I'm a social worker by training and inclination, and I have committed myself to do whatever I can to help people recover from mental and addictive disorders, which is why the use of seclusion and restraint as a so-called treatment goes against everything I believe in both personally and professionally. Why should practices that risk the lives of and inflict emotional and physical trauma on the people we are trying to heal be an option at all? They should not be. That's why I'm especially pleased to comment on the articles in this special section of *Psychiatric Services* on seclusion and restraint.

Reducing and eliminating the practices of seclusion and restraint has been a special passion of mine for nearly ten years, from my tenure as Deputy Secretary for the Office of Mental Health and Substance Abuse Services in Pennsylvania to my current role as Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services (HHS). At SAMHSA, we believe that the use of seclusion and restraint clouds our vision of a life in the community for everyone and impedes our mission of building resilience and facilitating recovery. This view squares with HHS Secretary Mike Leavitt's goal, as part of his 500-day plan, of protecting life, family, and human dignity.

Unfortunately, as the articles in this special section attest, traumatic and harmful experiences are all too common in psychiatric settings, and consumers perceive these events to be humiliating, dehumanizing, unreasonable, and distressing. Yet the picture is hopeful. Clearly, staff can learn and successfully use alternative behavioral approaches, particularly when supported by program leaders. The article by Gregory M. Smith M.S., and his coauthors, which is based on the Pennsylvania experience, shows that seclusion and restraint can be reduced and even eliminated, with no increase in staff injuries. In fact, one of the hospitals in Pennsylvania that became virtually free of seclusion and restraint saw a 67 percent decline in disabling injuries among patients and staff. In addition, Janice LeBel, Ed.D., and Robert Goldstein, M.P.H., have shown in their study that the elimination of seclusion and restraint not only saves money but also improves client outcomes and staff working conditions.

**A vision of recovery**

The goal of a transformed system of care, as envisioned by the President's New Freedom Commission on Mental Health, is recovery. The commission made clear that consumers must participate in the treatment process and be at the center of care. The use of seclusion and restraint keeps consumers at the margins; they can't learn to manage their illnesses and their lives when they are under external control—either physical or chemical. These practices further their dependence and isolation, leading to learned helplessness and hopelessness. Worse, such practices may keep individuals from seeking needed treatment out of fear of loss of autonomy and control.

The answer is clear. We must stop thinking of seclusion and restraint as treatment. They are a product of treatment failure. In fact, seclusion and restraint, at best, should be a safety measure of last resort, used only when all other options have failed (1). Seclusion and restraint cannot co-exist with a recovery-oriented system.

**The need for a culture change**

Although the vision may be clear, its realization requires planning. Policy changes are necessary but not sufficient to eliminate the use of seclusion and restraint. Success begins with a change in culture, from one of power to one of empowerment, from coercion to caring, and from hopelessness to hope. Leadership at the top is essential, but, as we learned in Pennsylvania, these changes can't be implemented by fiat—the buy-in of key staff is essential. Indeed, as Smith and his coauthors point out in their article, the values of hospital staff and community advocates and their commitment to a nonrestraint philosophy were the major reasons for the changes in attitude, culture, and environment in Pennsylvania's state hospital system.

Some specific steps can help support this important shift in culture. They include:

♦ An adequate number of qualified staff to meet patient treatment needs
♦ Staff training, especially in ver-
nal crisis management, including de-
escalation techniques
❖ Active treatment
❖ Active risk assessment and risk-
based treatment planning
❖ Availability and use of appropri-
ate antipsychotic medications
❖ An environment of care that pro-
motes patient comfort, dignity, privacy,
and personal choice
❖ State-level, aggregate data about
each hospital's incidents of seclusion
and restraint that are regularly used
to inform management and quality
improvement activities.

Policy changes that support these
efforts must be flexible to allow for
change and incorporate staff involve-
ment. Some policy options consistent
with current state or federal rules in-
clude:
❖ Seclusion and restraint must be
used only when the potential exists
for imminent physical danger to the
patient or others
❖ Seclusion may not exceed one
hour, and ongoing monitoring is
needed so that the patient is out of
seclusion as soon as possible
❖ A physician must physically as-
sess the patient within 30 minutes of
the first order and each reorder
❖ Physical restraint may not ex-
ceed ten minutes
❖ Persons in seclusion or restraint
must be kept in constant face-to-face
human observation
❖ The use of chemical restraint is
prohibited
❖ Whenever seclusion or restraint
is used, patient and staff debriefing
must occur, and feedback must be in-
cluded in the treatment plan to pre-
vent the use of seclusion or restraint
in the future
❖ Extensive staff orientation and
education is required.

SAMHSA's response
At SAMHSA, we are very aware of
the role that federal and national
leadership has played and will con-
tinue to play in reducing and eliminat-
ing the use of seclusion and restraint
for people of all ages who have mental
disorders. Before I came to SAMH-
SA, my colleagues and I, as members
of the National Association of State
Mental Health Program Directors
(NASMHPD), helped lead the way
with a position statement on the im-
portance of eliminating seclusion and
restraint (1). In 2003 SAMHSA con-
vened a National Call to Action to
Eliminate the Use of Seclusion and
Restraint that involved multiple con-
stituent groups. We have taken sever-
al steps toward achieving this impor-
tant goal.

Evidence-based practices and guide-
lines. In October 2004, SAMHSA
awarded eight State Incentive Grants
totaling $5.3 million over three years
to support efforts in eight states to
adopt best practices that will reduce
and ultimately eliminate the use of
seclusion and restraint in institutional
and community-based settings that
serve people with mental illnesses
and co-occurring substance use disor-
ders. In addition, we are funding a co-
ordinating center operated by
NAMSHPD, the first of its kind fo-
cused on seclusion and restraint. The
center will support the grantees, eval-
uate the program's impact, and pro-
mote effective, evidence-based alter-
native practices.

Training and technical assistance.
In addition to the coordinating cen-
ter, SAMHSA supports a number of
other training and technical assist-
tance activities. One such activity is a
major training initiative with
NAMSHPD's National Technical As-
ssistance Center for State Mental
Health Planning, which holds execu-
tive training institutes for senior-level
facility managers and state mental
health agency staff. Delegations from
46 states, territories, and the District
of Columbia have participated. An-
other activity is the Best Practices in
Behavior Support and Intervention
Project, a recently concluded three-
year grant program designed to iden-
tify best practices in preventing and
reducing the use of seclusion and re-
straint in facilities that serve children
and adolescents. In addition, a con-
sumer-centered staff training manual
is currently being pilot-tested in two
states. It will provide a practical train-
ing curriculum to help facilities de-
velop alternatives to the use of seclu-
sion and restraint.

Leadership and partnership devel-
opment. SAMHSA's leadership role in
reducing and eliminating seclusion
and restraint begins within the agency
itself, where a member of my execu-
tive team chairs our cross-cutting ini-
tiatives in this area; extends to other
departments and agencies within
HHS, such as the Centers for
Medicare and Medicaid Services; and
reaches other federal, national, and
state partners in substance abuse,
criminal justice, and education. We
are working together to reduce and
eliminate the use of seclusion and re-
straint in all settings.

Rights protection. To help protect
and enhance the rights of people with
mental illnesses to be treated with
dignity and respect, SAMHSA funds,
manages, and provides technical assis-
tance to the Protection and Advoc-
cacy for Individuals with Mental Ill-
ness (PAIMI) program, which is cur-
rently funded at $32 million. We also
support self-advocacy training for
consumers and promote the use of
advance directives.

Data collection. The continued de-
crease in the use of seclusion and re-
straint in Pennsylvania is attributable,
in part, to improved data collection
and greater transparency in the way
the information was shared and used.
At SAMHSA, we are identifying and
encouraging adoption of seclusion
and restraint performance measures.
In addition, the seclusion and re-
straint SIG requires the collection of
specific data.

As important as data are, we don't
need statistics to tell us that this is a
life-and-death issue. We know that
having even one person die or be in-
jured from these practices is one too
many. We know that there are effec-
tive alternatives that can be put in
place to protect the health and safety
of people of all ages with mental ill-
nesses and addictions. The time to
adopt these alternatives is now.

Reference
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