporters. The Hartford Courant series shocked us all by describing the magnitude of restraint-related death over a decade long period. These deaths occurred in a multitude of facilities being overseen by a number of different bodies—the states, through Medicaid or licensure programs; HCFA for all Medicare facilities; local government programs; the Joint Commission, and others. Yet none of us had an accurate compilation of all the restraint-related deaths that occurred under our respective auspices.

Seventeen states have instituted mandatory reporting programs for serious events, but even health officials in Massachusetts—one of the states with the strongest reporting laws in this country—have acknowledged that they rely on the press for most of their information. This is an unacceptable way to get information about the least tolerable outcomes in our health care system. As noted, the Joint Commission's sentinel event reporting system is voluntary rather than mandatory, and restraint-related deaths are the fifth most commonly reported type of sentinel event. With over 400 sentinel event cases now in our database, we are proud of the willingness of so many health care organizations to report and act upon their serious events. Yet regrettably, even our program did not have a record of all of the deaths detailed in the Hartford Courant series that occurred in accredited organizations since 1995.

If we cannot fully rely upon the completeness of reporting systems where they do exist, how do we improve upon the reporting and resolution of these tragic events which have now become a significant public policy concern in health care? The Joint Commission's Board of Commissioners has taken the position that the most effective way to address this need is to mandate the reporting of restraints-related deaths as part of an oversight framework that also facilitates—through protection from disclosure—the collection and review of "root cause" analysis information, from the responsible health care provider organizations, by accountable oversight bodies. These conditions are a *sine que non* for gaining a true understanding of underlying causes and developing appropriate preventive measures for the future.

ROOT CAUSE ANALYSIS INFORMATION

Requiring the conduct of substantive, in-depth analyses for each sentinel event—root cause analyses—is the next critical step to reduce the incidence of restraint-related deaths. This step introduces the critical goal of risk reduction—that is, reducing the likelihood that a similar death will occur for similar reasons in the same institution. Without this key step, reporting becomes the end game, and there is little evidence that mandatory or voluntary reporting of health care sentinel events, by itself, has led to improved patient safety or quality of care. The opportunity for improvements can only be created by a thorough, careful analysis of what went wrong. As noted, Joint Commission accredited organizations are required to perform a root cause analysis after the occurrence of each sentinel event.

"Root cause analysis" is a concept borrowed from the field of engineering. It involves a systematic evaluation of what processes failed and led to an unexpected outcome. In a given case, a root cause analysis would elucidate all factors contributing to a restraint-related death. It helps identify any system changes—such as review of staff competencies or training—that must take place to remedy any system failures that led to one of these tragedies. Coupling mandatory reporting with a requirement to learn and act would create powerful leverage toward reducing or eliminating restraints-related deaths. And for the vast majority of health care organizations which want to do the right thing, this approach would provide tangible guidance toward making changes in their organizational processes to prevent future occurrences of restraint-related deaths.

Therefore, we support federal legislation that will recognize root cause analyses as an essential risk reduction activity which must be sufficiently protected from public disclosure to permit a completely honest, 'no-hold-barred' approach to internal, self-evaluation. These analyses, once put on paper, become highly sensitive documents, and their creation and sharing with monitoring agencies will be resisted unless they are afforded a peer review-like protection, similar to what states now have in place for hospital internal quality review. We cannot emphasize strongly enough that any federal legislation aimed at increasing reporting of restraint incidents must include provisions to protect these specific documents. Otherwise, root cause analyses will not be adequately done—or done at all—and we will not make the essential progress toward preventing human tragedies.

PERFORMANCE MEASUREMENT

Restraints oversight also lends itself to preventive monitoring as a part of the emerging new quality measurement initiatives. The Joint Commission has also been a leader in this area, and is proud of its ORYX initiative that requires accredited organizations to submit quarterly performance data as part of a new continuous monitoring and evaluation process. We believe that ORYX holds significant promise for assisting organizations in monitoring and if appropriate altering their restraint use. There are currently 26 performance measures related to the use of restraints or seclusion that are now available for use by hospitals under ORYX. Six of these measures have been selected for quarterly reporting to the Joint Commission by individual accredited hospitals. They range in nature from measuring the prevalence of daily restraint use to reporting the actual percentage of restraint hours. Accredited nursing homes are also using some of the ORYX restraint-related measures for long term care. We have already received some feedback from accredited organizations that the use of ORYX measures has helped them improve their restraint use.

PUBLIC ACCOUNTABILITY

Public accountability through public reporting of restraint-related deaths provides a final strong lever to the reduction of future occurrences. The occurrence of a restraint-related death should not be kept either from the public or from those with quality oversight responsibility. These occurrences—in the most vulnerable of individuals—require immediate attention and, almost always intervention. Organizations can underscore their own commitment to change by publicizing the interventions taken following a restraint-related death.

The public should also expect that the oversight bodies responsible for monitoring restraint-related deaths will, through their own mechanisms, use their measurement information to identify and disclose "poor performers" to the public. Bad things happen, even in health care organizations otherwise providing good health care. However, a pattern of poor performance or a documented resistance to resolving quality or safety problems that place patients at risk for further serious occurrences should not be kept from the public. The Joint Commission has taken an aggressive approach to public disclosure for some time, and makes performance reports on individual accredited organizations available to the public at no charge.

BEST PRACTICES

There is another type of information-sharing that must be an essential part of any strategy to eliminate restraint-related events. When root cause analysis information is shared with oversight bodies, a powerful source of information on appropriate, and even best, practices is continually being created and expanded. The Joint Commission is already credited with saved lives by alerting health care organizations about dangerous practices that have come to light under our sentinel event program, and suggesting ways to prevent future sentinel events. A case in point is our experience in guiding hospitals in the appropriate storage of potassium chloride. After identifying a pattern of deaths across the country resulting from the inad-

vertent administration of concentrated potassium chloride as a result of packaging and labeling confusion, we alerted all accredited facilities to limit access to this potentially lethal solution. We also have issued a sentinel event alert on the issue of restraints, advising providers about effective alternatives to the use of physical restraints and the importance of seeking less restrictive measures to achieve treatment and safety goals.

JOINT COMMISSION COMMITMENT

This testimony began with a statement about the Joint Commission's commitment to reducing the number of restraint-related deaths in this country. That commitment is backed by a long-standing and continuing role in setting standards for patient rights and for the use and monitoring of restraints, and more recently, by the Joint Commission's leadership role in facilitating the identification of sentinel events, working with organizations to reduce the risk of future occurrences, and sharing "lessons learned" with all accredited organizations. But the Joint Commission does not intend to end its commitment there.

Early this year, our Board of Commissioners appointed a new high-level Restraint Use Task Force which will conduct a thorough re-evaluation of the Joint Commission's current restraints standards, on-site evaluation process, and other means for accessing information about restraints use. That Task Force is expected to make its final recommendations to the Board of Commissioners by the end of this year.

The Task Force launched its efforts last month by initiating a series of public hearings across the country. These hearings are designed to elicit input, both oral and written, from the public and other interested parties on their perspectives on the current oversight process and what can be done to make it more searching and meaningful. We are also seeking the input from the health professional communities, both separately and at these hearings, because we believe that more than just the accreditation process must change—there must be a significant change in what is considered acceptable practices and behavior by the entire community involved in providing psychiatric and psychological care. The first two hearings—in San Francisco and Atlanta—were extremely well attended and rich in the input provided. Interest in the third hearing, which is taking place in Alexandria today, is so great that we have had to divide it into two separate sessions. We should take great heart in the evident broad commitment of all of the parties at interest to close down one of the most sordid chapters on health care in this century.

CONCLUSION

The reduction of restraint-related deaths and other sentinel events is one of the most important issues facing us today. Again, we applaud the Subcommittee's leadership on the issue. We support and welcome the opportunity to bring together the strength of public and private sectors to address these issues, and we look forward to working with you.

STATEMENT OF THOMAS HARMON, EXECUTIVE SECRETARY, MEDICAL REVIEW BOARD, NEW YORK STATE COMMISSION ON QUALITY CARE

Senator SPECTER. We turn now to Mr. Thomas Harmon, Executive Director of the Medical Review Board of the New York State Commission on Quality Care.

Thank you very much for joining us, Mr. Harmon. We note your 20 years' work on supervising investigations of over 4,000 cases of abuse and deaths in mental health facilities. The floor is yours.

Mr. HARMON. Chairman Specter, Senator Harkin and others, thank you for this opportunity to speak on the matter of independent investigations into deaths in mental hygiene facilities, particularly deaths in which restraint or seclusion was a factor.

As noted, I work for the New York State Commission on Quality of Care, which is New York State's protection and advocacy agency. The commission has often been cited as a model for independent investigations. Most recently, the Hartford Courant series on deadly restraint lauded New York State as being one of the few states

requiring the reporting of all mental hygiene consumer deaths to an independent body for review and investigation.

I want to share with you my perspectives on what makes New York State unique and the value of the independent death investigations we conduct. The commission was created in 1977 by state law in New York to oversee programs serving the mentally disabled. Among other things, the law in New York required that all deaths and allegations of abuse be reported to our commission so that we can review and conduct investigations where necessary.

It was subsequent to that that we became New York State's federally designated protection and advocacy agency. However, in certain respects, New York State law confers upon the commission greater authority than most P&As are afforded under the federal laws.

For example, whereas New York State law requires that all deaths and allegations of abuse be reported to the commission, and we can then commence an investigation, most other P&A agencies do to receive that notification and can only commence an investigation when they receive a complaint or they have suspicion of abuse.

Let me cite two values of independent death investigations. The first is impartiality. All facilities, either by law, regulation or the mandates of their accrediting bodies, are required to conduct internal investigations of untoward events for the purpose of protecting their patients and consumers from future harm. And a lot of facilities endeavor to do that.

However, there are a number of factors which erode facilities' ability to do that faithfully, or erode the public's confidence in their ability to do it. Facilities in their investigative zeal may be quick to find and remedy the obvious smoking gun, like an employee error, for example, but not take the time to look at the underlying issues which set the employee up for that error. In facilities where serious events happen, very infrequently the facility may lack the requisite skills to investigate the matter as much as they desperately want to get to the bottom of what went on.

And sometimes it may be perceived that the facility's investigation is self-serving, and confidence in its results is reduced. The primary value brought by independent investigations is their impartiality. We have no self-interest to serve.

And as often as the commission has found problems in cases we have investigated and deaths that we have investigated, we found an equal number of cases, if not greater, where a death, as unexpected as it was, did not suggest problems in care. And we were able at that point in time to give the family and the facility alike some peace of mind in an otherwise discomforting time.

Finally, let me just say another value. And that is, independent investigations can go and bring lessons to beyond the walls of the facility where you are investigating. I have in my written testimony an example of where we investigated a death on Long Island, where towels were used to protect staff from biting and spitting. And the facility terminated that practice after we brought the hazards of that practice to its attention.

But when we learned that it was happening at other facilities in the state, we brought it to our state office of mental health, which

in February issued an alert to all hospitals across the state to terminate the practice.

In closing, I wanted to bring to you the commission's experience in conducting death investigations with the hope that it can be a model for other states, as you deal with this problem of restraint and seclusion deaths.

Thank you.

Senator SPECTER. Thank you very much, Mr. Harmon.

[The statement follows:]

PREPARED STATEMENT OF THOMAS HARMON

Chairman Specter, Senator Harkin and other Senators, thank you for this opportunity to provide testimony on the matter of independent investigations into deaths of individuals who are residents or patients of mental hygiene facilities, particularly deaths in which restraint or seclusion was a factor.

My name is Tom Harmon and I work for the New York State Commission on Quality of Care, New York State's designated agency within the federal Protection and Advocacy system. For over 20 years, the Commission on Quality of Care has conducted investigations into deaths, and other matters, within mental hygiene facilities. The Commission has often been cited as a model for independent investigations and most recently, in the Hartford Courant's October 1998 series Deadly Restraint, New York State was lauded as one of the few states requiring the reporting of all mental hygiene consumers' deaths to an independent agency for review and investigation. Having spent the majority of my twenty years with the Commission coordinating its death investigation activities, I want to share with you my perspectives on what makes New York State unique, the value of independent death investigations, and some of the key ingredients for a successful death investigation process. To supplement my testimony, I am also submitting written materials which amplify or further illustrate points I raise including the Commission's enabling legislation (Article 45 Mental Hygiene Law) and several reports published by the Commission which I believe you will find helpful.

NEW YORK'S UNIQUE SITUATION

Among the nation's P&A's, New York State's is unique. In the mid-1970's, New York State recognized the need for independent oversight of facilities serving its most vulnerable citizens—individuals with mental disabilities. And, with the enactment of Chapter 655 of the Laws of 1977, the Commission on Quality of Care was created. Among other things, the law required that all deaths and allegations of abuse occurring in mental hygiene facilities be reported to the Commission for its independent review and investigation. In subsequent years, the Commission was designated as New York State's P&A agency; however, in certain respects, New York State law confers upon the Commission greater authority than most P&A agencies are afforded under federal law.

For example, whereas NYS law requires that all deaths be reported to the Commission in a manner and form prescribed by the Commission and allows the Commission to commence an investigation where deemed indicated, other P&A's do not receive such notification and can only commence an investigation when they receive a complaint or have reasonable cause to suspect abuse.

THE VALUE OF INDEPENDENT DEATH INVESTIGATIONS

Time constraints prohibit me from extolling all the values of independent death investigations. But allow me to propose two chief ones. The first, in my opinion, is impartiality. All facilities, by mandates of law, regulation or accrediting bodies, are expected to engage in a process of risk management, critical self- examination or quality assurance, around untoward events in order to protect the individuals they serve from future harm. A great many facilities endeavor to fulfill this obligation faithfully. However, there are a number of factors which may erode even the best facilities' abilities to exercise this duty or may erode the public's confidence that it has been fulfilled, particularly with regard to the most serious of untoward events: an unexpected, sudden death or deaths related to restraint. Facilities in their investigatory zeal may be quick to find and remedy the obvious smoking gun, an employee who erred, for example, without taking the time to examine underlying systemic issues such as staff training, supervisory policies, and staffing allocations. In facilities where serious events happen infrequently, the facility may lack the req-

uisite skills to conduct an effective investigation, no matter how desperately it wants to.

The primary value brought by independent investigations into the most serious of untoward events is their impartiality; independent investigators have no self-interest to serve by their investigations. As often as the Commission has found that certain deaths suggested problems in care, we have found, in an equal or greater number of cases, that the death, perhaps as unexpected as it was, did not suggest problems; the Commission's impartial investigations found care was appropriate, thereby offering families and facilities alike some peace of mind in an otherwise discomforting time.

A second value of independent investigations, particularly those done by a single agency, is the opportunity for systemic reform or system-wide protection and prevention. During a recent investigation into a death on Long Island, the Commission found that facility staff would routinely hold a towel snugly over the mouths of patients they restrained. When advised by the Commission of the inherently dangerous nature of this intervention, the facility terminated the practice. However, the Commission learned that this practice was employed at other hospitals and brought the matter to the attention of our State Office of Mental Health which recently issued a statewide alert banning the technique. Additionally, the Commission put OMH in contact with the New York State Office of Mental Retardation and Developmental Disabilities to further explore a safer device employed by an OMRDD facility for preventing spitting or biting hazards during restraints.

The above example illustrates the value brought by an independent investigating body working collaboratively with regulatory agencies to bring about systemic reform, each propelling the other into finer and finer consumer service and protection practices. Other examples of these collaborative efforts include:

—In the early-1990's, our Office of Mental Health conducted an extensive review of restraint and seclusion practices in New York State and issued new policies on this subject, resulting in a reduction of the utilization of these interventions;

—Our Office of Mental Retardation and Developmental Disabilities has developed a rigorous protocol for approving and routinely monitoring the use of certain restrictive interventions; and

—Both regulatory agencies have developed training programs on the use of restraint, seclusion and physical interventions which emphasize alternatives to such interventions and tools to de-escalate situations to thereby reduce the need for their use.

While not all cases may suggest the need for system-wide reforms, many cases present opportunities to revisit staff training programs or reexamine and refine policies or procedures at individual facilities across the state. In this vein, the Commission has had much success with a series of case studies it produces for all facilities in New York State entitled, Could This Happen In Your Program? The series presents actual cases investigated by the Commission and invites readers to reflect on their own agencies' operations and whether lessons learned elsewhere have applicability in their programs. These training materials provide managers and direct care staff an opportunity to examine their own operations to prevent similar tragedies from occurring in their facility.

KEY INGREDIENTS

Realizing the benefits of independent investigations requires that the investigating body has all the needed tools. I'd like to briefly list some of the tools which have enabled the Commission to establish a noteworthy investigation process in New York State.

Understanding why a person died and whether the death suggests ways in which care can be improved is like putting together a puzzle. First, you need to have all the pieces; including not just information from the mental hygiene facility, but records and other information from, among others, coroners, medical examiners, general hospitals where the individual may have died or been treated, law enforcement personnel and Emergency Medical Services crews. Accessing this information in a timely fashion is important and, in New York State, the Commission's right of access is spelled out in State statute.

Once all the pieces have been amassed, one also needs individuals sufficiently expert in putting the pieces together and interpreting the picture which emerges. The Commission has nurses on staff who review the medical cases we investigate. But sometimes situations arise which require more detailed clinical analysis. The legislation establishing the Commission also provided for a Medical Review Board consisting of volunteer physicians, appointed by the Governor, to assist the Commission on a volunteer basis on matters it investigates. The physicians have specialties in

Forensic Pathology, Psychiatry, Surgery, Internal Medicine, and Pharmacology. Over the years their expertise has been of great value to the Commission, and the people we serve, in helping to assemble the pieces of the puzzles we are called on to solve and offer meaningful recommendations to protect the living.

In closing, I believe the Commission's independent investigations into unusual deaths and incidents of abuse, in collaboration with the efforts of our State's Office of Mental Health and Office of Mental Retardation and Developmental Disabilities, have led to important improvements in the quality of care afforded individuals with disabilities and could serve as a model for other states in their efforts to protect and best serve their most vulnerable citizens.

Once again, I wish to thank you for the opportunity to testify before you today.

[CLERK'S NOTE.—The written materials referred to in Mr. Harmon's statement do not appear in the hearing record but are available for review in the subcommittee files.]

Senator SPECTER. Mr. Rogers, would you bring those devices up so Senator Harkin and I can take a closer look at them?

Mr. ROGERS. It is a straightjacket.

Senator SPECTER. Straightjacket? Bring that up. Let us take a look at that.

Senator HARKIN. I have never seen a straightjacket in my life.

Senator SPECTER. Senator Harkin says he has never seen a straightjacket. How do you put this on?

Mr. ROGERS. Well, you put it on so usually your arms go back in the back. This one——

Senator SPECTER. The arms in the back?

Mr. ROGERS. Yes; I have not practiced this one. This one, your arms would just be inside, and the whole thing would be strapped around you so you could not make any moves at all.

Senator HARKIN. Oh, I see.

Senator SPECTER. Let us see how the others work. These are for hands and——

Mr. ROGERS. Right. These would restrain you by strapping your arms down to a gurney or to a chair, wherever they want.

Senator SPECTER. Come around here and show us how this would be applied.

Mr. ROGERS. All the way over there?

Senator SPECTER. Right here is fine.

Mr. ROGERS. Well, you take the individual, and you strap them, you work the strap through.

Senator HARKIN. What is all this stuff over here?

Mr. ROGERS. This is an interesting thing. This is a net they use.

Senator SPECTER. Before you do that, show us how these work.

Mr. ROGERS. And then you pull them down, and they strap to a chair or to a bench or whatever. Unfortunately, sometimes they strap you to a gurney, and that is actually a very dangerous practice. Because if the person gets violent, throws themselves around, the gurney can flip over. And if they are not being observed, the gurney lands on top of them, they can literally break their neck.

Mr. ROGERS. This they use by really throwing it over a person. And they can strap them down.

Mr. HARKIN. You have got to be kidding me.

Mr. ROGERS. This is used to, again, put the arms through. And then you can—this can hold the person totally down on whatever you set them down on, a gurney or onto a bed. And the idea is to hold them. Unfortunately, what happens in a lot of cases is the person is really upset and disturbed, obviously. You put them in

the restraints. They are sometimes put in way too tight. Their ability to breath, their ability to aspirate, is affected. And that is what causes a lot of the deaths.

Senator SPECTER. OK. Thank you very much, Mr. Rogers.

Senator HARKIN. It is like some kind of a torture movie, you know, like movies you see in wartime when they torture people. That is what it looks like.

Mr. ROGERS. Well, when the movies want to make a dramatic situation, they use these restraints. And it is pretty dramatic what it does to a person.

In my case, I came into the hospital for help, was not really that agitated. For some reason, the staff decided that I needed to be restrained. I can tell you, it took me a long time to go back to the hospital for help after having had that done.

Senator HARKIN. I can believe that.

Mr. ROGERS. Thank you, Senator.

Senator HARKIN. Well, thank you very much.

Senator SPECTER. Dr. O'Leary.

Dr. O'LEARY. Yes, sir.

Senator SPECTER. Beginning the questioning—and Senator Harkin and I will each take five-minute rounds and go to 10:30—is it realistic to have a requirement that there not be any restraint except on a doctor's order? That is one of the suggestions made in the legislation which is pending. And that seems like a very good way to limit these kinds of restraints which are so brutal to issues of absolute necessity. There is an exception in emergency situations where then a doctor would be called in with as prompt as possible review of it. But is it realistic to impose that kind of requirement on the use of these restraints?

Dr. O'LEARY. I think that it is a realistic requirement and, more than that, a necessary requirement.

Senator SPECTER. So you would endorse that.

Dr. O'LEARY. Yes; I really would. And I think the issue that actually is being begged is whether restraints should be used in any situations other than in an emergency situation. I think that is one of the issues that we all need to be looking at very seriously.

Senator SPECTER. Well, that would be quite a remedy, to require a doctor to authorize it. And maybe there could even be some provision on an emergency basis to require a doctor to review it, if that could be set up. We would have to examine that.

Mr. Harmon, you have in your resume stated that you have dealt with some 4,000 cases of abuse and deaths. How many of those are deaths?

Mr. HARMON. Oh, in the past 10 years, working for a medical review board, I probably have looked at 2,000 to 3,000 deaths in New York State.

Senator SPECTER. I join my colleagues in the compliment for the Hartford Courant. It is a phenomenal series. And it is in the great tradition of American investigative journalism to make a disclosure of this sort, which focuses congressional attention. Once we are acquainted with the problem, then we can move ahead to try to fashion an answer to it.

The estimates are about 150 deaths a year. But given the statistics of what you have worked on in New York State alone, it seems to me that that kind of an estimate is very, very understated.

Would you have—I see nods from Dr. Allen and Dr. Mohr. Would you have an estimate as to the number of deaths which result from excessive restraints in this country on an annual basis?

Mr. HARMON. Not nationally. I can say in New York State last year, in 1998, we received at our commission approximately 170 allegations of abuse or neglect involving restraints. And——

Senator SPECTER. Did those result in deaths?

Mr. HARMON. In four cases, there were deaths. So we had four deaths in 1998. In two of those cases, I think, I know, that upon investigation, we could find no problems in care. In the other two cases, there were problems.

Senator SPECTER. And the speculation is there would be a great many more unreported.

Mr. HARMON. No. I do not believe in New York State——

Senator SPECTER. You think they do report them there.

Mr. HARMON. By law, they have to. And we also require them to fill out forms that indicate whether or not restraint was used within a 24-hour period of——

Senator SPECTER. Well, I suspect that notwithstanding tight reporting requirements, that a lot are unreported. People have a tendency not to report when the information might lead to liability on their part. I do not want to impugn your report as in New York State, but my experience would suggest that.

Dr. Allen, listening to the case of your son, absolutely horrible, and we all sympathize with you. Having had 16-year-old sons myself, I can understand and appreciate your anguish. As you have related the circumstance, there was more than carelessness.

There was a degree of recklessness, which really crosses the homicide line. What you have stated goes to involuntary manslaughter. And perhaps recklessness in the extreme can constitute malice for murder in the second degree.

You may not want to answer this question now, but I would like you to give some consideration, and the other panelists as well, as to whether legislation ought to have criminal sanctions attached to it, as well as licensing and reporting. I see a lot of nods in the audience. If you get a little tougher, you may find a little more deterrence. But the case you describe really shrieks out for a degree of recklessness, which is homicide.

What do you think, Dr. Allen?

Dr. ALLEN. Certainly I think there has to be a degree of accountability. And we can have national standards, and we can have better training. But I agree with you, sir, that perhaps there needs to be a deterrent.

Senator SPECTER. Dr. Mohr, one final question. My red light is on. I am very much impressed with your comment that it is a psychiatric convention contrasted with a psychiatric necessity. On a broader educational picture, how do we tell the people of America, who are in this field, the workers, those who are there, what the appropriate standards are beyond doing what is conventional and so damaging? What can be done to educate us to what really is medically necessary?

Dr. MOHR. I think there is two parts to your question. Number one, we do not really have a good research foundation. So we have no good programs to teach people. We have promising practices. And what I would recommend is to teach people what our promising promises are, people in the profession and in our schools, what our promising practices are, and then to continue to do research to see whether we can just simply do better.

Senator SPECTER. Thank you very much, Dr. Mohr.

Senator Harkin.

Senator HARKIN. Again, I want to thank all of you for being here and for your excellent testimony. I especially want to commend for the record, Mr. Rogers, your quotes from, if I can find it here, your home state, Mr. Chairman, a Mr. Curie.

Mr. ROGERS. Yes; from Pennsylvania, Deputy Secretary Curie.

Senator HARKIN. I do not know his position. What is his position?

Mr. ROGERS. He is the Deputy Secretary for Mental Health in the Department of Public Welfare.

Senator HARKIN. You said that Pennsylvania's experience proves that the use of seclusion and restraint can be eliminated or greatly reduced when there is a treatment environment that focuses on the strengths of the individuals being served, that protect patients' dignity, comfort and privacy, et cetera. You said the options available today make the elimination of seclusion and restraint an extremely realistic goal.

Anyway, I——

Mr. ROGERS. Yes; Secretary Curie, who is the Deputy Secretary, Department of Public Welfare, has made it almost a personal campaign of his to really review what the state is doing when it uses restraints in their state hospitals. And in one case, in Haverford State Hospital, which is just outside of Philadelphia, they eliminated, six months prior to the closing of the hospital, they eliminated all use of restraints.

It is really possible, if you really look at how people are using it, what the practices are, why they are using it, and to put some real standards in and to have leadership, you know, being held accountable to move to the point where you have tons of incidences of restraints to nearly zero incidents.

Senator HARKIN. Dr. Allen, again, you talked about the importance of staff training, certification, that type of thing. And it has pointed out that only three states have licensing and training standards. Just a little bit more elaboration for me. What do you think ought to be included in something like that? And could we address that at the national level?

Dr. ALLEN. Truly, I do not know if training can be addressed at the national level. I think that needs to be addressed at the individual state levels. But I think we need to look at the need for restraints, or the use of restraint, as being viewed as a system failure and not a patient failure. And staffers have to be trained, and they have to understand. I mean, I think they have to be trained on de-escalation techniques other than manhandling and wrestling a child or an individual down to the floor.

But I think staff also must understand not just what to do, but why they are doing it and how that can be effective. And I think that staffers have to be taught that. And they must see their job

as facilitating the patients regaining their own self-control while maintaining a sense of dignity, and not punishing them for being out of control.

Senator HARKIN. Right. That is what Mr. Curie was saying. He is talking about deescalation techniques and that type of thing, which I am not all that familiar with.

Mr. ROGERS. What we find is that if you have an institution where treatment is the primary thing, not just custodial care, where people are really evaluating what the individual needs, you do not end up using restraints. Restraint happens because, in a lot of situations, all they are doing is providing sort of a custodial care. It is like a jail.

So people get into trouble. Staff gets into trouble. And people get hurt. And what we need to do is create a different standard and a different method of treatment for people.

And restraints, if we eliminate restraints or eliminate that option, it actually has the impact of people having to find other options to deal with people. Deescalation is a technique of, when I am confronting somebody and they are coming back at me, if I come back at them harder, then we get into a fight. If I find ways to step back, talk slower, quieter, I can usually bring the situation down.

Senator HARKIN. I just have to believe, just looking at these macabre devices that you showed us here, that just coming at someone with something like that is enough to instill fright and apprehension and can lead to all kinds of reactions in an individual. I mean, how would you feel, how would anyone in this audience feel, if someone came at you with one of those and was going to put you in one of those? I mean, man, you have to have some kind of drastic emotional reaction to that.

Mr. ROGERS. Especially since a lot of people that are psychiatric patients have histories of abuse in their childhood.

Senator HARKIN. Sure.

Mr. ROGERS. And what happens is that just triggers in them—you are talking about people that are veterans, that have faced abusive situations and have trauma, post-traumatic syndrome. They are going to react. You come at them like that, they are going to fight back. And unfortunately, people get hurt.

Senator HARKIN. One thing I would like to clear up, though, I think, Dr. Mohr, you kind of touched on that, is that there is a general perception that restraints and these kinds of devices are used only for people with mental disabilities. But you have pointed out that they are used often with people with other types of disabilities. Would you elaborate on that a little bit, please?

Dr. MOHR. What I can elaborate on is to reiterate what I have said, that restraints are a convention. They are a psychiatric convention, and they are a way of maintaining patient and milieu control. They are not by any stretch of the imagination in my mind therapeutic. They are used in psychiatric facilities, and they are used with the developmentally disabled and frequently used inappropriately.

Senator HARKIN. I see my time is up. Just one last thing. We are looking at what we can do here legislatively. And, Dr. O'Leary, what will the Joint Committee on Accreditation of Hospitals—now

you are going to start looking at this and what you could start doing, right?

Dr. O'LEARY. Yes; now we think there are real opportunities for improvement here. I think the Pennsylvania model is an excellent example of the things that can be done to really reduce restraint use. Pennsylvania has actually been using the Joint Commission standards and some of the new measurement techniques to focus attention on restraint use.

So we are going to do, I think, some major things to improve the oversight process.

Senator HARKIN. Would you keep us advised of that?

Dr. O'LEARY. We certainly will do that.

Senator HARKIN. Thank you.

Senator SPECTER. Thank you very much, Senator Harkin.

Thank you very much, all. Again, I commend the Courant for the investigative reporting which has focused on the issue.

And we are going to be taking a very close look at the requirement that a doctor would have to authorize the restraints and some checks and balances as to the types of restraints and the duration, and perhaps even a closer look at whether there ought to be some criminal sanctions applied in the egregious cases which really move from negligence to recklessness, which could be a manslaughter charge or even more. But I think this has been a very informative session.

And I thank my colleague, Senator Harkin, for his work and Senators Dodd and Lieberman for their leadership on this important field.

CONCLUSION OF HEARING

Senator SPECTER. Thank you all very much for being here, that concludes our hearing. The subcommittee will stand in recess subject to the call of the Chair.

[Whereupon, at 10:35 a.m., Tuesday, April 13, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

MATERIAL SUBMITTED SUBSEQUENT TO CONCLUSION OF HEARING

[CLERK'S NOTE.—The following material was not presented at the hearing, but was submitted to the subcommittee for inclusion in the record subsequent to the hearing:]

NONDEPARTMENTAL WITNESSES

PREPARED STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

This statement is submitted for the record by the American Psychiatric Association. The APA is the national medical specialty association representing more than 41,000 psychiatric physicians nationwide. Our members work and practice in all settings, including public and private hospitals, private practice, group practice, research programs, and academia.

First and foremost, APA commends the Subcommittee for holding this hearing on the use of seclusion and restraint. We deeply regret, however, that we were in effect "uninvited" from public testimony and were thus not allowed to testify in person. While we understand the severe time constraints that limited the hearing time to one hour, we must note that the public hearing on this volatile, complex, and highly emotional issue was clearly unbalanced, particularly given the fact that not a single psychiatrist—the physicians on the front line of treatment—was allowed to testify.

It is absolutely vital that public hearings provide an opportunity for clinicians, Members of Congress, patient advocates, and patients/consumers to sit down together and discuss vital patient care issues. It is our hope that a dispassionate examination of restraint (and of seclusion), including deaths and serious injury caused by restraint (or seclusion), will further APA's overarching objective of ensuring the provision of all medically necessary treatment of psychiatric patients in an environment that is safe and humane for patients and for staff.

CONGRESS SHOULD FIX THE PROBLEM WITH RESTRAINT USE WHEN IT UNDERSTANDS THE CAUSE

The spate of recent news stories (e.g., Hartford Courant, Fox Files) has focused public attention on the care of psychiatric patients in the inpatient or residential setting. As a matter of general principle, APA, of course, believes that seclusion or restraint should not cause patient deaths.

The stories in the press are lamentable, and we reiterate that seclusion or restraint should not cause deaths. Efforts to increase the safety of seclusion and restraint and to decrease deaths caused by these interventions must be based on a clear understanding of the causes of deaths and serious injury. Precipitous action (for example, regulatory changes) prior to a full examination of the factors leading to safety problems may have unintended negative consequences without any improvement in safety.

For example, it is not clear at this time:

—How many psychiatric patients were in inpatient or residential treatment settings?

—How many of those patients were secluded or restrained?

—For how long were patients secluded or restrained? Were the facilities JCAHO accredited? State licensed?

—What post-event root cause analyses took place?

—What were the results of those analyses?

—What is the incidence of patient-to-patient assaults during this period? Patient-to-staff assaults?

These are but a few of the questions that we believe must be answered in order to determine what shortcomings now exist in the federal regulatory and JCAHO processes as well as in current clinical standards of care.

PROBLEMS WITH RESTRAINT AND SECLUSION MUST BE SEEN IN THE CONTEXT OF THE PATIENT POPULATION AND THE FACILITIES IN WHICH THEY ARE TREATED

It is vital to note that the incidence of use of seclusion and restraint, and particularly deaths or serious injuries caused by such use, cannot be viewed in the abstract but must be seen in the clinical context in which treatment occurs.

Psychiatric facilities today face unprecedented challenges. Whether by managed care or by more traditional health insurance, there is great pressure not to admit patients to the more expensive inpatient setting unless there is simply no alternative. That means that the patients we see in these settings are more seriously ill than ever before. Many—perhaps most—are in the acute stages of their illness, and their underlying illnesses are more likely to be severe.

At the same time, psychiatric facilities and the physicians and other health professionals who work in them are under greater budgetary pressure than ever. For example, the Balanced Budget Act of 1997 reduced payments to so-called "TEFRA" hospitals (i.e., those hospitals—including psychiatric hospitals—that are exempt from the Prospective Payment System) by $5 billion.

So disadvantageous was this reduction that representatives of the psychiatric hospital industry have decided to pursue PPS coverage. Likewise, payments to psychiatrists and other health staff are constantly being squeezed by insurers, whether Medicare or private.

Bluntly, psychiatrists and other health professionals and the facilities in which we work are being asked to do more than ever for patients who are more acutely ill than ever before with less resources. It is particularly disturbing to APA that discussion of resource commitment has, thus far, been entirely absent from the public discourse.

THERE IS MORE AGREEMENT THAN DISAGREEMENT BETWEEN PSYCHIATRISTS AND PATIENT ADVOCATES ON THE APPROPRIATE USE OF SECLUSION AND RESTRAINT

APA has a long-standing record of involvement with the development of general guidelines and principles for the use of seclusion and restraint. For example, the Report of the Task Force on Seclusion and Restraint (1984, amended 1992) provides a very thorough overview of the practices in seclusion and restraint as they are used in the treatment and management of violent and disruptive behaviors in the treatment setting. The report also reviewed alternatives to the use of physical controls, and it includes a very helpful discussion of indications, contraindications, and emergency use of seclusion and restraint. We are attaching a copy of the Task Force Report as a submission for the record.

In response to APA's concern about the patient care implications of the Courant series, APA Medical Director Steven M. Mirin, M.D. directed that APA convene a panel of experts first to develop a statement of general principles on seclusion and restraint and, second, to develop clinical best practices standards.

The Joint Statement of General Principles on Seclusion and Restraint by the American Psychiatric Association and the National Association of Psychiatric Health Systems is also attached to this written testimony. We must note for the record that the Joint Statement is to be viewed at the present time as a "work in progress," having not yet been formally reviewed and approved by the governing bodies of our two associations.

We believe a careful review of these documents shows that there is more agreement than disagreement on general principles governing the use of seclusion and restraint between physicians and most patient advocates.

Here is a brief summary of the key points of our General Principles.

—Seclusion and restraint are interventions that carry a degree of risk. They may be used where, in the clinical judgement of medical staff, less restrictive interventions are inadequate.

—Seclusion and restraint may be indicated (a) to prevent harm to the patient or other persons including other patients, family members, and staff, and (b) to ensure a safe treatment environment.

—A physician should write seclusion and restraint orders.

—The physician should examine the patient and ensure appropriate monitoring and care throughout the episode.

—Staff should be thoroughly trained and have demonstrated competence in the application of safe and effective techniques for implementing seclusion and restraint.

—Patients should be removed from seclusion or restraint when, in the physician's judgement, the patient no longer poses a threat to himself/herself, other patients, family members, or staff.

—Use of seclusion and restraint should be minimized to the extent that is consistent with safe and effective psychiatric care and the specific clinical needs of the patient. Likewise, staff should be trained in the use of alternative interventions that may reduce the need for seclusion and restraint. Facilities should engage in a continuous quality improvement program that seeks to minimize the use of seclusion and restraint consistent with good standards of clinical practice and the needs of individual patients.
—Death and serious injury from interventions involving seclusion and restraint must be reviewed internally. In addition to internal review, external review by, or subject to, an accrediting organization may also be required, with appropriate legal and confidentiality protections.

THE CURRENT JCAHO PROCESS IS EDUCATIVE AND OFFERS A USEFUL MODEL FOR CONGRESS

Let us now turn to a brief review of the JCAHO process. As you know, the standards for seclusion and restraint were significantly modified approximately 24 months ago. These modifications are consistent with and support the key points in our statement of general principles. Before additional changes are made, it is our judgement that the effect of the new standards on practice should be assessed.

The sentinel event policy and procedures is discussed in detail in the JCAHO "Special Report on Sentinel Events" published in the Perspectives of November/December, 1998. Under standards set by the JCAHO and effective in January, 1999, and laid out in the Accreditation Manual, a "sentinel event" is "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof." Serious injury is defined to specifically include "loss of limb or function." It is useful to think of these as catastrophic events involving death or severe permanent injury.

Sentinel events are divided into two basic categories: reviewable and non-reviewable. Reviewable events include those that have "resulted in death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition," and a series of specifically iterated events including suicide, rape, and surgery on the wrong patient or body part. "Major permanent loss of function" is defined as "sensory, motor, physiologic, or intellectual impairment . . . requiring continued treatment or life-style change."

JCAHO-accredited facilities are encouraged to report reviewable sentinel events voluntarily as they occur. Facilities are required to prepare a root cause analysis and action plan and to submit both to JCAHO. Sentinel events reported to JCAHO are included in the Joint Commission's Sentinel Event Database. Information covered includes sentinel event data, root cause data, and risk reduction data; non-identifiable aggregate data are released.

The core, then, of the current JCAHO process is, in the words of the Commission, "to increase the general knowledge about sentinel events, their causes, and strategies for prevention." As a practical matter, this aspect of JCAHO activities is educative. That is a critical component of efforts to minimize the general use of seclusion and restraint and to eliminate deaths caused by seclusion and restraint.

As you know, hospital staff will typically hold after-the-fact debriefings when patients are restrained or secluded, and certainly when death is caused by seclusion or restraint.

Any change in these standards must be carefully weighed against the impact it will have on reporting of sentinel events and on its consequences for the best possible patient care.

We acknowledge and are sensitive to these concerns, and we also believe there may be complex issues related to liability and discovery that the Congress and the Joint Commission must also consider if they decide to change the standards for reporting of sentinel events involving seclusion and restraint.

THE JCAHO PROCESS CAN BE STRENGTHENED

Nevertheless, APA supports the strengthening of current sentinel event policy to require the reporting of deaths caused by seclusion or restraint, as well as application of the strengthened policy to serious injuries that meet the JCAHO definitions.

We stress here that we speak strictly for psychiatry, and not for the purposes of our Joint Statement of General Principles. It follows that any shift in policy must also carefully consider the information that may be required to be reported, especially in light of the need for confidentiality of data included in the reports. Even greater care must also be taken to preserve the confidentiality of records if Congress considers directing the JCAHO to amend its disclosure policy to report information to other bodies.

SURVEYOR TRAINING AND EDUCATION ARE CRITICAL COMPONENTS OF EFFECTIVE OVERSIGHT

Another area of potentially useful discussion is surveyor training. We believe that the new survey process that requires the surveyor to interview patients in restraint or seclusion, as well as the nursing and other staff responsible for their day-to-day care, is a marked improvement. This "hands on" surveying process gives a better picture of actual restraint issues than interviewing senior medical staff or simply reviewing records.

We also emphasize the critical need for the surveyors to determine a facility's compliance with the standards requiring staff training. The literature clearly indicates a correlation between staff training and a reduction in the use of seclusion and restraint.

CURRENT FEDERAL LEGISLATION TO RESTRICT THE USE OF SECLUSION AND RESTRAINT IS FRAUGHT WITH PROBLEMS

As you know, in addition to current JCAHO activities, legislation has been introduced in the House and Senate to require reporting and review of deaths and injuries of psychiatric patients.

It is not our purpose to review the bills in this testimony, although we would be pleased to provide a detailed analysis for your review. We note, however, that there are serious technical problems with all of the bills, including the following:

—Inappropriate restrictions on the use of seclusion and restraint (i.e., for the safety of patients only, not for staff or others; no consideration of the treatment environment);

—Potentially problematic external (beyond JCAHO) data disclosure with inadequate confidentiality protections;

—Duplicative and adversarial involvement of the protection and advocacy systems in reviewing and investigating deaths and serious injuries of psychiatric patients;

—Imprecise definitions; and,

—Failure to provide resources to meet the requirements established by the bills.

As clinicians, we believe that the ultimate responsibility for the decision to seclude or restrain the individual psychiatric patient must rest with the treating psychiatrist. Well-intentioned law and regulation are at best a crude instrument that cannot be a substitute for individual clinical expertise and judgement in which the treating physician and the rest of the staff work as a team to make informed decisions about optimum treatment for the individual patients in their care.

The fact remains that we are treating sicker patients in shorter time and in more acute stages of their illness. This population is one in which—regardless of what one may feel about restraints or seclusion—we simply cannot allow our distaste for the intervention to take the place of clinical judgement and the safety of patients, staff, and others.

APA STRONGLY SUPPORTS RESEARCH ON THE USE OF SECLUSION AND RESTRAINT AS AN INTEGRAL PART OF ENSURING THE SAFE AND EFFECTIVE USE OF THESE INTERVENTIONS

We must be careful not to vest unexamined anecdotal information about restraint elimination with the status of "best practice" when we truly do not know if that is the case, or whether such practice is applicable to all patient populations in all treatment settings. The APA strongly supports the need for more research on these issues.

ANY SOLUTION TO THE CURRENT PROBLEMS WITH SECLUSION AND RESTRAINT MUST INCLUDE THE COMMITMENT OF RESOURCES FOR STAFFING AND STAFF TRAINING

Finally, we believe that the current JCAHO emphasis on education offers useful lessons to Congress about staffing and patient care. We absolutely agree that staff must be trained in the appropriate and safe use of seclusion and restraint and that competency should be regularly demonstrated. Staffing levels are also a vital issue.

We underscore, therefore, our continuing concern about legislative or regulatory efforts that will materially increase the costs of care without concomitantly providing the resources to deliver such care. This is a major failing of each of the three bills now pending in the Congress and should be a matter of concern to the Subcommittee as it considers changes to current standards on restraint in behavioral health care and on sentinel event policies.

Thank you for this opportunity to submit a statement for the record. It is our hope that the Congressional interest in this vital patient care issue will provide for a thoughtful review of the clinical issues associated with the use of restraint and se-

clusion and will lead to changes that truly ensure the provision of all medically necessary treatment to psychiatric patients in an environment that is safe and humane for patients and staff. To achieve this balance it is vital that psychiatrists be allowed to participate in these discussions.

PREPARED JOINT STATEMENT OF GENERAL PRINCIPLES ON SECLUSION AND RESTRAINT BY THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE NATIONAL ASSOCIATION OF PSYCHIATRIC HEALTH SYSTEMS

This is a statement of general principles on the use of seclusion and restraint in psychiatric treatment facilities and in psychiatric units of general hospitals. "Seclusion" is defined for this statement as "locked door seclusion." "Restraint" is defined for this statement as "physical or mechanical restraint." "Serious injury" is used as defined by JCAHO as of April 1999.

GENERAL PRINCIPLES

1. Our general goal is to ensure the provision of medically necessary psychiatric treatment in an environment that is safe for patients and staff.
2. Seclusion and restraint are interventions that carry a degree of risk. They may be used when, in the clinical judgement of medical staff, less restrictive interventions are inadequate or are not appropriate, and when the risks of these interventions are outweighed by the risks associated with all other alternatives.
3. Psychiatric treatment facilities and psychiatric units of general hospitals should have established procedures for the use of seclusion and restraint that conform to federal, state, or local regulations and standards of practice.

USE OF SECLUSION AND RESTRAINT

4. Seclusion and Restraint may be indicated: a. To prevent harm to the patient or other persons, including other patients, family members and staff, when other interventions are not effective or appropriate. b. To ensure a safe treatment environment when other interventions are not effective or appropriate.
5. Use of seclusion and restraint is a matter of clinical judgement that should include a thorough understanding of the clinical needs of the individual patient and the context in which the use of seclusion or restraint is being considered.
6. Special care should be taken in assessing the clinical need for the use of restraint in special populations. Examples of special populations are children and adolescents, the elderly, and the developmentally disabled.

PREVENTING THE NEED FOR SECLUSION AND RESTRAINT

7. The use of seclusion and restraint should be minimized to the extent that is consistent with safe and effective psychiatric care and the specific clinical needs of individual patients.
8. The provision of optimal psychiatric treatment, including appropriate use of psychosocial and pharmaco-therapeutic interventions, is an important component of a strategy to reduce the use of seclusion and restraint.
9. Another component of optimal psychiatric care is staff education and training. Treatment facilities must have appropriate numbers of trained staff who are familiar with the care of the specific patient population in the unit or facility.
10. Staff should be trained in the use of alternative interventions that may reduce the need for the use of seclusion and restraint.

ORDERING AND IMPLEMENTING SECLUSION AND RESTRAINT

11. Seclusion and restraint are medical interventions that require a physician's order.
12. The physician should examine the patient and ensure appropriate monitoring and care of the patient throughout the episode.
13. Staff should be thoroughly trained and have demonstrated competence in the application of safe and effective techniques for implementing seclusion and restraint for the patient populations under their care. The techniques used should be approved by the medical staff.
14. Restraint should be applied with sufficient numbers of staff to ensure safety of the patient and staff.
15. Patients in seclusion or restraint should be carefully monitored and observed at intervals frequent enough to ensure their continued safety and the provision of humane care.

16. The decision to continue seclusion or restraint should not be viewed as "routine." Patients should be removed from seclusion or restraint when, in the physician's judgement, the patient no longer poses a threat to himself/herself, other patients, or staff.

17. The use of seclusion and restraint may be traumatic for some patients. The treatment team should consider post-intervention counseling whenever clinically indicated.

TREATMENT PLAN REVIEW

18. A staff debriefing should follow each episode of seclusion or restraint. The debriefing should include an assessment of the factors leading to the use of seclusion or restraint, steps to reduce the potential future need for the seclusion or restraint of the patient, and the clinical impact of the intervention on the patient.

19. Use of seclusion and restraint, particularly when a pattern exists with an individual patient, should prompt a review of the patient's treatment plan.

20. Psychiatric treatment facilities and psychiatric units of general hospitals should engage in a continuous quality improvement process that seeks to minimize the use of seclusion and restraint consistent with good standards of clinical practice and the needs of individual patients.

INTERNAL AND EXTERNAL OVERSIGHT

21. Quality assurance measures for seclusion and restraint should provide for the appropriate involvement of family members or other public parties. These measures must protect patient confidentiality and the clinical integrity of the treatment program.

22. The decision to order seclusion or restraint requires the clinical judgement of the treating physician, therefore policies governing seclusion and restraint are best dealt with through flexible and easily amendable mechanisms such as hospital policies and procedures and administrative regulations.

23. Each psychiatric treatment facility or psychiatric unit of a general hospital should have, in place, a system to review the frequency and use of seclusion and restraint by each of its clinical units or groups with the intent of sharing best practices across units and facilities.

24. Death or serious injury resulting from interventions involving seclusion and restraint must be reviewed internally. In addition to internal review, external review by or subject to an accrediting organization may also be required, with appropriate legal and confidentiality protections.

[CLERK'S NOTE.—The Report of the Task Force on Seclusion and Restraint does not appear in the hearing record but is available for review in the subcommittee files.]

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