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PSYCHIATRIC UNIT OF A STATE REGIONAL MENTAL HEALTH CENTER

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SECLUSION ROOM USAGE AT AN ACUTE CARE PSYCHIATRIC UNIT OF A STATE REGIONAL MENTAL HEALTH CENTER

By

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ABSTRACT

SECLUSION ROOM USAGE AT AN ACUTE CARE PSYCHIATRIC UNIT OF A STATE REGIONAL MENTAL HEALTH CENTER

By

Harry Wesley Wright

This study had the purpose of examining factors which influenced the incidence of seclusion room usage in a state regional psychiatric facility. Three areas of interest were examined: (a) patient characteristics which were associated with the decision to seclude; (b) the influence staff training had on seclusion room usage; and (c) the impact various treatment modalities had on the use of seclusion as a means of behavior control.

The subjects were 110 hospitalized inpatients at an acute-care, admitting unit of a State of Michigan regional psychiatric facility. There were two groups: the treatment group, which consisted of all patients secluded for the first time over a ten month, ten day period, December 1, 1986 through October 10, 1987; and a "control" group, which consisted of a random sample of non-secluded patients, who were admitted during the same time period as the secluded population.

Four forms of treatment were available: (a) milieu alone; (b) milieu and work-activity; (c) milieu and medications; and (d) milieu, work-activity, and medication. Whether or not a patient received a particular treatment was dependent on the person's psychiatric condition, legal status, or desire to be involved in the treatment program. Also, the regular staff of the admitting unit received 40 hours of training, May 4 - 8, 1987. The characteristics of all secluded subjects were examined prior to and after the staff training. In addition comparisons were made between secluded and non-secluded patients. A series of t-tests and Chi-square tests ruled out the statistical significance of the training program as a factor in the incidence of seclusion. Results indicated there was a relationship between seclusion incidence, diagnosis, and medication treatment.

The findings suggested that psychiatric hospitals can reduce the incidence of seclusion by being more aware of when patients are bi-polar or schizophrenic; and that active treatment especially medication beyond the milieu can assist patients to be more in control of their actions, and thus avoid more restrictive forms of behavior control.

HARRY WESLEY WRIGHT

1988

To my father, Harry Wesley Wright, who would have enjoyed calling me "Dr.", but did not live to do so; to my mother, Helen P. Wright, whose nurturing planted the seeds of my work in psychology; and to Marlin H. Roll, Ph.D., who made it possible for me to begin the study, but who unfortunately passed away before he could see the fruits of his labor in the results -- to all of you this dissertation is dedicated, in that you provided significant parts of the foundation upon which this experience was built.

"If someone comes to you and asks your help, you shall not turn him away with pious words, saying: 'Have faith, God will help you.' You shall act as if there is no God, as though there was only one person in the world who could help this man -- yourself."

-- Martin Buber

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James H. Duke said: "If you find a turtle on top of a fence post, you know it had some help." When a dissertation is completed, the student had a great deal of help, and I certainly did. There is no way I could mention everybody, but I want to acknowledge as best I can those who played a significant part in facilitating my reaching this point in life. Their support, understanding, and encouragement contributed to the completion of this dissertation. I undertook this study because I wanted to contribute to more effective treatment of persons who, for the most part, are economically disenfranchised. I have spent twenty-six years of my life working with persons who have struggled with life because of one reason -- they were poor, economically. But they were rich in so many other ways, and because of their generosity, I have learned most of what I know -- so to clients from Delray, Jackson, Lansing, State Prison of Southern Michigan, and the Caro Regional Mental Health Center, I thank you because you taught me so much.

Several mentors have played a significant part in my growth and development as a person and a psychologist. The Rev. Mr. George H. Yount was my pastor as a youth, and he

pushed me in the right direction. Richard T. Gore, Ph.D., at the College of Wooster, stimulated my intellectual curiosity in ways which still effect me. George Smith, when I was at McCormich Theological Seminary, taught me to communicate more effectively. Clark Moustakas, Ph.D., touched my deep inner self when I studied at Merrill-Palmer Institute, and his impact is still felt as I struggle to be authentic to myself. When I attended Eastern Michigan University, James Weeks, Ph.D., provided me friendship and new insights into psychological assessment. At Michigan State University, William Farquahr, Ph.D., introduced me to some of the great psychological philosophers, and I am better as a psychologist because of him. Floyd Echols, ACSW, when he was at the Caro Regional Center, provided me freedom to be the most effective professional I could be, and showed patience when I made mistakes, allowing me to learn from them.

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I am grateful to all.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER I

INTRODUCTION

More than three million years ago, human life appeared on the earth in some form. A definition of humanity in the course of history has been difficult to ascertain; but there does seem to be some consensus that "humanity" is a function of both a cabability to communicate and an ability to think. Within this long period of human existence, written records have extended back only a few thousand years. But brief glimpses of "primitive history" through art and oral tradition have given an albeit fuzzy picture of earlier times.

In the course of attempting to be aware of history, historians have often focused on questions related to the mysteries of the human mind and spirit. The relationship of both to behavior has been extensively examined. A part of this process has focused on abnormal behavior, or psychopathology. Other words have been used: deviancy, madness, lunacy, mental illness, and mental disorders. Mental disorders, and understanding the causative factors, were often a religious or philosophical concern, as much as they were a medical one. More often than not, the two

points of view were linked together. For example, Coleman, Butcher, and Carson (1980) indicated the following:

> The earliest treatment of mental disorders of which we have any knowledge was practices by stone age cave dwellers some half million years ago. For certain forms of mental disorders, probably those in which the individual complained of severe headaches and developed convulsive attacks, the early shaman, or medicine man, treated the disorder by means of an operation now called "trephining". The operation . . . consisted of chipping away one area of the skull in the form of a circle until the skull was cut through. The opening . . . presumably permitted the evil spirit that supposedly was causing all the trouble to escape. (p. 25)

An argument could be made that the above procedure was an early form of psychiatric treatment.

Since those early beginnings, religion and psychiatry have made quantum leaps in the way troubled and mentally disturbed people are treated. The progress can be observed as history has evolved. But even though various cultures have advanced in the ways mentally ill people have been treated, many old practices still persist. One, seclusion, has been a part of behavior management methodology since various societies have attempted to deal with those who were mentally different.

That seclusion, as part of the treatment spectrum, still is being used in the Twentieth Century is both curious and interesting. It becomes more so in light of the fact that psychiatric treatment as currently practiced is varied in its modalities, and has become more oriented to a scientific frame of reference. New methods of diagnosis, in the form of the PET-Scan, can predict with some certainty whether or not an individual has been afflicted with a bi-polar condition or schizophrenia. Treatment has progressed to where the effectiveness of a medication can be ascertained through sophisticated hemotology studies.

Aside from the advances in treatment and diagnostic technology, psychiatry, in the Twentieth Century, has many methodologies. These practices have attempted to build on empirical advances. But, for the most part, treatment is still considered closer to an art than a science. In this context many forms of treatment have existed, and continue to do so. They have included the following therapies: medication; individual and group; various activity formats, such as recreation, music, and occupational; and milieu. For persons hospitalized, the milieu becomes the most intensive kind of treatment and the most inexact. In the context of milieu treatment, especially in acute care and admitting facilities, seclusion has been experienced by many psychiatric patients.

Seclusion, as a behavior management technique, has been

common in most private and public psychiatric facilities; it has been a means of managing aberrant behavior since the beginnings of psychiatric history. As seclusion has continued to be used, it has created much controversy and discussion, including the generation of significant court cases. Because of the recent focus on seclusion, most states have addressed the issue through mental health codes, administrative policies, and change in facility practices.

The State of Michigan Department of Mental Health has been part of the national policy development process. Statements regarding the practice of seclusion and restraint have been put in place in state code (Appendix A) and Departmental Administrative Policy and Rules (Appendix B). An essential part of policy has been the requirement that each inpatient DMH facility and program formulate appropriate policy guidelines regarding seclusion and restraint practices. It was also required that each treatment facility report on a quarterly basis summary statistics on incidents of seclusion and restraint. It was in the context of this reporting procedure that this study was conceived.

The Caro Regional Mental Health Center is located in Caro, Michigan, approximately 90 miles north of Detroit and 30 miles east of Saginaw. The facility, for the past five years, has had a psychiatric population of 110 and one seclusion room that was available when patients lost control

of their behavior. As required by departmental policy, quarterly reports were submitted by the facility director. But the reports only related information about incidents of seclusion and restraint. Because it was thought more was needed, the Utilization Review Committee of the Caro facility decided to audit the seclusion process. There was a desire to examine additional factors related to incidents of seclusion, including the following: average duration of episode, sex, race, legal status, diagnosis and average age of secluded patients. Thus far nine reports have been submitted, beginning with January 1, 1986 and ending with June 30, 1988. (Appendix E)

The audit reports were summary data, based on persons who were secluded. There was no comparison made to the population of patients who were not secluded. The data was not tested in any way for levels of significance in relation to stated hypotheses. There was no evaluation of the data in relation to treatment strategies. With these limitations, and others not stated, the committee gained from the data some insight into areas of concern which could be investigated in greater depth at a later time. The following represents a summary of some of the information: (1) Persons secluded were primarily schizophrenic, with bi-polar, manic, second; (2) most persons secluded were involuntarily committed; (3) aggression to staff or peers was the primary stated reason for individuals being secluded

except for one reporting period; (4) persons from counties with an urban center were more likely to be secluded than those from rural counties; (5) in some reporting periods, black patients were secluded more than their proportion of admissions; (6) males were generally secluded more than females; (7) the average age was about 35.

Much of the data did indicate concerns, and brought out questions that were of interest. It was because of that interest and the following reasons that this study was undertaken: (1) seclusion is still a significant form of behavior control in psychiatric hospitals and has a potential for abuse; (2) economically disenfranchised persons have constituted the population of state hospitals and become at risk for seclusion; and (3) little empirical work has been accomplished in this area of psychiatric behavior control.

Purpose of the Study

The purpose of this study was to empirically examine seclusion room usage at an acute care psychiatric unit of a state regional mental health center. The variables of interest were patient characteristics; modalities of treatment experienced by patients; and staff training. The relationship of these variables to the incidence of seclusion was tested. Previous studies have provided an unclear picture as to whether or not there was a relationship between decisions to seclude and patient

characteristics (Borstein, 1985; Convertine, 1980; Flaherty, 1980; Gerlock, 1983; Roper, 1985; Schwab, 1979; Soloff, 1979, 1985, 1987). The literature was inconsistent in providing a clear-cut picture of the impact active treatment had on usage of seclusion as a behavior control intervention (Anders, 1977; Bornstein, 1985; Gerlock, 1983; Roper, 1985; Soloff, 1985; Wadeson, 1980). There was little research regarding the influence of staff training (DiFabio, 1978; Romanoff, 1987; Tardiff, 1985). Few of the studies were based on empirically based designs.

In this study first-time secluded patients provided the basis of the research, as well as a random sample of non-secluded patients. Past research has not yielded results which have been consistent. Clarification on this significant issue can help staff understand how to minimize seclusion room usage, and find more therapeutic means to assist patients in regaining control of their lives. In addition, if bias is involved in decisions to seclude, training can address this problem and remove bias as a factor in secluding a patient. Finally, it is important to discover if active treatment helps reduce the incidence of seclusion. If it does, then responsible staff can devise more effective programs to enhance the patient's mental state.

Statement of the Problem

The problem investigated was approached in three ways. One issue examined was whether or not decisions to seclude were based by patient characteristics such as age, sex, race, socio-economic status, diagnosis, or legal status re: admission. Based on preliminary studies conducted at the Regional Center, it was anticipated that some relationship would emerge between incidence of seclusion and certain kinds of pataient characteristics, especially diagnosis, race, age, and physical stature.

The second area investigated by this study was the effect various kinds of treatment would have on the incidence of seclusion. The treatment variables considered were milieu, work activity, and medication. Based on clinical experience, it was expected that the work activity program and medication would have a significant impact on reducing incidence of seclusion.

A third aspect evaluated was whether or not a staff training program for the regular staff of the admitting unit would reduce the incidence of seclusion and the average length of time in seclusion. The one week staff training program had as its purpose teaching staff about the basic philosophy of the facility, which was to minimize external control and to maximize patient internal control. The researcher anticipated there would be a statistically significant reduction of the incidence of seclusion that

could be attributed to the staff training program.

Other areas of interest, but not statistically tested, were reasons for seclusion; temporal issues such as work shift and day of the week secluded; and percentage of seclusion incidents in relation to census and admissions.

The subject groups compared were as follows:

A. First-time secluded patients during a period covering December, 1986 through October 10, 1987.

B. A random sample drawn from all non-secluded patients admitted during the same time-frame as A.

In addition, a comparison was made within the secluded group between those secluded prior to the training program and those secluded after the training program. Staff characteristics were also examined. The training program time period was May 4 - 8, 1987.

Research Questions and Hypotheses

As indicated earlier, the primary objective of this study was to investigate factors related to the incidence of seclusion, with special attention paid to characteristics of patients who were secluded, the effects of various treatment modalities, and the impact of staff training. Comparisons were made between secluded and non-secluded patients in order to ascertain the significance of patient characteristics as well as the effects of various treatments. Using a pre-training post-training comparison, incidence of seclusion and patient characteristics in

relation to seclusion incidents were examined. An appropriate alpha level, .05, was determined for consideration of statistical significance in all analyses. In order to test these questions, several research hypotheses were formulated. The hypotheses, stated in the null format, were as follows:

Hypothesis 1: There are no differences in patient characteristics when comparing secluded and non-secluded patients. The following patient characterstics were considered:

1. Sex;
2. Ethnic group;
3. Age;
4. Height;
5. Weight;
6. Stature;
7. Education;
8. Marital status;
9. Military experience;
10. County of residence;
11. Geographic area;
12. Living situation;
13. Job status;
14. Occupation;
15. Income;
16. Year last employed;
17. Legal status;
18. Previous treatment;
19. Year began;
20. Times in C.R.C.;
21. Times in other hospitals;
22. Diagnosis.

Hypothesis 2: There are no differences in treatment variables when comparing secluded and non-secluded patients. The following variables were considered:

1. Milieu alone;
2. Milieu and Medication;
3. Milieu and Work Activity Program;
4. Milieu, Work Activity, and Medication.

Hypothesis 3: Comparing the pre-training secluded group with the post-training secluded group, there are no differences in the relative influence of variables that lead to seclusion. The following variables were considered:

1. Sex;
2. Ethnic Group;
3. Age;
4. Height;
5. Weight;
6. Stature;
7. Education;
8. Marital status;
9. Military experience
10. County of residence;
11. Living area;
12. Living situation;
13. Job status;
14. Occupation;
15. Income;
16. Year last employed;
17. Legal status;
18. Previous treatment;
19. Year began;
20. Times in C.R.C.;
21. Times in other hospitals;
22. Diagnosis;
23. Secluded/not secluded;
24. Date secluded;
25. Day of week secluded;
26. Days after admission secluded;
27. Shift secluded;
28. Duration of seclusion;
29. Incidents of seclusion;
30. Reason given;
31. Treatment received;
32. Staff sex;
33. Staff race;
34. Staff seniority;
35. Staff classification;
36. Staff trained;
37. Mentally ill census;
38. Admitting unit census.

Definition of Terms

The terms described in this section are defined as they are used in the text of study. Many of the basic

definitions had their origin in the Psychiatric Glossary (1984), with permission to quote granted (see Appendix ___)

Acute Care: Psychiatric care given when a patient's illness is in its most intense and exacerbated state. Usually, the acute state is early in a psychiatric episode.

Agitation: Motor activity that is excessive, and is usually nonpurposeful and associated with internal tension. Examples are: inability to sit still, pacing, excessive energy, and fidgeting.

APA: American Psychiatric Association: The primary professional organization for psychiatrists in the United States.

Biological Psychiatry: Treating mental illness with an emphasis on treatment approaches that use drugs to reduce symptoms. Causes of mental illness are thought to have a physical, chemical or neurologic basis.

Bipolar Disorder: A major affective disorder in which there are either episodes of mania or depression, or both. Bipolar disorders may be subdivided into manic, depressed, or mixed types, depending upon presenting symptoms.

Chemical Restraint: The administration of medication, regularly, or as needed, for the purpose of preventing or stopping disruptive, destructive, aggressive, self-injurious, or other behaviors considered dangerous to the individual or others (Orlando, 1982).

Chronic Mental Illness: A psychiatric condition which

persists over a long period of time, and disables the person. Generally, this is associated with schizophrenia, and usually progresses to an irreversible psychosis.

Commitment: A legal process which facilitates admission to a psychiatric hospital. Usually, it applies to a court procedure, but can also be voluntary.

C.R.C.: Initials for the Caro Regional Center, or Caro Regional Mental Health Center, located in Caro, Michigan, or more precisely Wajamega, Michigan.

Deinstitutionalization: Change in the focus of care in mental health from traditional in-patient institutional settings to community-based out-patient services.

Delusion: A false belief that a person holds onto despite clear evidence to the contrary, and it is a belief not accepted by persons in the individual's culture. An example would be a person who thinks she is the bride of Christ.

Depression: When describing a mood, this refers to feelings of sadness, despair, or discouragement. It can be reactive, as in response to a significant loss; or it can be a part of a bi-polar condition, which is based on a bio-chemical imbalance. Sometimes this kind of condition can result in extreme agitation.

D.M.H.: Initials used to refer to the Department of Mental Health, State of Michigan.

Dual Diagnosis: Refers to persons who are diagnosed with

both a psychiatric problem such as a Bi-polar illness and a drug problem, e.g. cocaine abuse.

Dynamic Therapy: Therapy which emphasizes examining motivation, meaning, and biologic insticts as a part of a process of understanding human behavior. The treatment focus is on the patient talking and working through the problem areas.

ECT: Commonly called "shock" treatment, but correctly called Electroconvulsive Therapy; a small electric currrent is used to induce convulsive seizures, which have a positive effect in treating depression. The treatment was first introduced in 1938.

Empathy: The awareness that one person has about the meaning of feelings, emotions and behavior of another person. Some think of it as the ability to "walk in another's shoes".

Etiology: The process of understanding the causes of a disease.

Existential: Refers to the way a person experiences the world and takes responsibility for what is happening.

Exorcism: A religious practice or ritual used in earlier times to drive out "evil spirits" in mentally ill people.

First-Time Admission: In the context of this study, refers to a first admission during the time frame of the study, i.e. December 1, 1986 through October 10, 1987. The

patient could have been previously hospitalized in the admitting unit earlier, or later during the time-frame of the study.

Geographic Area: Refers to the kind of area where a person had lived prior to admission to the hospital. Examples are city, small town, rural area, inner city, or suburban.

Guidelines of Care: Policy statement regarding various forms of treatment to be made available at the psychiatric unit of the Caro Regional Center.

Hallucination: A sensory experience that occurs in the absence of actual external stimulus. In psychiatric populations the most common are auditory and visual.

Incidence: The number of cases of a disease or behavior which took place in a specific time period.

Insight: Having an understanding about the nature and extent of an illness; in this situation mental illness.

Involuntary Commitment: Being admitted to a psychiatric facility against the will of the patient; usually, a probate court effects the order as the result of a petition.

JCAH: Joint Commission on Accreditation of Hospitals; an agency that surveys and accredits hospitals as fulfilling their particular standards.

Labile: Rapidly shifting emotions; unstable.

Legal Status: Refers to the means of admission into the hospital, e.g. voluntary or court-ordered examination.

Living Situation: Indicates the level of independence a person had prior to a psychiatric admission; e.g. dependent meant having resided in an adult foster care home; Semi-independent indicated having lived with a family member; independent described having relied on one's self.

LRA: Least restrictive alternative; a legal as well as a clinical concept; used in the context of behavior management, where in choices of treatment, the least restrictive measure is chosen in order to manage out-of-control behavior.

Mental Illness: An illness with psychologic or behavioral manifestations, which is characterized by symptoms that result in impairment in functioning. In a legal sense, it is considered a disorder of mood or thought, where the person's judement is impaired, the individual is a danger to others, self or property, or cannot take care of basic needs.

Milieu: See definition Chapter III.

Moral Treatment: This was a philosohy of treating mental patients that emerged in very last part of the 18th century and first half of 19th century. The emphasis was on removing restraints and treating people in a humane and kindly way.

NIMH: National Institute of Mental Health; a federal government agency which funds research programs.

Occupational Therapy: A therapy approach which

utilizes purposeful activities as a means of altering the course of an illness. The program is viewed as a means to assist the patient to regain self-control and self-esteem.

PET Scan: A form of x-ray using computer technology to diagnose schizophrenia and bi-polar illness.

Poly-Pharmacy: Using more than one medication to treat a mental disorder. Generally, this process is discouraged.

Precipitants: In this study, reasons given for patients being secluded. The focus is on behavior and the intensity of agitation and agression.

Psychosis: A thought disorder which effects a persons ability to think, remember, communicate, and interpret reality.

Psychotropic Medication: Medication which is used primarily to treat mental illness. Examples are Haldol, Mellaril, and Elavil.

QMHP: Qualified mental health professional; a person who monitors and coordinates a treatment program.

Resident Care Aides: Commonly called direct care staff, or attendants; persons who work directly with a group of patients in a residential building of a psychiatric hospital. At CRC, RCA staff also work with patients in activities away from the residential area.

Restraint: The use of any device or mechanical method to restrict the mobility of an individual, or the movement, use of, or access to, any portion of an individual's body

for the purpose of preventing or stopping disruptive, destructive, aggressive, self-injurious, or other behaviors considered dangerous to the individual or others (Orlando, 1982).

Retrospective: In this instance, evaluating data based on events that have already taken place, and not manipulated by the researcher.

Schizophrenia: A large group of disorders that usually are psychotic, manifested by characteristic disturbances of thought, affect, perception and behavior, and usually lasting six months or more. It is believed that the etiology of the disease is organic in nature.

Seclusion: Confinement of an individual alone in a locked or lockable space for protection of the individual, others, or property, and/or contingent on exhibition of specific behaviors (Orlando, 1982).

Side Effects: In the context of medication usage, effects on the body that are not normal and sometimes dangerous. Two common effects are tardive dyskinesia and dystonia.

Staff-O-Genic: Staff actions which result in patient behavior which is not appropriate.

Stature: A characteristic of patients, combining the variables height and weight. The measure is pounds per inch of height.

Treatment Team: A group of staff who are primarily

responsible for the treatment of patients. The team consists of the following: Psychiatrist, social worker, psychologist, occupational therapist, nurse, and direct care staff.

Underclass: A sociology term which refers to a group of people who have become disenfranchised economoically, and find it difficult to break the cycle because of systemic forces.

Utica Crib: A restraint device created in the 19th century, which was used to control overly aggressive mentally ill people.

Summary and Overview

In chapter I, the reader was introduced to seclusion as a behavior control method, and as a problem in psychiatric treatment. The history of this methodology was shown to be long, controversial, and troublesome. Even with the paradox of seclusion, it is still used extensively in public and private hospitals. As a result of legal cases, particularly Youngberg v. Romeo (1982), states such as Michigan have developed codes, policy and rules regarding seclusion and restraint.

Because of the attention paid to seclusion room usage in recent years, researchers have examined practices related to the behavior control method. For the most part, the results of the research have been inconsistant. Also most of the research has not been emperically based. The intent

of this research was to address some of the points of unclearity, and add new dimensions to the current literature. Of particular interest is whether or not structured treatment programs will facilitate a reduction in the incidence of seclusion; and whether or not a staff training program will impact on seclusion room usage patterns. Finally, it was examined as to whether or not patient characteristics contributed in any biasing way to the decision process regarding seclusion.

Chapter II reviewes pertinent historical, theoretical, legal and research literature. The methodology of the study is described in Chapter III. The results of the data analysis are contained in the fourth chapter. Chapter V presents a summary of the study, major findings, conclusions, discussion, and implications for future study and practice.

CHAPTER II

REVIEW OF RELATED LITERATURE

An Historical Review

Psychiatric historians have taken the view that the study of human behavior is as old as recorded history: "The history of psychiatry is, at the same time, the history of civilization. As man increased his knowledge of the world around him, he also increased his knowledge of the world within." (Kaplan and Sadock, 1981, p.1)

The views about abnormal behavior became more clear as ancient societies moved from oral tradition to writing ideas and points of view. There were "references to mental disorders in the early writings of the Chinese, Egyptians, Hebrews, and Greeks [which] show that they generally attributed such disorders to demons that had taken possession of the individual." (Coleman et al., 1980, p.25)

In many of ancient cultures, spirits were viewed as either "good ones" or "evil ones". It depended upon what kind of behavior was being exhibited, as to whether the inhabiting spirit was called positive or negative. This belief was part of a broader perspective which had as a foundation that good and bad spirits "were widely used to

explain lightning, thunder, earthquakes, storms, fires, sickness, and many other events that otherwise were incomprehensible". (Coleman et al., 1980, pp. 25-26)

Most, if not all, of the deviant behaviors were viewed as stubborn ailments, and it became a significant pursuit to discover the causes of the madness. In the context of evil spirits inhabiting the person, Gross (1978) reported the following: "The Assipu priest-physicians of ancient Mesopotamia preached that mental illness was generated by devils within the body. They could only be exorcised by religious magic, including incantations which bear remarkable resemblance to modern psychotherapy. (p. 100)

In another part of the region, "The Hebrews spoke of the one God, Yahweh, as a cause of mental illness." (Gross, 1978, p. 100) Yahweh was viewed as the creator and arbiter of health and disease, with mental illness as one manifestation of His wrath. Gross (1978) summarized from I Samuel 27-31 in the Old Testament, a threat that Yahweh seemingly enforced against King Saul, which resulted in Saul going into a deep depression, and then suicide. This was thought to be a fulfillment of a statement attributed to Moses in Deuteronomy 28:28: "The Lord will smite you with madness . . . and confusion of mind". (p.100) The interpretation of this particular incident was seen in the following way: "Apparently this was thought to involve primarily the withdrawal of God's protection, and the

abandonment of the individual to the forces of evil". (Coleman et al., 1980, p. 25) So central to Hebrew theology was the belief about the religious basis of mental problems that treatment for these problems was reserved strictly for the priests. This frame of reference was maintained even when lay physicians began to deal with various illness. (Gross, 1978, p. 100)

Early Greek culture believed supernatural powers were the primary reason for mental disorders. Basically, the belief was that possessed people were being punished for offending the gods, one being the goddess "Mania". (Kaplin et al., 1981, p. 1) The deviant behavior for which "Mania" was blamed could be close to what is currently called bi-polar illness, manic phase.

Early Greek culture provided no specific treatment or care facilities for the mentally ill. But, as wisdom and knowledge grew, Gross (1978) noted that "Aesculapian healing temples were constructed on beautiful sites, adorned with gardens and offering luxurious baths". (p. 100) Gross further stated that in settings such as these, instructions were given concerning diet, cleanliness, and dreaming.

Most likely, the healing temples were a form of the seclusion process. McCoy and Garritson (1983) observed the rooms were designed so patients could sleep and dream away their illness. (p. 9) In a similar vein, Wells (1972) discovered an observation written by a Roman, Soranus, in

the second century A.D.:

> Have the patient lie in a moderately light and warm room. The room should be perfectly quiet, unadorned by paintings. . . . Do not permit many people, especially strangers, to enter the room. And instruct them to correct the patient's aberrations while giving them a sympathetic hearing. (pp. 410-413)

However, it would be a mistake to presume that all the treatment was as humane as in the Aesculapian temples. Coleman et al., (1980) said that often those who were too ill to be helped were turned away; or those who were recalcitrant were starved, flogged or chained. So basically the early Greek period was one of transition. Exorcism and harsh means were used in the context of accepted beliefs in demonology, but the Greek time period was a beginning of more enlightened treatment of mental disturbances. (p. 26)

As a part of this period of transition, and the evolution of ideas concerning mental illness, several Greek, Roman, and Arabic scholars expressed the belief that mental disorders were a part of natural functioning and phenomena. Plato and Hippocrates effectively put forth this position in the fourth century, B.C. (Sarason, 1976, p. 9) The problem was that as enlightened as these persons were, "superstitious practices continued to determine the popular attitude toward the mentally ill who were neglected, banned, or persecuted". (Kaplan and Sadock, 1981, p. 21)

Instead of the progressive approaches of Hippocrates, and others, many preferred less desirable means of "treatment" such as bleeding, purging, and mechanical restraints. Most likely the dark ages in the history of abnormal psychology began around 200 A.D., at the time of the death of Galan, a Roman devoted to the tradition of Hippocrates. At this time popular superstition prevailed, and most of the medical people of Rome returned to believing in some form of demonology. (Coleman et al., 1980, p. 29)

The Dark Ages in European history were brought about by the fall of the Roman Empire toward the end of the fifth century. The growth of superstition continued, and as noted above, impacted on the treatment of individuals inflicted with various forms of mental illness. As theology, superstition and demonology became intertwined, "human beings. . .became the battle grounds of demons and spirits who waged eternal war for the possession of their souls". (Coleman et al., 1981, p. 30)

During the Dark Ages Christianity became predominant, but treatment accorded the mentally ill was not reflective of the Christian gospel of "Agape" or love. Benign attitudes were suppressed, with belief in mysticism and witchcraft becoming wide-spread. Religion became contaminated with magic and alchemy, and "the authoritarian church arbitrarily labeled specific behaviors unwanted or undesirable and claimed it could exorcise the demons that

possessed people". (Sarason, 1976, p. 9)

In contrast, during medieval times, it was primarily in Arabic countries where the more scientific aspects of Greek thought on mental illness survived. In 792 A.D. a mental hospital was established in Baghdad, and others were established in Aleppo and Damascus. In the context of the treatment received by the mentally ill, there was a significant discrepancy between the apparent humane treatment given in these areas and the more primitive and cruel treatment given in Christian countries. (Coleman et al., 1980, p. 29)

In addition to the Arabians, there were others in this time frame who attempted to present an enlightened and scientific view. But more often than not they were labeled heretics or trouble makers. As these individuals attempted to suggest the thought that strange behavior might result from a psychological or physical malady, it was summarily rejected. As McMahon (1976) stated:

> Medicine during the Middle Ages and the early Renaissance was hopelessly inadequate when coping with bizarre behavior. Most diagnoses of mental disturbance by layman and "physician" alike seemed to amount to labeling the patient either a "madman" or a "fool". (p. 22)

Even though by contemporary standards, the attitudes and treatment for the mentally ill were primitive, generally

people were treated in a benign way. In some cultures, those who were seen as deviant were viewed as being special and possessing unique religious powers. But over-all, persons were allowed to roam free and were left to their own devices, unless they became a problem. Then the various treatments of the time were put in place. Coleman et al. (1980) made this observation:

> During the early part of the medieval period, the mentally disturbed were for the most part treated with considerable kindliness. Much store was set by prayer, holy water, sanctified ointments, the breath or spittle of the priests, the touching of relics, visits to holy places, and mild forms of exorcism. (p. 29)

But as theological beliefs and ideas concerning mental illness became more developed and confounded, so too treatment became more harsh. There seems to be a correlation between the rise of the institutional church and the rather ingenious ways that were devised to deal with those people who were viewed as different. If persons were seen as devient or dissident, they were dealt with in harsh and cruel ways, and justified by church leaders as a means to maintain the peace and the purity of the church.

It was in this context that the embryonic development of seclusion and restraint methodology began to emerge. The following was the belief which justified the harsh treatment of those considered mentally ill:

> It was generally believed that cruelty to people afflicted with "madness" was punishment of the devil residing within them, and when "scourging" proved ineffective, the authorities felt justified in driving out the demons by more unpleasant methods. Flogging, starving, chains, immersion in hot water, and other torturous methods were devised in order to make the body such an unpleasant place of residence that no self-respecting devil would remain in it. (Coleman et al., 1980, p. 33)

Thus, as the middle ages wore on, exorcism of persons supposedly possessed by unknown and harmful intruders became a regular occurence. It was in this context that beliefs regarding witchcraft began to appear. As this train of thought began to grow in the early 15th century, the new system of printing, which facilitated communication, spread the belief. Pope Innocent VIII, through a papal bull, in 1484 encouraged persecuting those accused. (Kaplin and Sadock, 1981, p. 3) There were some who were detractors, but they were basically a minority. By the close of the 15th century, persons mentally ill were considered heretics and witches. (Coleman et al., 1980, p. 34)

In addition to the harsh treatment given, including the placment of mentally ill persons in prisons or in the cellars of monasteries, by the 15th century some unique means were employed to exclude the "mad". Miller (1976)

wrote about "ships of fools" and described the process this way where mentally ill people were placed on:

> ships with instructions to the captain to discharge them at the next port. . . . The typical response. . .was to return these troublesome people to their native city, and thus for a period the mad wandered back and forth across Europe." (p. 4)

In the 16th century, monasteries and prisons slowly relinquished caring for persons with mental disorders. As this happened, special institutions for mentally ill persons began to be established in significant numbers. Miller (1976) reported about an historian who had written abouton the mentally ill in the Renaissance and called the time, "The Great Period of Confinement". The newer approach involved not only the mentally ill, but many other kinds of "troublesome" persons. At first the purpose was containment and maintaining social order; but restraint and seclusion became more predominant. (p. 45)

Coleman et al., (1980) wrote about the beginning of the confinement period, and the establishment of one of the first hospitals, or asylums, created. It was the monastery of St. Mary of Bethlehem in London, which was created in 1547 under an edict of Henry VIII. Its name, as time passed, became shortened to "Bedlam", and the institution became known for deplorable practices and cruel treatment of mental patients. (p. 29) McMahon (1976) indicated that in

places such as Bedlam, mentally ill persons were caged like wild animals. If an individual was thought to be dangerous, chaining him/her to the wall was the primary means of control. (p. 23)

Many during the period were not comfortable with what was happening; therefore rationalizations emerged which went beyond the theological and medical justifications. McMahon wrote about this time, including material from Foucault:

> One of the reasons given for treating patients in this fashion was that they were considered specially endowed by nature with special "abilities" such as those found in animals in which the "lunatic was protected from whatever might be fragile, precious, or sickly in man". For example, it was thought they could inherently survive the cold, and thus had no need to be covered or warm. Furthermore, this animality of the patient could only be mastered by severe dicipline or torture. (p. 24)

Coleman et al. (1980) presented an outline of the growth of asylums for the mentally ill, which were established in various countries during the next three centuries: Mexico (1566), France (1641), Moscow (1764), Vienna (1784), Philadelphia (1756), and Williamsburg (1773). It was noted that the hospital in Williamsburg was the first facility constructed in the United States which had as its exclusive purpose treatment of persons with mental

disorders. The authors also stated the basic problem with these early asylums was they were essentially modifications of prisons. Persons confined in them were treated more like animals and criminals than sick persons. (p. 39)

The treatment given was justified by the animal like rationalization indicated above. Yet, in this period, "the arrangements that presented the insane as wild and dangerous beasts was an appeal to the public to accept the moral yardstick of the absolute state of its own measure of reason". (Doerner, 1981, p. 17) Doerner then described how most mentally ill persons were treated:

> Special forms emerged, whereby the unreason of the insane was related to social rationality. . . . The insane occupied a special position -- and particularly the most dangerous among them namely the frenzied, the angry, the threatening, i.e. the maniacs. These were . . . exhibited as caged "monsters" to a paying populace. . . . These exhibitons in Paris, London and various German cities vied for audiences with animal acts. . . They were displays of a wild and untamable nature, of "bestiality", of absolute and destructive freedom, of social danger which could be demonstrated far more dramatically behind the bars of reason. (p. 16)

The point of view the "exhibitions" showed was that mentally ill people reflected humanity in a fallen state. It was vividly shown to the people, and was to be a deterent

to the populace so they might more readily be motivated to avoid Satan and thus be in a state of grace.

Snelling (1943), focusing on seclusion and restraint, gave an overview of how the chronically mentally ill were treated in a hospital in Paris.

> The patients were ordinarily shackled to the walls of their dark, unlighted cells by iron collars which held them flat against the wall and permitted little movement. Ofttimes there were also iron hoops around the waists of the patients and both hands and feet were chained. Although these chains usually permitted enough movement that the patients could feed themselves out of bowls, they often kept them from being able to lie down at night. . . . The cells were furnished only with straw and were never swept or cleaned; the patient was permitted to remain in the midst of all the accumulated ordure. (pp. 54-55)

Coleman et al. (1980) observed that conditions for mentally ill people in the United States were not much better. They gave the following description of treatment in colonial times:

> The mentally ill were hanged . . . tortured and otherwise persecuted as agents of Satan. Regarded as subhuman beings, they were chained in specially devised kennels and cages like wild beasts, and thrown into prisons. . . like criminals. . . . They were left to

> wander about stark naked, driven from place to place like mad dogs. (pp. 40-41) subjected to whippings as ?? vagrants and rogues. (pp. 40-40)

Coleman et al. further noted:

> Even as late as 1830, new patients had their heads shaved, were dressed in straitjackets . . . and placed in a dark cell. If these measures did not quiet unruly or excited patients, more severe measures such as. . . cold baths were used. (p. 41)

Even with the controling and punishing methods described in the preceeding paragraphs, the late eighteenth and early nineteenth centuries was a period of transition in the care of the mentally disturbed. It was realized that not all mental patients had to be confined, secluded or restrained. The person who who most symbolized this period of change was Phillipe Pinel, a French physician who was appointed to be the director of the La Bicatre Hospital in France. The movement was known as "moral treatment", and had a significant influence on how mentally ill people were cared for in Europe and in the United States. (Almond, 1974 (p. xxxiv)

Pinel believed mental patients should not be chained or confined in dungeons, but instead be treated with consideration and kindness. He argued for reform during the French Revolution, and as a part of an experiment the chains were removed, after many had been shackled for over 30

years. Living areas were made more habitable, and patients were allowed to walk around the hospital grounds and generally have freedom of movement. The response was often miraculous, with many patients who had been confined for years going home with symptoms in remission. (Coleman et al., 1980, p. 42)

During this period there were others who contributed to reform. In Italy Vincenzo Chiarugi (1759-1820) prohibited cruel methods of restraint or physical force, with the exception of occassional use of a straitjacket. William Tuke (1732- 1822) in England began a hospital for mentally ill Quakers, and developed a treatment philosophy based on principles related to moral treatment. The only means of restraint were strait-waistcoats, and confinement rooms for temporary occupancy. (Kaplin and Sadock, 1981, pp. 4-5)

In the United States, the transition from the superstitious to more humane treatment was facilitated by the moral therapy movement that was going on in Europe. Benjamin Rush (1754-1813) and Dorothea Dix (1802-1887), wew particularly influencial with both reformers being effected by the work of Pinel and Tuke. Tuke had an impact in Pennsylvania because Quakers from England settled in the state, and imported with them Tuke's treatment philosophy of dealing with the mentally ill. (McMahon, 1976, p. 24)

McMahon saw Benjamin Rush as an advocate for reform and one who encouraged more humane treatment of those who

experienced mental problems. He placed great emphasis on organic reasons as being a significant contributing cause of mental disturbance. (p. 24) Jimenez (1987) writes about Rush in the following terms: He "made the first and most elaborate attempt to link somatic and ethical dimensions of insanity in this country". (p. 72) He believed the brain was essential to understanding the process and cause of mental illness. Thus, he was "distinguished by being one of the first American authors to describe madness as a disease". (p. 73)

But Jimenez observed that related to the organic perspective was the moral dimension. Rush agreed with Pinel's category of moral insanity, a concept which Rush introduced to the United States in 1786. Thus, as Rush speculated about mental illness, and saw it partly as a moral and spiritual phenomenon, he thought:

> Madness could affect both the will and the reason, since the will was thought to be the seat of moral faculty. The notion that the will was affected by madness was central to the belief that failure of willpower could lead to the condition. (p. 73)

The belief Rush had about the will being the seat of the moral faculty contributed to a paradox in his point of view. He believed in "moral insanity", and that the will also had a great deal to do with controlling behavior. Rush further thought that passions were a part of what made

madness what it was; therefore, control had to be imposed when there seemingly was no control. For instance, he invented the "tranquilizing chair" as a means to bring mentally disordered persons back to sound reasoning. This was a torturous device in which the patient was immobilized by use of straps. The feet were tied to the bottom of the chair; the hands to the arm rests; and the torso to the back of the chair. About the head was placed a block-like apparatus, which apparently squeezed in on the temple areas. (Coleman et al., 1980. pp. 44-45)

The punishing nature of some of Rush's treatment had a direct relationship with his belief about the reason for mental illness. From Rush's standpoint "madness" was often brought about by lack of control and excesses of the mind or body. Based on this frame of reference, aside from the restraining chairs, he used other means that were typical of the period such as purging, blistering, dunking in water, blood-letting, and use of straitjackets. Solitary confinement was also used. All were thought to be useful, especially for the unruly and those inflicted with the wildness of mania. (Jimenez, 1987, pp. 108-109)

But Benjamin Rush was a symbol of the transition period, and he established the first hospital that had as its purpose treating persons with psychiatric problems. Based on Tuck's philosophy, in 1817, the Friends' Asylum was created in Philadelphia, and this was the first American

Hospital that had moral treatment as its basic treatment philosopy. Almont (1974) reported that over the next 30 years 18 hospitals were built for this kind of treatment. At first, they were privately backed, and then joint state-private institutions were created. The first of these was in Worcester, Massachusetts. (p. xxxv)

In 1833, the Worcester State Lunatic Hospital opened and was created for the "furiously mad". It had the premise that the hospital would have a system of humane treatment that would not include whips, confinement, starvation, or suffocation in water. But half of the 164 admitted were viewed as hopeless and out of control, and they were confined. Thus, from the beginning, the original purpose of "moral" treatment was violated. In addition, the confinement at Worcester served the purpose of removing the people a great distance from the "sane population" of the state. (Jimenez, 1978, pp. 114-115)

In the middle 1800's, the 19th century optimism about moral therapy provided a rich background for Dorothea Dix to begin her work. Coleman et al. (1980) stated that between 1841 and 1881 she carried on an intense campaign:

> that aroused the people and the legislatures to an awareness of the inhuman treatment accorded the mentally ill. Through her efforts many millions of dollars were raised to build suitable hospitals and some twenty states responded directly to her appeals.

(p. 45)

Overall, she is credited with the establishment of thirty-two hospitals, two of which were in Canada. In addition, she directed the reform of the asylum system in Scotland and several others countries. (Coleman et al., 1980, p. 50)

In spite of the impact of Rush and Dorothea Dix, attitudes toward the mentally ill were still based on superstition, fear, and repugnance. But with Dix's work there was a significant beginning to a public system to treat mental patients. "at the same time the original small asylums had been transformed into large custodial institutions to house chronically ill patients. Once again, the therapeutic function provided by the milieux was reverting to confinement." (Gunderson, Will, and Mosher, 1983, p. 2)

According to Jimenez (1987) the direction toward confinement had begun in Massachusetts with a 1796 law which authorized the detention of those called "furiously mad". With this legal justification, the trend toward confining the harmless insane became accepted policy. This movement carried into the nineteenth century, and into the twentieth as well. This meant that the custodial mental hospital became the primary solution for treating mental illness all over the country. By 1875 there were more than sixty state-supported mental institutions in the United States. (pp. 137-138) Coleman et al. (1980) noted that the rural

institutions Dix advocated as places for moral treatment became in the last half of the nineteenth century:

> the big house on the hill" with its high turrets and fortresslike appearance (and) became a familiar landmark in America. . . . To the general public . . . the asylum was an eerie place, and its occupants a strange and frightening lot. (p. 46)

The hospitals were supposed to be centers of holistic treatment, and places where persons could experience meaningful care. Instead they became large facilities, housing thousands of emotionally disturbed persons. The reformers who advocated moral treatment inadvertently created chaos. With the large influx of patients from all directions, the staff and the facilities became overtaxed to the breaking point. Because of the large numbers, control rather than treatment became the central issue. (McMahon, 1976, p. 26)

Almond (1974) presented a picture of the period by citing Henry Burdett, an English physician who in 1891 described care in American mental hospitals through a four-volume study called Hospitals and Asylums of the World. Burdett said "it would appear lunatics in America were still regarded as a class to be confined first, and perhaps cured afterwards". American institutions were depicted as being overcrowded, deteriorating, extensively using physical restraint and manipulation, and very seldom having a

therapeutic orientation. (p. xxxix)

Because of the increasing numbers of people, many being unmanageable, various devices were created for purposes of control. For example, as late as 1882, many institutions used the "Utica crib". It had the shape of a single bed, with slats eighteen inches in height on the sides. The top and bottom were also covered with slats. The person would be forced into the crib, and kept there many hours, until he/she calmed down.

Clifford Beers, in 1908, published A Mind That Found Itself. In this autobiographical account he described his own mental illness and treatment in three institutions. Chains and other torture devices were not used, but the straitjacket was. He told of the painful immobilization of the arms, and how this affected him and other overwrought mental patients by increasing inner excitement. (Coleman et al., 1980, pp. 45-46)

In addition to devices such as the crib and strait jacket, the seclusion room became a reality in the many hospitals built in the late nineteenth and early twentieth century period. Inspection of buildings built during this time shows numerous rooms being set aside for seclusions purposes. This was true in the large public hospitals and in the smaller private facilities as well. As the hospitals became more overcrowded, and control issues became more predominant, staff persons, for the most part, were

untrained or unaware of issues related to moral treatment. When difficult management issues arose, and because of staff attitudes toward the mentally ill, the seclusion room became the primary answer to solving the problems of out-of-control patients.

Another significant change began to take place as treatment philosophies changed in the decades around the turn of the twentieth century. As written above, one of the contributions of Rush was his thought that the causes of mental illness could be found in the organic realm. As this focus began to take hold, physical means of treatment became more predominant.

All through history, there have been attempts to alter the behavior of the mentally disordered by means of physical manipulations. Earlier, mention was made of treatment directed at the body through the process of a trephined skull. Barbiturates have been used for centuries as a means of calming hyperactive persons. McMahon (1976) noted that various forms of "shock treatment" also have been used since the eighteenth century. Examples of some rather primitive and gruesome procedures included dropping persons into snake pits or a vat of cold water, and injecting the person with various diseases such as small pox. The idea behind all of this was to stimulate the organism to the point where the individual would be shocked into reality and sensibility. (p. 251)

This kind of treatment was often used as a form of punishment and control as well as being used in attempt to heal and cure. Coleman et al. (1980) observed:

> The fundamental purpose seems to have been not so much to frighten the person out of his or her madness, but rather either to punish the demon in residence in the patient's body or to alter the patient's physical or biological state which was presumed to be the underlying cause of disorder. The latter rationale still forms the basis of biological treatments of the present day, though methods have become more sophisticated and more guided by scientific advances. (p. 617)

In the early 1900's, the intrapsychic or dynamic approach came into being, especially with the Freudian influence. In some respects, this persepctive has its heritage in the moral treatment movement, and made use of some of its methodology, especially "talk" therapy. But in the United States, as the Twentieth Century progressed, Kaplan and Sadock (1981) observed the period could be "characterized by a rather strong dichotomy between the biological orientation and the dynamic orientation". (p. 10)

The biological, or physical, methods did become an important part of treatment methods in the 1930's and the 1940's, especially shock treatments and psychosurgery. Coleman et al. (1980) wrote that shock treatments, or

convulsive therapies, in contemporary times, came into usage when insulin shock therapy was introduced in 1932. This method of treatment was seen as dangerous, unreliable and disappointing. In its place came electro-convulsive therapy (ECT), which was introduced in 1938. At first, this means of treatment was used for a variety of psychiatric conditions including schizophrenia, hysteria, obsessive-compulsives, personality disorders, various other forms of neurosis, and depression. Without understanding why, it was discovered that ECT had positive effect on depression, and is currently used in most private hospitals as a form of treatment for endogenous type depression.

Coleman et al. also wrote about a surgical procedure which was introduced in the 1930's, "prefrontal lobotomy", "In the two decades between 1935 and 1955 (when the new anti-psychotic drugs became widely available) tens of thousands of mental patients throughout the country and abroad were subjected to prefrontal lobotomy and related neurosurgical procedures." (p. 620) This form of treatment was an attempt to help people who were suffering chronic psychoses. But a tragic feature was that psycho-surgery became a means of controling unruly and out-of-control patients. The problem with the surgical procedures, in addition to the misuses, was significant side effects, including death.

The point in bringing in the development of these

various treatment modalities in the context of a study on seclusion is that these approaches were used as ways to control patients who would be out of control or who would not conform. Ken Kesey (1962) in One Flew Over the Cuckoo's Nest particularly brought out this perspective in a fictionalized account of his own experience in psychiatric treatment. His primary character was a rebelious person, who would not be controlled within the context of the milieu of the hospital. As a result, he first was secluded and restrained. When he continued to rebel, ECT was administered. Finally, when he disrupted the facility routine one time too many, a prefrontal lobotomy was performed.

Kesey's position has been criticized as not reflecting the reality of much of psychiatric treatment, but these procedures were used as a means of control and restraint in recent past history. An example will illustrate how these treatments were used to control patients who would not, or could not control themselves or fit the expectations of the treatment facility. In the middle 1950's, at a private 100 bed middle-west psychiatric hospital, ECT was used as a means of treatment as well as control. This facility also made extensive use of seclusion and restraint, especially with straitjackets. ECT was used for a variety of diagnostic categories as well as when patients became unruly and unmanageable.

The procedure was to first seclude an agitated individual in one of the fifteen seclusion rooms located in the basement of the acute-care building. In addition, various barbiturates were used in conjunction with the seclusion room. If the person did not calm down, then he/she would often receive ECT. The patients all reported fearfulness about receiving ECT, and often the promise of the procedure acted as a deterrent to out-of-control behavior. A common comment by some direct care staff was, "If you don't shape up, you'll be zapped". In July 1954, the psychotropic medication, Thorazine, was introduced to the facility for experimental use. Almost immediately, seclusion room usage was cut in half, and as this facility moved into the emerging era of pharmacology, so did a new form of restraint, i.e. chemical restraint and control.

In the same hospital, another way to control patients was the use of enemas at least twice a week. This practice at the facility was never explained medically. Because constipation was not a significant problem of the patients, the practice was reflective of the early purgings that were used hundreds of years ago.

As mentioned earlier, the 1950's brought in a new era when medication compounds were discovered which could significantly impact on treatment outcomes. Coleman et al. (1980) reflected on how drugs were used prior to the introduction of psychotropic medications in the 1950's:

> Early efforts in this direction were limited largely to a search of chemical compounds that would have soothing, calming, or sleep-inducing effects. Such drugs . . . would make it easier to manage distraught, excited, and sometimes violent patients. Little thought was given to the possibility that the status and course of the disorder itself might actually be brought under control by appropriate medication; the focus was on rendering the patient's overt behavior more manageable and thereby making restraint devices such as straitjackets unnecessary. (p. 621)

As psychoactive medication became a more central part of treatment, especially in custodial facilities, seclusion and restraint practices did go through a process of change, i.e., treatment facilities used seclusion rooms with less frequency.

As the 1960's progressed into the 1970's, with the new therapeutic developments, psychiatric patient population figures began to become smaller. Jimenez (1987) observed that until the middle of the Twentieth Century:

> The custodial mental hospital was the dominant solution all over the country. . . . By 1875 there were over sixty public mental hospitals in the United States. In 1976, thirteen years after the federal government inaugurated a policy of deinstitutionalization and a reduction in the number of state mental hospitals

> through the Community Mental Health Centers Act, there were three hundred public mental health hospitals in the country. (p. 138)

For a period well into the 1980's the reduction in patient population continued. But in recent years, the patient numbers in public hospitals has begun to creep up to 1963 levels. As admisions increased, and as there have been significant cut-backs in the availability of financial resources for mental health care, problems related to seclusion and restraint usage again became significant.

The historical survey is summarized in Table 1. It shows that seclusion and restraint has been consistantly used from the earliest times to the present.

Table 1: An Historical Overview of the Treatment of the Mentally Ill

TIME PERIOD	SOURCE OF ILLNESS	TREATMENT METHOD
To 500 BC	Demons, spirits whether "good" or "bad"	Exorcism, religious incantations
500 BC to 100 BC	Greek popular: Super-natural powers; Greek scholarly: natural powers	Some religious through healing temples. For others, flogging and chaining.
100 BC to 400 AD	Enlightened view: physical reasons; popular view: devils and demons	For enlightened, retreats and quiet; Popular view - purging, bleeding, and mechanical restraints. Benign - people roaming free.
Dark ages to 1500's	Spirits inhabiting, demons, evil spirits and devils	Exorcism, burning at stake torture, chaining, imprisonment, isolation
1600's	Demons, animalism "special abilities"	Confinement in prison, small homes, work houses, and wandering; also seclusion and restraint.
1700's	Primitive physical etiology	Cages, chains, purges, bloodletting, jail, first hospitals.
1800's	Spiritual and physical	Moral treatment, some including physical modalities; large facilities in U.S.; seclusion and restraint towards end of century.
1900 to present	At first Psychological causes, and later biological and stress induced.	Large hospitals, talk therapy, pharmacology, ECT and various forms of restraint and seclusion

Recent Historical Perspectives

As the historical review showed, various forms of seclusions and restraint have been used to deal with mentally disturbed persons. Contemporarily, patients have continued to be placed in seclusions rooms; restraints are still used, including straitjackets; and lately, chemical restraint by means of medicinal compounds has become more common. As behavior control interventions, seclusion and restraint have a long history. But many over the years have raised questions about the validity of seclusion and restraint, either from a treatment philosophy point of view, a legal perspective, or a recipient rights frame of reference. Soloff (1987) made this observation:

> In an era of psychodynamic sophistication and pharmacologic advances, discussing physical control of the mentally ill may seem distinctly anachronistic. To some, the discussion may suggest regression to the methods of a less enlightened era. Memories may be evoked of the nonrestraint movement of the last century, which challenged the legitimacy of physical controls as a form of treatment for the mentally ill. (p. 119)

There have been some attempts to establish treatment programs where there will be no use of physical restraints. Gove and Lubach (1969) report on one program known as the "Northwest Washington Hospital -- Community Pilot program".

The program came into being in the 1960's, when non-traditional approaches were encouraged and funded by the federal government through the National Institute of Mental Health.

Greenblatt, York, and Brown (1955) wrote about some significant attempts to eliminate the use of seclusion and restraint practices at the Boston Psychopathic Hospital during the 1940's and early 1950's. The primary goal was to use the social environment of the hospital for therapeutic purposes. Greenblatt et al. believed that various forms of restraint and isolation of patients were an "evil" which at first may have served some purpose, but had since outlived its usefulness. It was stated:

> The "evils" we have discussed consist, therefore, essentially in overroutinization, emphasis upon procedure rather than the person, lack of knowledge concerning patients' feelings among the staff, and lack of adequate motivation for serving the basic psychological, as contrasted with physiological, needs of patients. (pp. 83-84)

In spite of the philosophical questions, seclusion and restraint remain as treatment and control methods. A vast majority of psychiatric hospitals continue to have areas which are called a variety of names -- quiet room, isolation room, seclusion room, segregation room, or multipurpose room. All have the stated purpose of protecting the

patient, peer patients, and/or staff from violent or out-of-control behavior, which would lead to injury or to the destruction of property.

Because practices concerning seclusion and restraint remain a troublesome concern to the mental health community, the topic has generated increased discussion in recent years. This is best illustrated by the interest the American Psychiatric Association has taken on the issues of physical controls in treatment. A task force was appointed in 1981, and the results of the work of that group were published in a report Task Force Report 22: Seclusion and Restraint (1985); and in book form (1984) under the title of The Psychiatric Uses of Seclusion and Restraint. It is because of the uses and potential abuses of seclusion and restraint that the issue of physical control has continued to plague the mental health field.

The APA Task Force Report (1985) placed the subject in this perspective:

> Today the scope of this problem, its social and professional implications are poorly understood outside of psychiatric circles and underestimated by many within the mental health field. . . . We live in violent times. . . which extends to the working reality of the psychiatric treatment setting. . . . Social forces outside the profession direct our efforts toward the care of violent patients in ever growing numbers. (p. 3)

In its report, the Task Force mentioned social policy decisions which have impacted on mental health practices. Coleman et al. (1980) told of one significant policy development which took place in 1963, when funding from the federal government was made available through the Community Mental Health Centers Act. This program came about as the result of a message sent to Congress by President John F. Kennedy and his request that there be "a bold new approach" to mental disorders. Since the enactment of the legislation, over 700 community-based centers have been formed. The basic goal of the program was to deinstitutionalize persons from large custodial psychiatric hospitals, and return as many as possible to the community.

On the positive side, there was a significant reduction in patient populations of the large state custodial hospitals. Many of the people were able to succeed in staying out of hospitals because of the out-patient programs of the community mental health agencies, and the newly discovered medications which helped persons keep psychiatric symptoms under control. On the negative side, Tardiff (1985) spoke about deinstitutionalization creating a flood of chronically disturbed patients who were:

> often poorly prepared for independent existence, inadequately supported by community resources, increasing the visibility and frequency of . . . violent behaviors in the community. . . . These

> patients turn in increasing numbers to emergency rooms of the community mental health centers or general hospitals, and a variety of acute psychiatric inpatient settings for . . . treatment. (p. 3)

Legislative funding priorities in recent years have affected the ability of community agencies to respond in significant and meaningful ways. In the 1960's, when the community mental health legislation was enacted, there was a committment to funding the programs, even in the times when defense spending was increasing because of the Vietnam war. President Johnson maintained during this time a "guns and butter" policy, as far as budget priorities were concerned. Thus, many social programs received their fair share. But as economic and political times changed, so did the fiscal priorities. Mental health programs became more and more the responsibility of states and counties, meaning that many programs were not renewed. Slowly, pressures began to build whereby hospital in-patient levels started moving upwards, with many of those returning for hospitalization being more prone to out-of-control or violent behavior.

Social Forces and Seclusion

Even though social policy has impacted on the seclusion and restraint question, other social forces also have played a central part in confounding the problem. The increase of poverty and economic disenfranchisement has been a part of this. Auletta (1982) wrote of a society that has been

developing a significant underclass who have struggled to survive, and thus live with a great deal of distress.

One result of the negative stress can be extreme anger, and also atypical psychotic breaks. Since these persons have not been able to afford private hospitalization, they end up at emergency centers, community-based psychiatric treatment facilities, or many, eventually, at state-supported acute care units. Most are involuntary, and will not take medication at admission or prior to a court decision. Thus, when violence happens, seclusion and restraint is one behavior control option significantly employed. Ryan (1971) states the problem is that most of these people are blamed for their illness, when the reality is that they are psychologically breaking down under the pressure of being poor.

In terms of the underclass and poor being psychiatrically hospitalized, the "blaming the victim" syndrome created an additional dilemma. Most staff who attended to the mentally ill in treatment facilities came from a middle class background, or at least had that cultural influence as a part of their makeup. In many psychiatric facilities that provided services for poor people, many of the staff had a great deal of difficulty being empathic to the stresses of the underclass and disenfranchized. Because of the lack of understanding, communication problems often resulted. This showed most

often when aggression on the part of a patient became a problem, and the lack of communication often ended up with patients being secluded rather than less restrictive means used to solve the problem.

Another social issue which has impinged on psychiatric units is alcohol and substance abuse. An emerging diagnostic puzzle has been that of the dual diagnosis, and attempting to ascertain whether a psychiatric problem is purely a case of mental illness; or whether the psychotic-like behavior is being caused by drugs or alcohol. Soloff (1987) considers the problem to have epidemic proportions. In the 1960's and the 1970's the drugs of choice were LSD, amphetamines, PCP, along with marijuana and heroin. These drugs have often resulted in organic damage to the brain, causing a greater number of violence-prone individuals. The consequence has been that many persons experienced psychosis, aggression to others, suicide, or self-mutilation. In later years, "crack cocaine" has taken over in the urban centers and in many rural areas; the full implications of this epidemic have not become known. But psychiatric units have increasingly admitted persons with new disorders of chemically associated violence. Alcohol abuse has had a similar outcome. The end result has been the creation of new behavior management problems in psychiatric facilities, both public and private.

Legal Issues Related to Seclusions

Another dimension of social policy that became more prominant has been legal challenges. Treatment issues, especially psychiatric ones, have come to the forefront in the courtroom during the last twenty years. Most likely, this trend comes in the context of a greater awareness of and commitment to civil libertarian issues. As a part of this awareness, our society has become more litigation oriented; and seclusion and restraint issues have not escaped the emerging process.

Garritson (1983) gave information about legal applications that have focused on a treatment premise called the "least restrictive alternative". This premise was first applied in the landmark case of Lake v. Cameron (1967). The case focused on involuntary commitment to a psychiatric hospital, and whether a patient had the right to be considered for a treatment setting that was less restrictive. The plaintiff won her case, and other cases followed which extended into the treatment received in hospitals. One case, Rennie v. Klein (1979) resulted in a court ruling "that antidepressant and antimanic medications were less restrictive than antipsychotic medications". (p. 16) Two of the most significant cases have been Youngberg v. Romeo (1982) and Rogers v. Okin (1979).

Tardiff (1985) considered Youngberg as the primary case which has focused on seclusion and restraint. Romeo, a

profoundly retarded person, was an involuntary patient at Pennhurst State School and Hospital in Pennsylvania, and while hospitalized was injured on many occasions. The injuries sustained were sometimes due to his own violence, and on other occasions due to the reactions of other residents. In the context of the violence, Romeo was often physically restrained. Pennhurst and its officials were sued because Romeo claimed he had a right to freedom of movement as well as safety and training. Dix (1987) stated the court ruled in favor of Romeo when it held "that a safe environment must be provided and that any decision to restrain (seclude) a patient must be made in accordance with a professional judgment and not in a cavalier manner". (p. 202)

Youngberg established, according to Coval (1983) three new constitutional torts: (a) the right to be free from undue bodily restraints; (b) the right to personal protection and security; and (c) the right to adequate treatment. In terms of restraining an individual, it was found that the "shackling" must be the least restrictive means of dealing with a patient, and there must be compelling reasons for whatever restraining action is taken. Coval noted that an implication of the case was that restraints cannot be used for the convenience of the staff. Regarding the compelling reasons for restraint, Justice Powell, in delivering the opinion of the Supreme Court,

stated the decision regarding reasonable restraint must be based on the judgment exercised by a qualified professional, and that liability is present "when the decision by the professional is a substantial departure from accepted professional judgment". (pp. 15-16)

The Supreme Court decision in the Romeo case was not clear in its clinical implications, according to some observers. Tardiff et al. (1985) stated:

> Perhaps the most important point about Youngberg v. Romeo is not precise rule of law announced by the case but rather its general and clear-cut attitude about the propriety of deferring to professional judgments and the clinical considerations. . . . Romeo teaches that legal and ethical concerns will give substantial flexibility to clinicians. . . . (and) . . . suggests that emergency seclusion or restraint may well be warranted to prevent behavior that would be seriously . . . disruptive to the therapeutic community. (pp. 14-16)

Tardiff's belief was that Romeo did give a great deal of leeway, but not in non-emergency situations. Also, using seclusion and restraint for punishment purposes was not fitting; and for treatment purposes, questions were unanswered.

Wexler (1982) agreed that clinicians and staff possess a great deal of legal leeway in administering seclusion and

restraint in emergency situations. But, even with this kind of flexibility, there is a "Catch-22" kind of situation whereby staff had to be cognizant of protecting patients from themselves and others, but yet be aware of the least restrictive alternative applicable. Wexler considered the case in the context of treatment questions, particularly an approved behavior therapy program. If such a program sought to use methods such as locked time-out and contingent restraint only with regard to patients engaging in, or about to engage in, behavior that was destructive, disruptive, or seriously dangerous, then Romeo could be interpreted in such a way that could be comparable to an emergency situation.

Cook (1983) summarized the impact of Romeo, and stated that mentally disabled persons cannot be deprived of due process and certain "liberty interests", such as:

1. Reasonable care and safety;
2. Freedom from bodily restraint;
3. Adequate food, shelter, clothing and medical care;
4. Those liberty interests to which convicted criminals are entitled; and
5. Adequate training and habilitation to ensure the enjoyment of liberty interests that are recognized as constitutionally required.

Cook comments further in regards to freedom from bodily restraint:

> Residents of institutions have the right to freedom

> from the inappropriate use of . . . physical restraints. The right also encompasses confinement in a "seclusion" room or "time-out" room and may preclude unnecessary strictures on the movement of residents. (pp. 346-357)

Gutheil (1980) discussed the Boston State Hospital case, Rogers v. Okin (1979). This litigation came about because of a dispute by a group of mental patients who wanted to enjoin certain seclusion and medication practices at the hospital, and who desired to recover damages from those responsible for the practices. One of the patients was a large man who had problems with outbursts of aggressive behavior. He was secluded for thirty days, though in the latter days of the seclusion he received progressively longer time-out periods. He was also medicated while in seclusion. The court ruled the first four or five days of seclusion were fitting, but the remaining days were viewed as questionable. It also ruled that a patient who was competent had the right to refuse medication. As medication has become more prevalent in psychiatric treatment this is a significant issue. Rogers v. Okin also had significant impact on issues related to seclusion and restraint versus treatment.

Gutheil (1980) expressed that the case created significant problems in the treatment of mentally disabled people, especially concerning seclusion and medication

practices in relation to historical treatment responsibilities. If the use of seclusion, restraint and medication must be curtailed and /or limited, the issues that remain center on the rights of innocent third parties, the orderly administration of institutions, and the welfare of psychotic patients themselves. The conclusion was that the Boston State Hospital case showed with clarity how far apart the law and the pragmatic world of clinical issues can be, and that some resolution is required. In addition, the Rogers decision, Gutheil believes, created more questions than it answered.

Coval (983) summarized another case related to the issue of seclusion and restraint, which was Clites v. Campeeli (1982). Clites was a mentally retarded person who at age 21 was admitted to a State of Iowa residential facility for the developmentally disabled. In 1970 his treatment program included the prescribed use of psychoactive medication used in a poly-pharmacological way. He was also secluded, restrained, and shackled to his bed in a spread-eagle fashion. Because of the use of the medication, tardive dyskinesia developed in a way that was permanent and disabling. The court ruled against the State of Iowa in the following areas: on excessive use of psychoactive drugs and polypharmacy; failure to follow precautionary fitting measures; and neglecting to abide by industry standards of care practices. In the issue related to seclusion and

restraint, the court ruled staff did not have knowledge of the institutional policy on physical restraints, and that physical restraint was used for the convenience of the staff, and not for reasonable medical treatment.

The "least restrictive alternative" is a central concept in seclusion and restraint issues. Gutheil et al. (1983) believed the concept of the least restrictive alternative (LRA) has been misunderstood and probably misapplied in relation to interventions commonly used in psychiatric hospital wards, i.e. seclusion, restraint, and forced medication. In a clinical and ethical analysis of problems in the applications of LRA, the authors presented evidence which demonstrated the arbitrariness of the classification of restrictiveness. Based upon the examination of the issues, Gutheil et al. concluded that LRA was an inappropriate model for dealing realistically with clinical issues raised by the involuntary treatment of the institutionalized mentally ill.

Garritson (1983) looked more favorably on the least restrictive alternative. She viewed the treatment concept as progressive and enlightened, but believed that LRA was susceptible to subjective interpretation. As a means to create more objective criteria for the LRA frame of reference in treatment, six dimensions of restrictiveness were discussed: structure, techniques, attitudes, regulations, enforcement and patient characteristics.

Structure was related to the forms of restrictiveness; regulations were described as the policy of an institution; enforcement was defined as consequences that apply to staff, if policy was not followed; attitudes were seen as staff perception of patients and degrees of staff authoritarianism; and patient characteristics were discussed as the level of functioning of the patient. It was stated that further research was required to determine the degree of restrictiveness routinely experienced by patients with different kinds of symptoms.

Some authors rejected outright the use of restraint and seclusion and other intrusive means of treatment. Murray (1979) presented this point of view in the context of unresolved ethical issues that relate to hospitalization on an involuntary basis at a state hospital. He assumed a strong civil libertarian point of view, viewing the use of seclusion and restraint as a form of patient punishment. He stated these tactics of control were both immoral and illegal.

State and Facility Policy

Because of the philosophical, social policy, legal and environmental pressures, state mental health agencies have attempted to address the issue of seclusion and restraint through a variety of policy statements. The American Psychiatric Association, through its task force on seclusion and restraint, surveyed mental health directors in the 50

states of the U.S. Tardiff (1985) reported that the survey generated 36 responses from state directors, with 23 reporting state-wide written regulations and 20 reporting policy established by each state facility.

The substance of the survey, according to Tardiff, was that most states were in agreement on the basic indicators of need for restraint and seclusion, with the reasons focusing on preventing harm to the patient or to others. A few included general disturbance and destruction of property as reasons for isolating the patient from the rest of the milieu of the ward. Also, a number of states did report problems in implementing the seclusion guidelines and policy. There was a great deal of variability in areas such as who makes the decision about secluding; how long a person may stay in seclusion and restraint; and required documentation.

The Michigan Department of Mental Health has established statewide and local policy requirements, and these are based on the Michigan Mental Health Code (1986) (Appendix A) and Department of Mental Health Administrative Rules (1987). (Appendix B) The seclusion section of the Administrative Manual stated the follow purpose:

> To establish policies and standards for the use of seclusion when seclusion would be of clinical or therapeutic benefit for the patient/resident, or to prevent a patient/resident from physically harming himself or

> others, or in order to prevent patient/ resident from causing substantial property damage. (p. 1)

The application covered all programs operated by DMH or under contract with the state agency. Justification was covered, along with time requirements, record-keeping, who may authorize seclusion, and requirements for evaluation while a person was secluded.

As part of DMH requirements, each facility was to have in place resident policies regarding seclusion, as well as a freedom of movement policy. Each state-supported DMH institution must report on a quarterly basis to the central office. The total number of facilities involved was seventeen and covered the developmentally disabled, mentally ill, forensic, adolescent and children's units.

The Caro Regional Center served both the developmentally disabled and the mentally ill, with the one seclusion room located in the Psychiatric Unit admissions building. The Caro policy (1986) (Appensix C) was institution wide, and was oriented to the treatment program at the Caro Regional Center. The policy statement reflected statewide policy and directives, with the addition of the term "temporary" in the Caro language. The facility policy regarding seclusion and restraints was discussed by Roll (1985):

> We have only one seclusion room in the facility, located in the admissions/acute care unit. The room is

> seldom used except for new admissions when we have not obtained a treatment order. . . . Seclusion is NOT used for any purpose other than to protect patients and staff when the patient is not able to control his behavior. . . . Mechanical restraints are only used in the medical treatment area when necessary for medical treatment, e.g. I.V.'s. . . . Medications are monitored closely, and every effort made to avoid excessive medication and polypharmacy. (p. 1)

The belief behind the treatment program as outlined by Roll was that it was not necessary to control patients unless they were endangering themselves or others. The primary aim of the program was to help individuals to control themselves. When a person's behavior was not fitting, the goal of a treatment program was to assist the person in gaining control of his/her behavior. Punitive responses to pathological behavior were not tolerated; rather assistance was given to effect more appropriate behavior.

The use of restraint was covered in resident policy (1983) at the Caro Regional Center, and was similar to State seclusion policy. A significant difference was that restraint was used solely in the developmentally disabled hospital ward. On the other hand, medication restraint was sometimes used with the mentally ill population. In this kind of situation, if staff observed a patient escalating

toward aggressive and/or out-of-control behavior, a request or recommendation was made for as as-needed, or PRN, shot, usually Ativan or Haldol.

Within the organization of the Caro Regional Center the Behavior Management Committee was concerned about uses of seclusion and restraint within the institution. One of the functions of the Committee was to make certain that policies regarding seclusion and restraint were followed, and alternatives to secluding patients were considered. The Behavior Management Committee also had the task of reviewing particular seclusion incidents that lasted more than two hours, or when an individual patient was secluded more than three times in an admission.

Research and Theoretical Questions

Staff Training

The issue of staff involvement and awareness of institutional policy was a critical issue in relation to seclusion practices. Soloff (1987) stated that "The psychiatric literature is strangely silent regarding the actual techniques of properly applying seclusion and restraint". He then said:

> Psychiatric residents are rarely prepared for managing violent or disruptive patients, and nurses, attendants, and security staff fare little better in their training. The theory and practice of seclusion and

> restraint must be effectively taught to front-line mental health personnel. (p. 132)

Tardiff (1985) observed that the APA task force review showed uniform techniques regarding seclusion and restraining maneuvers were lacking on a nationwide basis. The report did point out that the Department of Mental Health in Maryland had a program for certification of mental health personnel in seclusion and restraint techniques. The State of Michigan also had developed a training program for direct care staff in order to sharpen staff skills in least restrictive alternative interventions, when patients become disruptive.

Romanoff (1987), in reporting about management and control at Western Psychiatric Institute in Pittsburg, emphasized the seclusion and restraint policies. Out of two weeks of training in clinical orientation: "a total of 18 training hours [are] devoted to the clinical management and prevention of patient violence. . . . These skills are periodically updated, and staff receive annual certification in crisis control." (p. 242) Others have discussed the need for staff training, including Gertz (1980); Hacket (1981); and Lehmann (1982). This review did not discover empirically-based studies which evaluated the outcomes of staff training programs, and whether or not usage of seclusion was reduced because of the training.

Various approaches to training included demonstration,

lecture, use of audio-visual materials, small group discussion, and direct observation. DiFabio (1978) described a program that taught the use of restraint through role-playing and discussion. The program focused on techniques of management, feelings generated by having to restrain a patient, and policies of the institution. She said the value of the program was that it generated empathy toward the patient, fostered understanding of policy, and helped staff have a feeling of shared experience and mutual respect. DiFabio believed the program could be applied to different kinds of psychiatric settings.

General Issues

Various types of research literature regarding general questions concerning seclusion were readily available. The following is a sample of a larger population of articles and reviews. McCoy (1983) observed that seclusion as a method of psychiatric treatment remained controversial from a variety of perspectives, including treatment philosophy, ethical, and legal. In order to provide a rationale, two theoretical explanations were presented: (1) a technique to reduce sensory stimuli for patients who were overly sensitive to the environment; and (2) to protect group integrity. It was recognized that personal liberty questions were involved when considering whether or not to seclude a patient.

Roper (1985) reported on an audit on the use of mechanical restraints and seclusion in psychiatric care. Issues considered were patient diagnosis, medication usage in relation to seclusion and restraint, and time of day that incidents of seclusion and restraint took place. In addition, purposes and outcomes for seclusion and restraint were considered. One finding was that usage of seclusion/ restraint was highest during the day. Based on the study a standard care plan was devised to deal with the problem.

A view of the role of physical restraint was considered by Rose and DiGiacomo (1978), wherein the practice was considered to be a specific therapeutic technique with definable indications, dosages, contraindications and side effects. The approach was similar to how medication usage would be indicated or contraindicated. It was stated that few guidelines have appeared in recent psychiatric literature, thus the need for the approach. One dimension considered in the article, going beyond commonly stated reasons for secluding patients or restraining them, was the request for restraint by the patient. Criteria for evaluating the duration and effectiveness of the treatment were proposed by the authors.

One perspective considered that has not often been covered in the literature, or in guidelines regarding seclusion and restraint, was that of secluding a patient in order to defend the social mileau. Soloff (1979) completed

a study of ten patients who were not psychotic but required restraint. The patients involved in the study were persons who were diagnosed as possessing an immature personality pattern, or a borderline personality syndrome. Often the precipitating factor was an episode of impulsive behavior which was disruptive to the social environment but not dangerous to it. Examples given of such behavior were self-abuse and suicidal behavior.

Reasons Given to Seclude

Generally, though, seclusion and restraint were prescribed because of violence to others, and because of the perceived need for behavior control. In many institutions disruptive behavior that was viewed as not dangerous to others was a secondary factor involved in decisions to seclude. As an overview to this section, the sample of articles chosen reflects a rather pragmatic approach to violence and control of the behavior. In most respects, the focus was on how and what to do. In this review, unique aspects of the literature reviewed will be highlighted.

Etiological considerations must be carefully weighed by emergency psychiatric specialists, so observed Jacobs (1983). He stated that in the context of admitting, emergency, or acute care units, the staff must recognize the interplay of biologic, psychologic, or social factors when a patient was in an exacerbated psychological situation. He also believed that interview and intervention procedures

must be willing to diverge from traditional psychiatric examination procedures. He expressed there was no certain way to prevent violence, but believed that a multidisciplinary approach would help minimize violent patient episodes, and thus the need for seclusion.

A point of view not often stated was given by Anders (1977). He suggested that when a patient became violent other patients be directed to leave the area and the potentially violent patient be encouraged to verbalize rather than act out. The significance of this point of view was that a patient often feeds off of the reactions of peer patients. The violent patient was often attempting to enhance his/her own self-esteem by acting out in the presence of an audience. Anders presented strategies for calming the potentially violent patient, including the identification of the anxiety, ways of giving reassurance, and provision of alternative non-violent actions.

Lion (1972) wrote in "Restraining the Violent Patient", that physical curbs on aggression were meaningful to patients who were afraid of going out of control. Verbal intervention should come before physical restraint was employed. As a part of the process, Lion asserted that the potentially violent patient must be told she/he will be prevented from acting on her/his impulse. If physical restraint has to be used, it was not viewed as a final step. Staff contact was essential, and allowing the patient to

vent was required.

A specialized team approach when managing violent behaviors was encouraged by Lenefsky, de Palma, and Locicero (1978). A sequence of orderly, planned actions should be carried out by a team of 2-4 staff members. One-on-one restraint was discouraged and viewed as undesirable, because the staff could become dependent on one person in an emergency situation. A key person on the team must be identified, and this person should serve as facilitator of the specific action. After an intervention, it was recommended that a post-episode discussion be held in order to relate to potential anxiety aroused by the restraint action, to discuss other possible options, or to evaluate the whole behavior management procedure.

In England, a consultative document "The Violent Patient" (1971) was issued for the benefit of psychiatric nurses in response to appeals from within the nursing profession for guidance on handling patients who were violent. The article issued typical guidelines for dealing with aggressive patients. But the opening statement was different from most points of view: "The essential process in the care of the potentially violent patient, as of all patients, is to establish and nurture a good relationship with him, to gain his trust and confidence." (p. 15)

Psychological management should never be overlooked as a means of dealing with violent patients, so stated Lion

(1981) in another article. He examined the combined approaches of psychopharmacologic and psychotheraeutic approaches. Lion focused on minimizing the individual's sense of helplessness and of being out of control, since both could intensify rage and belligerance. One means to accomplish this was by engaging in a one-on-one involvement and avoiding, if at all possible, the need for a number of people involved in holding the patient down. This stands in contrast to the Lenefsky et al. point of view expressed above.

Lion also indicated that on an institutional level, assaults were generally underreported. He believed patterns of staff and patient encounters need to be studied more extensively. One perspective he suggested was one which has not been supported by many, i.e. sometimes it was more effective to restrain a patient mechanically within the context of the milieu, rather than separating that person by means of seclusion.

Wells (1972) recorded, over a period of a year, observations on the use of seclusion rooms at a university hospital psychiatric in-patient unit. He concluded, first of all, that the use of seclusion can be an effective tool to control destructive behavior, especially for some schizophrenic, hypomanic, organically impaired and depressed patients. Even though the numbers were relatively low in comparison to total admissions (4%), he thought the

possibility existed that with a properly designed setting, and better trained staff, fewer persons could be treated without having to resort to seclusion.

Issues related to handling physically assaultive patients in state psychiatric hospitals were considered by ScLafani (1986). He observed that in the 1980's persons "entering the patient population in state psychiatric hospitals tend to be younger, sicker, and more assaultive". (p. 8) Because violence was becoming more prevalent in hospitals, and with that an increase of assaults on staff as well as on other patients, a general protocol for crisis management and intervention was thought to be needed. He outlined a five-step crisis management protocol as a means of diffusing violence and by showing concern and interest. The steps were as follows: (1) Therapeutic Environment and Programming; (2) Verbal Intervention; (3) Team Approach; (4) Pharmacologic Intervention; (5) Mechanical Restraint.

Patient Characteristics

Characteristics of patients and situations leading to seclusion made up a significant percentage of the content of various investigations on the subject. The studies reviewed focused on four primary categories: characteristics or demographics of patients secluded or restrained; precipitators of seclusion or restraint; temporal factors related to seclusion, including incidence, length of time in

seclusion, as well as the month, day of week, and time of day the patients were secluded; and treatment considerations, including the use of medication and structured programming.

Many investigators included in their studies demographic characteristics as factors that could be related to seclusion and restraint practices. Soloff (1987) believed that the implicit question underlying the inclusion of these factors was whether or not "systematic bias in the use of seclusion that is not related to the therapeutic principles of the method suggest it is being used as a sanction". (p. 129)

Soloff, Gutheil and Wexler (1985) in a literature review concluded:

> Schizophrenic and manic patients appear at highest risk for seclusion in acute treatment settings. . . . Young patients are secluded more than older patients. Race and sex bear no significant relationship to incidence of seclusion, and where trends appear involving these variables, the question of systematic bias should be entertained. Chronicity of illness and involuntary commitment are correlated in several studies with increased incidence of seclusion. (p. 655)

Other literature supported the Soloff et al. perspective that schizophrenic and manic patients appeared at highest risk for seclusion in acute care units: Gerlock

(1983), Tardiff (1984), Schwab (1979), Roper (1985), and Borstein (1985). This was also true for young patients, who were secluded more often than older persons: Tardiff (1984), Borstein (1985) and Tardiff (1985). But some studies disagreed on the sex issue, suggesting that males were more at risk for being secluded than females: Tardiff (1984), (1985) and Borstein (1985). Convertine (1980) did not discover a correlation between psychiatric diagnosis and seclusion usage.

Race as a variable involved in seclusion practices was considered by most researchers not to be a significant factor; and this generally supports the frame of reference of Soloff et al. (1985). But several presented evidence that race correlated with decisions to seclude: Flaherty (1980), Roper (1985), Gift et al. (1985), (1986), Soloff and Turner (1981). Flaherty and Meagher (1980), in particular, affirmed this position. Their study ruled out the possibility of more severe pathology in Black patients by assessing mental illness intensity with the Brief Psychiatric Rating Scale. Flaherty and Meagher concluded there was racial bias involved in seclusion decisions, and it was attributed to subtle stereotyping and the staff's greater familiarity with white patients.

Legal status as a factor in seclusion decisions by staff was significant for some: Bornstein (1985) and Oldham (1983). Okin (1985), (1986), on the other hand, disagreed.

Okin (1985) concluded that legal status was not correlated with seclusion usage, but that diagnosis, violent-related behavior, prior admissions and demographics were predictors of an at-risk person for seclusion and restraint.

Other characteristics which emerged in various research projects suggested some other correlates with seclusion: marital status (single or divorced) Bornstein (1985), Oldham (1983), previous history of hospitalization: Oldham (1983), Soloff and Turner (1981); and background of violence: Bornstein (1985) and Binder (1979).

Precipitants of Seclusion

Soloff et al. (1985) presented a table of precipitants of seclusion or restraint, and drew the summary data from ten studies which were listed in the references. The results are outlined in Table 2.

Table 2: Seclusion or Restraint Precipitants Indentified in Ten Studies*

Study	Precipitant	Unit of Measure	%
Ramchandani (1981)	Shouting, loud, agitated violent threat or attack	Patients secluded	54.3 41.3
Phillips (1983)	Multiple reasons including violence to self, screaming	Incidents	39.0
	Agitation, poor impulse control		31.0
	Act of violence toward others		30.0
Convertino (1980)	Disruptive or agitated behavior	Incidents	38.0
	Violent behavior		31.0
Oldham (1983)	Escalating agitation	Incidents	38.0
	Threats to others		25.0
	Assaultiveness		21.0
Sololl (1981)	Attack on staff with contact	Incidents	34.6
	Agitation escalating not able to control behavior		24.3
Mallson (1978)	Disruptive Behavior to Mileau	Incidents	34.4
	Assaultive to others		24.3
Schwab (1979)	Overstimulation	Cited reasons	28.0
	Agitation		17.0
	Poor impulse control		15.0
	Threatening assault to others		6.0
	Actual assault		4.0
Plutchik (1978)	Agitated and uncontrolled behavior	Incidents	21.0
	Violent behavior		15.3
Binder (1979)	Agitation	Incidents	13.0
	Uncooperativeness		12.0
	Anger		10.0
	Violent behaviors		12.0

* From "Seclusion and Restraint in 1985" by P.H. Soloff, T.G. Gutheil, and D.B. Wexler, 1985, Hospital and Community Psychiatry, 36, pp. 652-657. Copyright 1982 by Hospital and Community Psychiatry. Adapted and reprinted by permission. Appendix N.

This table defined behavior, events, or precipitators which preceded a patient being secluded. The report stated:

> Of the ten studies that explicitly measured precipitating events, nine cited a nonviolent behavior pattern as leading to the greater use of seclusion. This behavior was variously described as "behavior disruptive to the therapeutic environment", "agitated, uncontrolled behavior", and "escalating agitation". In the nine studies actual physical attack ranked below nonviolent behavior as a precipitating factor. (p. 656)

Seclusion was also used for administrative sanction, verbal abuse, refusal to participate in activities, or medication non-compliance. (p. 656)

In contrast to Soloff et al., Tardiff (1985) found that assaultiveness was a significant characteristic leading to seclusion. Bornstein (1985) discovered that primary precipitators for seclusion were verbal and physical assaults against staff. Soloff and Turner (1981) concluded that seclusion was used primarily to contain physical violence. They thought one reason for this was that the patients secluded tended to be economically disenfranchised, with the violence being engendered by anger and frustration.

Temporal factors related to seclusion room usage were considered by Soloff et al. (1985). Eleven retrospective (14-24) and two prospective studies (25, 26) were

summarized based on the incidence of seclusion or restraint. All involved a variety of adult psychiatric inpatient settings. Table 3 presents the overview of the 13 studies.

Table 3: Restraint or Seclusion Incidence Reported in 13 Studies of Adult Psychiatric Inpatient Units

Study	Population	Setting	Incidence %
Wadeson (1976)	Acute, Public Status Unknown	NIMH Research Unit	66.0
Phillips (1983)	Acute, Public Voluntary/Involuntary	State Hospital Research Unit	51.0
Binder (1978)	Acute, Public Voluntary/Involuntary	Crisis Intervention Unit, Locked Psychiatric Unit	44.0
Schwab (1979)	Acute, Public/Private Status Unknown	University General Hospital	36.6
Plutchik (1978)	Acute, Public Voluntary/Involuntary	Municipal Psychiatric Facility	26.0
Convertino (1980)	Acute, Public Patient Status Unknown	Locked Unit, Community Mental Health Center	24.0
Oldham (1983)	Acute, Private Voluntary/Involuntary	University Psychiatric Hospital	18.0
Soloff (1981)	Acute, Public Voluntary/Involuntary	University Psychiatric Hospital	10.5
Mattson (1978)	Acute, Private Voluntary	General Hospital Psychiatric Unit	7.2
Ramchandani (1981)	Acute, Public Voluntary/Involuntary	General Hospital Psychiatric Unit	4.7
Wells (1972)	Acute, Public-Private Status Unknown	Locked Psychiatric Unit, University Hospital	4.0

Table continues

Study	Population	Setting	Incidence %
Soloff (1978)	Acute, Active Duty Voluntary/Involuntary	Military Hospital	3.6
Tardiff (1981)	Chronic, Public Voluntary/Involuntary	State Hospital	1.9

* From "Seclusion and Restraint in 1985" by P.H. Soloff, T.G. Gutheil, and D.B. Wexler, 1985, Hospital and Community Psychiatry, 36, pp. 652-657. Copyright 1982 by Hospital and Community Psychiatry. Adapted and reprinted by permission. Appendix N.

The following was stated by Soloff et al. concerning the results shown on Table 3.

> The incidence of seclusion and restraint varies directly with two parameters: the composition of the patient population and the treatment philosophy of the unit. Specific variables relevant to the incidence of seclusion include hospital setting . . . (public and private), type of care (acute or chronic), and patient status (voluntary or involuntary). (p. 654)

Then they considered the role of medication and seclusion:

> The philosophy of the unit toward the use of medication and medication-free observation for diagnosis or research relates directly to the incidence of seclusion. . . . The highest incidence of seclusion, 66 % was found on an NIMH research unit for schizophrenia where a treatment philosophy of medication-free maintenance was part of the research strategy. (p. 654)

In summary, the acute care public facilities had a higher percentage of incidents of seclusion than did the private. Also for private and public facilities there was a positive correlation between incidence of seclusion and the number of committed patients. The private hospitals tended to have a lower incidence of seclusion in as much as they exercised more control over who entered the hospital. (pp. 654-655)

Temporal Factors in Seclusion

Soloff et al., along with considering incidents of seclusion, also presented data related to the duration of seclusion and correlates. They stated concerning average length of time in seclusion:

> In some studies, it correlates with age, sex, and psychosis at the time of seclusion; in others, it appears more directly related to philosophy of care. . . . In the prospec tive study the mean duration of seclusion episodes was 10.8, with a median of 2.8 hours and a range of 10 minutes to 120 hours. Patients under age 35 spent more total time in seclusion than did older patients. Patients who were psychotic spent more time in seclusion than nonpsychotic controls. Men had longer individual seclusion episodes than women. (p. 656)

During the course of the review, Soloff et al. discovered what they considered to be significant disparities in seclusion times and a lack of correlation "between duration,

precipitating behavior, and diagnosis". (p. 656) They observed:

> Unpleasant questions [are raised] about arbitrary determination of duration of seclusion and its potential use as a punitive sanction. . . . Factors outside the individual patient's immediate needs may play a role in determining duration. (p. 656)

Other temporal factors studied were the time of day, day of the week, and related time issues. Gerlock (1983) considered a variety of time issues, including daily and seasonal variation, weather, biorhythms and horoscopes. Peak seclusion was during the late night and early morning; more seclusion occurred during the winter and spring, with April and January being the highest months. There was no correlation between incidence of seclusion and the weekend, when there were fewer structured activities.

Schwab and Lahmeyer (1979) showed in their study on a general hospital psychiatric unit, that the highest incidence of seclusion was between 10 pm and 2 am, with forty-five percent of the patients being secluded in this time period. Oldham (1983) found that the peak occurrence of seclusion usage was during the day when time was not structured, or when key staff were unavailable. Roper (1985) conducted two chart audits, covering 43 incidents of seclusion and restraint. He discovered the highest percentage of isolation or physical control was during the

day shift, with a total of forty-three percent of incidents being initiated by the day staff.

Treatment Issues and Seclusion

Incidence of seclusion in relation to general treatment considerations has been considered by some investigators. Of particular interest was the relationship between incidence and duration of seclusion and medication usage. Roper (1985) discovered that individuals who were medicated in conjunction with being placed in seclusion stayed secluded longer than those who were not. Bornstein (1985) found that persons secluded were on an inadequate medication regimen. Schwab (1979) showed that patients who required seclusion received pharmacotherapy more frequently. Gerlock (1983) had the same finding as Schwab; his control group most commonly received antidepressants, or no medication.

Oldham (1983) and Gerlock (1983) both considered in relation to the incidence of seclusion the issue of time structuring and availability of activities. Oldham thought that not having structured activities effected seclusion incidence in terms of increased usage. Gerlock did not find a similar correlation.

Summary and Conclusion

In the literature review, four areas of concern were covered: (1) characteristics of secluded patients; (2) precipitants of seclusion; (3) temporal factors in

seclusion; and (4) treatment issues. In each category, the following areas had conflicting answers:

A. Characteristics of patients secluded and the possible presence of a systematic bias:

1. Though young males were primary candidates in most studies, some studies indicated sex was not significant;

2. Most studies indicated race was not a factor, but several disagreed;

3. Legal status was not seen as a factor in some studies, especially involuntary commitment; but others did not concur;

4. Diagnosis, especially schizophrenia and manic, was seen as significant, but some investigators did not agree;

5. Limited study has been completed on other demographic factors, e.g. marital status, socio-economic status, education, place of residence.

B. Precipitators leading to seclusion:

1. There was not consistent agreement among investigators about the significance of nonviolent and violent events precipitating decisions to seclude;

2. Few studies considered the correlation between demographic characteristics, treatment issues, and precipitators of seclusion.

C. Temporal factors involved in seclusion:

1. Temporal factors, including incidence and duration of seclusion, were not often correlated with demographic characteristics of patients who were secluded;

2. Relationships between incidence and duration of seclusion and various treatment modalities, including medication and structured activities, were not often considered;

3. The relationship between time of day and day of the week to incidence and duration of seclusion was not

considered by many investigators.

D. Treatment issues in relationship to seclusion usage:

1. The results were mixed in relation to medication involvement and the incidence of seclusion;

2. The effects of activities were not often considered in studies dealing with seclusion;

3. Staff training and its impact on seclusion has not been systematically studied.

Based on the historical overview and the review of the literature, it was apparent that seclusion as a means of behavior control in psychiatric treatment remains an enigma and controversial. Seclusion usage has remained a significant means of behavior control in psychiatric facilities. But legal interventions have changed how hospitals make use of the seclusion alternative. Now, as a result of litigation, the concept of least restrictive alternative has entered into the nomenclature, and has impacted on seclusion policy. As a result, many states and treatment centers developed policy statements regarding the use of seclusion and restraint. Also, the literature has reflected the change by focusing on seclusion as one of the last resorts in behavior control. Research in this area has for the most part been descriptive in nature, with some exceptions. More often than not the research has been retrospective.

In this research project, an attempt was made to build on what has been accomplished, and to consider unanswered questions related to seclusion room usage. It was first of

all retrospective. Characteristics of patients who had been secluded were examined and secluded patients were compared to a random sample of non-secluded patients. These two groups consitituted the treatment groups, with the non-secluded group acting as a control group. Psychiatric treatment variables for these two groups were evaluated, with the focus being on the milieu, medication, and a structured work activity program. A new dimension was evaluated: the effect staff training had on incidents of seclusion. For the statistical tests, the dependent variable was incidents of seclusion for the first time secluded patients.

Finally, in order to be complete, summary data for all incidents of seclusions during the time frame of the study was reviewed. No statistical tests were effected on this data, but it was evaluated. In addition, data gathered related to the circumstances of decisions to seclude was also reported. The setting and methods of the study are more fully outlined in Chapter III.

CHAPTER III

METHODOLOGY

Introduction

This chapter presents the methods used in the study to accomplish the research goals. The following descriptions are included: the setting, subjects, variables of interest, sources of data, and research design. Also, the statistical procedures used in analyzing the research data are described.

The Setting

The research project on seclusion room usage was designed and implemented at the Caro Regional Mental Health Center. The Caro Regional Center, or CRC, is located in the central, eastern part of the lower peninsula of Michigan, in an area called the "Thumb". The closest residential community is Caro, Michigan, which has a population of 4,500, and is the county seat of rural Tuscola County. Saginaw, Michigan is approximately 30 miles west, and Detroit, Michigan is 90 miles to the south.

The Caro Regional Center is an agency of the Michigan Department of Mental Health with responsibility for

providing services to both developmentally disabled and mentally ill persons. The developmentally disabled population is 270; and the mentally ill population is 127, including a 17 bed specialized independent living program. The annual C.R.C. budget is $32,000,000, and 700 people are employed at this facility.

The hospital provides psychiatric services for a catchment area designated by the Michigan Department of Mental Health. At the time of study the following counties were served by the hospital: Huron, Saginaw, Sanilac, Tuscola, Bay, Arenac, Lapeer, Midland, Gladwin, and St. Clair. The largest percentage of patients, 41%, come from Saginaw County. Although the Michigan Mental Health Code requires direct admission of certain patients, every effort is made to have admissions screened by the staff of the appropriate Community Mental Health Board and community alternatives utilized when available. In all cases, CMH staff are notified of admissions, since placement and after-care are considered a CMH responsibility. Only adult persons receive services. The Caro Regional Center is accredited by JCAH (Caro Regional Mental Health Center Profile, 1988, p. 5).

The psyciatric program unit functions under the inter-disciplinary treatment team concept. All professional staff are assigned to one of three treatment teams, and each team serves a designated group of patients. One of the

professional members serves as a team leader, and has the responsibility of facilitating the weekly treatment team meeting for which she/he is responsible. All patients assigned to the treatment team have a professional who is the Qualified Mental Health Professional (QMHP). The QMHP is responsible for the development and implementation of the individual treatment plan that is created for the patient. The treatment plan designates the responsibilities of direct care staff on each shift. Responsible direct care staff are invited to participate in team meetings and share observations about patients for whom they have responsibility. The patient participates, and family members and CMH staff also are often involved in treatment planning meetings (Caro Regional Mental Health Center Profile, 1988, p. 7).

The psychiatric unit is part of the total program of the Caro Regional Center. There are five psychiatric residential buildings, including the acute care/admitting building, Woodside Cottage (C-5). Other facilities are shared with the developmentally disabled program. These include the gym, Work Activity Center, the Center Mall, the medical unit, and administrative offices. Other support services are also shared, including transportation, maintenance, the store, and medical records.

The focus of the research was the acute care/admitting unit. This residential unit has 21 beds and serves both

males and females. All patients who are admitted to CRC pass through Woodside Cottage. The building is a 24 hour intensive care unit, and contains the only seclusion room on the grounds of the facility. The building is shaped like the letter T (Appendix L). There is a male and a female wing; a main hall, with a nursing station and three bedrooms; and the dining area and kitchen. All residential rooms are on one floor. The front of the building consists of offices and a visitor area. The residential area is locked at all times. There is a recreation area in the basement, but it was not in use at the time of the study. All activities took place in the lounges, or in the day room (which was the dining area at meal times). There are two television sets available, one in each of the lounges. There is also a piano in the female lounge.

The supervision at Woodside is intensive because of the needs of patients who are admitted. Most are admitted in state of crisis, and require close attention. It is the intent of the program that most patients will remain at Woodside for a short time. As soon as the patient is thought stable enough to participate in an out-of-cottage program, she/he is transferred to another residential building (Caro Regional Mental Health Center Profile, 1988, p. 41).

During the course of the study the average monthly admissions were 49; and the average monthly census for the

total pyschiatric program was 96. Readmissions constituted 55% of the admissions, and involuntary patients made up 76%. The average number of days in the hospital for a patient who was discharged was 48. In recent years, the nature of the population of psychiatric program has changed to more seriously ill and chronic patients.

Subjects

The subjects of the study were patients in the psychiatric program unit from December 1, 1986 to October 10, 1987. There were two groups: secluded patients and non-secluded patients. The secluded group was first time secluded patients who were in the admission unit during the course of the research. If persons were discharged, readmitted, and secluded again, they were not counted more than once in terms of the population pool. Incidents of seclusion and time in seclusion for readmissions were counted. After adjustments 52 persons were in this group.

The non-secluded group was chosen from admitted persons on the basis of a monthly stratified random sample. The count for each month was determined by the initial number of people secluded during the same month. For example, if eight patients were secluded in December, 1986, then eight petients were selected at random without replacement from the 49 people admitted that month. This proceedure was replicated for each of the remaining nine months. The random sampling process was as follows: For each month, the

names of all admitted non-secluded patients were written on slips of paper, and placed in a container. The slips were appropriately mixed up, and a draw made. After each draw, the slips were again mixed up. This procedure continued until the fitting number had been drawn. The non-secluded group numbered 58.

The final group of "subjects" was the staff at the admitting unit. The primary statistical analysis was completed in relation to the patient population. But implicit in the research was the staff, and the role they played in the seclusion process. Patients, with few exceptions, do not place themselves in seclusion. Staff do, in response to some action or behavior on the part of a patient. This research examined, in a cursory way, the impact of staff on the decision making process to seclude. The involved staff were regular and relief staff at the admitting unit. All the regular staff participated in the May 3-8, 1987 training program, which will be discussed later.

It is important to indicate that the researcher did not manipulate the subjects involved in this research. The study, as noted earlier, was a retrospective one. The subjects were part of the existential reality of the program, in that they were a part of the natural scene which was being observed.

The Research Variables

The psychiatric program treatment variables considered by this study were the following: milieu therapy; milieu and medication therapy; mileu and the work activity program; and milieu, medication, and work activity. All three forms of treatment were, for the most part, available to all patients at the admitting unit. Whether or not a person received a particular form of treatment was dependent on the individual's condition, behavior, legal situation, or willingness to be involved in the treatment process. The reality was that all persons did not receive the same kind of treatment. The one form that was consistently available to all patients was milieu therapy.

Milieu Treatment.

Milieu Treatment was defined by the American Psychiatric Association (1980) as "Socio-environmental therapy in which the attitudes and behavior of the staff of a treatment service and the activities prescribed for the patient are determined by the patient's emotional and interpersonal needs. This therapy is an essential part of all inpatient treatment" (p. 91). Gunderson (1986) outlined five programatic activities which contribute to the therapeutic atmosphere: (1) containment, (2) structure, (3) support, (4) involvement, and (5) validation. In the context of these activities, the acute care/admitting unit milieu treatment will be examined.

Most of the admitted patients at C-5 either were confused, depressed, suicidal, or agressive. For those persons viewed as being a danger to self or others, containment was the first task of the psychiatric milieu in C-5. The unit building was locked at all times as noted earlier. There were no bars or security screeens. The first task of the program was defined as providing safety for the patients.

The second dimension, structure, had the purpose of promoting an atmosphere where a person could begin to regain self-control. Willmuth (1987) stated "structure promotes change by providing a predictable organization of time, place, and person for patients" (p. 6). The structure provided by C-5 began the moment a client entered the ward. For most patients, prior to being admitted, their lives were unstructured and disorganized. When newly admitted people told of their pre-admission life style, the common theme was they had nothing to do and little to which to look forward. One patient stated: "when I leave here and go back into the neighborhood, it's like falling off a cliff." He meant he was faced with the problem of finding some kind of structure once he left the structured life in the hospital.

The first tasks in the admitting unit were assessments, which required contact with the professionals involved. The Guidelines of Care (1986) (Appendix G) required the following admitting assessments: psychiatric examination,

physical examination, activitiy assessment, nursing assessment, and social assessment. While at C-5, the person may also be evaluated by a psychologist, nutritionist, or an occupational therapist. Finally, the patient was to be interviewed by the assigned qualified mental health professional.

All residential buildings including the admitting building had scheduling and activity requirements, and these are found in "Guidelines of Care", (a) meals, (b) assisting in setting and clearing tables, (c) off-grounds activities, (d) maintaining living area, including making beds, (e) maintaining personal hygiene, and (f) building recreational activities. Recreational activities in the context of admitting unit included watching television, table games, reading, and some outside activities. These may have included walks, playing basketball, or using the yard swings. During the week, on a daily basis, a crafts group was held, usually for an hour.

Involvement was a natural component of structure. It was viewed as an essential aspect of facilitating a patient being able to regain control of his/her life. For the confused, involvement in the milieu was seen as a means of assisting the person to regain order and clarity. For the depressed, being involved was a way energy levels could be raised and thoughts that caused depression refocused. The aggressive patient was encouraged to take part in activities

as a means of re-directing negative and potentially destructive energy. Whatever the activity, the treatment had as its focus helping the person regain control of life by involving the individual in treatment in a pro-active way.

Most patients, when they were admitted to the psychiatric unit, experienced low self-esteem and/or a high sense of alienation. These attitudes generally governed the lives of people diagnosed as psychotic or depressed. An important aspect of the milieu that attempted to relate to these beliefs was the support offered by all staff, from psychiatrist to housekeeper. When people were demoralized and felt separated from life around them, the support offered by all levels of staff became essential. During the day and afternoon shifts there were the following full-time staff available: one registered nurse, one licenced practical nurse, three resident care aides, and at least one domestic services aide. If patient needs required it, one or more attendants were made available on an as needed basis. Though each discipline had its unique function, the underlying responsibility was to interact with the patients, and to work with them in gaining back a sense of self-esteem, self-control, and purpose. The staff who were with the patients eight hours a day more often than not became the "therapists" in that they were there in those spontaneous moments when people chose to open up about what

was troubling them.

When staff support resulted in the patient experiencing empathy, validation became the final part of the milieu formula. Validation is that part of the treatment puzzle which enhanced the patient's ability to think positively about self. It was also the most difficult to measure and assess. Gunderson believed that validation had an essential part to play in helping paranoid and borderline patients attain a greater ability for closeness and self-identity.

In order to comprehend the meaning of the milieu aspect of treatment in the admitting unit, Roll (1985) outlined the underlying philosophy:

> We do not feel it is necessary to control the individual, unless he is in fact endangering himself or others, but rather it is our aim to help him be able to control himself. In a sense, the treatment milieu is an experimental social setting for the patient, where the expression of his psychopathology does not result in punitive responses from the staff, but assistance in selecting more appropriate behaviors" (p. 2).

The direct care staff had the responsibility of carrying out the admitting unit milieu treatment approach. Roll addressed the issue of their involvement in this fashion:

> The direct care staff is considered the crucial element in this treatment approach. It is they who must

> understand the treatment objectives, and consistently reinforce the appropriate behaviors. The professional staff have responsibility for assessing the needs of patients, for working together with the direct care staff to develope an appropriate treatment program." (p. 2)

Work Activity Program.

Another treatment variable was the work activity program. This program was governed by the administrative rules of the Department of Mental Health (see Appendix B). Patients from the admitting unit participated in the work program, but not in all cases. The "Guidelines of Care" (1986) stated: "Under normal conditions patients admitted to the Psychiatric Treatment Program will remain at Woodside (C-5) Admissions Unit for 48 hours before they will be assessed for participation in the Work Activities Center Program." There were some exceptions when patients started the work program within 24 hours. During the study period 20% were referred to the Work Activity Center.

The program began at 9 a.m., and C-5 patients returned at 1 p.m. At the work center the first task was an assessment to determine a suitable work assignment. Choices of work included wood sanding, wood finishing, bicycle repair, sewing, weaving, ceramics pouring, ceramics cleaning, ceramic painting, grounds crew and the print shop.

Roll (1987) stated that the primary purpose of the

program was "to assist the patients in developing a 'Pattern of Success' in responding to social expectations. . . . The emphasis is on task completion, following directions, working cooperatively with others, and other psychosocial as opposed to vocational skills and behaviors common in the work setting" (p. 3). When tasks were completed, the patients received pay for their work. The pay was a secondary part of the work program, in that Roll considered the process to be a form of therapy. The focus was to help patients get into a "pattern of the day" that was as normal as possible, including getting up, getting ready for work, doing the work, and using leisure time appropriately.

Medication Therapy.

As indicated earlier, psychophamacology as currently practiced had its beginning with the introduction of Thorazine in 1954. Prior to this time the options regarding drug therapy were minimal, and there was a significant reliance on psychological and milieu forms of treatment. But in the last two decades, biological psychiatry has emerged as being the primary modality of treament. Willmuth (1987) stated: "Biological psychiatry stresses relief of individual pathology with the milieu serving primarily to shelter the patient and ensure his compliance with drug treatment." (p. 6).

At the time of the study, the facility had four full-

time psychiatrists and two part-time resident psychiatrists who worked weekends. There were three treatment teams, each having an assigned full-time psychiatrist. Every patient admitted to the acute care unit was evaluated by the assigned doctor within 24 hours. At that time it was determined how fitting the patient was for medication. If a patient was voluntary, or had signed a treatment agreement, then medication was ordered if needed. The administrative rules of the Department of Mental Health (1987) stated that medication was not to be ordered prior to a court hearing "unless the individual consents or unless administration of chemotherapy is necessary to prevent physical injury" (p. 18).

The medications used in psychiatry, and at the admitting unit, were classified in five major catagories: (a) antianxiety drugs, (b) antidepressants, (c) antimanic drugs, (d) antipsychotic drugs, and (e) antiseizure drugs. The unwritten policy of the psychiatric unit was that the least amount of medication was prescribed in order to help the patient regain control of her/his thought process or behavior. While a patient was on medication, the person was reviewed at least weekly by the treating psychiatrist in order to ascertain progress on the medication regimen. If behavior had changed toward the person being more in control, the medicine was usually titrated downward. The titration process was continued until minimal dosages were

reached and symptoms could be controlled at those prescription levels. Nursing and direct care staff also observed the patient for significant changes and communicated these observation to the treating psychiatrist.

A final observation about medication: most patients do not like being on psychotropic medication. Many of the persons that were admitted to the acute care unit had been on medication because of previous psychiatric episodes. Even though they had information which indicated a necessity to stay on medication in order to maintain stability, most when they felt better ceased taking the prescription. The medications were powerful, and had the potential of significant and uncomfortable side effects. Many patients described the feeling as "being in a chemical strait-jacket". Berger (1977) stated the dilemma this way:

> Each time any of these powerful medications is prescribed, we have to consider the drawbacks as well as the advantages of each medicine for each individual patient. . . . It is important to be aware that all of these new medicines may have disturbing side effects. . . . Some . . . are drowsiness, dry mouth, low blood pressure, fibrillations, tremors, and weight gain" (p. 61).

Patient Characteristics.

Also examined in this study were patient characteristics of people secluded and not secluded. The

characteristics considered were suggested by the literature review, and preliminary studies conducted by the psychiatric unit utilization committee (see Appendix E). Most of the data was collected at admission and placed on a face sheet (Appendix I). Also, the information was generated by the various professional disciplines, with appropriate reports being placed in the assessment section of the clinical record of the patient. Patient characteristics were included so it could be determined if any of these variables were systemically related to the seclusion process. Of particular interest was determining if any bias contributed to the seclusion process decision making.

As a part of the review of the clinical record, criteria and conditions related to the seclusion process were also considered. This involved looking at some basic staff variables such as sex, race, seniority, and classification. The staff component was also joined with training program variable, in order to ascertain any effect the training program had on staff. Other issues considered were reasons for seclusion, time factors, and census data.

The Training Program

On May 4-8 the psychiatric program unit held its first comprehensive staff training program. It was aimed at focusing on the treatment offered by hospital as a whole, and the admitting/acute care unit in particular. All

available full-time regular nursing and RCA staff of Woodside Cottage (C-5) were involved, with 21 staff from all three shifts taking part in the program. Also, two new nurses took part in the program. While regular staff were in training, relief staff provided treatment services in C-5. Because schedules were staggered, the open window of the study was May 1-10, 1987. This allowed for staffing adjustments so that persons were able to participate in a Monday through Friday training schedule.

This particular training approach was unique as compared to previous training efforts. In the past, staff had been trained in relation to a variety of issues which were applicable to the Regional Center program as a whole. The previous training was not oriented to the unique needs of the psychiatric program and the admitting/acute care unit. The need for the training program was based on several factors: (1) over half of the C-5 staff were relatively low in seniority, and had little experience working with psychiatric patients; (2) many of the staff had been experiencing symptoms of job-related burn-out; (3) psychiatric admissions were increasing and placed a great deal of pressure on the admitting building staff; (4) as a result of a series of short training sessions, staff expressed the need for more intensive training.

Because of these factors, the Facility Director approved the one week program. A representative team of

staff was appointed to develop the content of the training program. The persons involved were: the director of psychology, a nurse supervisor, and a senior direct care staff person. This group not only created the program outline, but also put together the content of the training sessions. This included scripting and taping a series of vignettes which portrayed what was called staff-o-genic behaviors.

The staff training program had the following goals:

1) to teach staff the underlying philosophy of the psychiatric unit;

2) To enhance the ability of staff to communicate more effectively with persons who were hospitalized.

3) To enable workers to understand better the concept of mental illness and the various diagnoses which were treated at the psychiatric unit;

4) To consider the most effective and least restrictive means to assist patients to be more in control.

5) To help the care providers understand the specific functions of the admitting unit.

The training program schedule which was developed to fulfill these purposes, is Appendix J.

At the end of program, all persons were given a multiple choice examination (Appendix K). After the exam was scored, each employee who participated in the training experience was interviewed by representatives of the

planning group. The post workshop interviews had the purpose of further evaluating what was learned by staff. The employees were graded on a pass/fail basis; 18 staff persons passed, one was conditionally passed, and two failed. The two who did not succeed were by mutual consent of management and labor transferred to other program units.

The Seclusion Procedure

The use of seclusion as a behavior management method at C-5 is governed at three levels: Michigan Mental Health Code, (1986) (Appendix A); DMH Administrative Rules, (1987) (Appendix B); and CRC Resident Policy, (1986) (Appendix C). When JCAH accreditation is an issue, the policy and practice is evaluated by guidelines found in Special Treatment Procedures, Consolidated Standards Manual, 1987 (Appendix D).

A patient may be secluded, according to DMH policy, for one of three reasons:

(a) when justified and specified in the plan of service as being of clinical benefit to the patient/resident, or

b) for the purpose of preventing a patient/resident from physically harming himself or others as substantiated in the clinical and/or medical records, or

c) to prevent a patient/resident from causing substantial property damage.

CRC policy requires that "a dangerous resident may be ordered in seclusion by a supervisor. Telephone authorization from a physician must be obtained within one-half (1/2) hour after imposition of an emergency seclusion." (p. 2)

A separate chronological record is kept to show specific instances of seclusion usage. The record is kept on a specified form (Appendix I), which includes the following information: the patient's name, case number, date of birth, county of residence, reason for seclusion, date of incident, time seclusion began and ended and behavior at the end of seclusion. The staff is expected to observe the patient every fifteen minutes, and a professional staff person had to evaluate the patient at least every two hours. Completed reports are turned over to the medical records department, which tabulates the total number of incidents and duration of the incidents.

It was stated above that seclusion is ordered by a supervisor, which at C-5 means the nurse supervisor. Each shift at Woodside has a supervisor nurse who is in charge of RCA, or direct-care staff. During the course of the study there was a change in practice, in terms of who requested seclusion. In the earlier months, some RCA staff who were involved initially in the incident leading to seclusion requested the management procedure. After the training program, all requests for seclusion were made by nursing

(R.N.) staff. This did not mean that the R.N. involved actually initiated seclusion; rather, it meant that he/she authorized it.

Theoretically, the following was supposed to happen: if direct care staff were involved in a difficult management process, and they thought it required seclusion, the request to seclude was made to the nurse (often while on the way to the room). In those few moments, the supervisor was supposed to determine if the action was the least restrictive alternative. If that was judged to be the case, then approval for seclusion was given, and authorization received from the on-call physican.

Thus far, seclusion has been discussed in the context of policy and procedure. In order to ascertain the process as completely as possible it is important to be aware of what is happening to the patient during admission.

When a patient enters the milieu of a psychiatric hospital, crisis is a central reality for the individual involved. The crisis is felt because of two primary reasons: first, the shock of going into a controlled environment which is generally viewed as oppressive and foreign. Everything is different, including the bed slept upon, food eaten, the over-all ambiance of the building, and the strangeness of the people, both peers and staff. This dynamic is an expression of the milieu, described above.

The second reason is that the patient is generally

experiencing a level of impairment which is both frightening and bewildering, especially when compared with the premorbid state. This kind of experience distorts how external reality is being perceived by the person in crisis. This is an expression of major mental disorders which contributes to most people being admitted to any psychiatric hospital, particularly the Caro psychiatric program. Liberman, Eckman and Phipps (1987) have outlined conditions which contribute to the vulnerability and predisposition of an individual being impaired, and thus hospitalized. Writing in the context of schizophrenia, it was stated:

> The appearance of. . . characteristic schizophrenic symptoms and impairments may be caused by changes . . . such as the following:
>
> 1. The underlying biological . . . vulnerability . . . physiologically stressed, e.g., by abuse of alcohol or street drugs;
>
> 2. Stressful life events or daily levels of tension intervene . . . e.g., overstimulating, critical, or overinvolved family relationships;
>
> 3. The individual's . . . support network . . . diminishes, e.g. family member dies, therapist terminates, or patient leaves home;
>
> 4. Social problem-solving skills . . . atrophy as a result of disuse, reinforcement of sick role, or loss of motivation. . . .

> Either too much environmental change, stressors, or ambiant tension or too little coping skills and social support can lead to a break down and exacerbation. (p. 1)

The intensity of thought and feeling that the exacerbation generates creates a situation which, as noted above, increases the probability that seclusion as an intervention will take place around the admission event. This study has shown that 25% of incidents of seclusion occurred on the day of admission, and an additional 20% happened one day after admission. Therefore, 45% of the incidents of seclusion took place within 36-48 hours of admission. Also, 80% of secluded persons were involuntarily committed to the hospital, and were transported to the admitting unit either by police officers or in an emergency vehicle. In almost all instances, when people were transported in this fashion, they came to C-5 in some kind of mechanical restraint, either handcuffs or leather cuffs. Thus, when the involuntary state was added to the equation, seclusion became even a greater reality.

Data Collection Procedures

The primary data source for the research was the clinical record, or chart. Each patient admitted to the psychiatric unit has a chart which was opened for that person. The record consists of: the treatment program, daily progress notes, assessments, medical and psychiatric

orders, medical records and test results, legal documents including a patient information form, and communications. Most of the data used in this study was generated by the progress notes, assessments, and face sheets. The seclusion forms completed by staff, when there was an incident of seclusion, were placed in the patient's progress notes. Copies of these forms were made by the responsible nurse, and forwarded to medical records. The copies of the seclusion forms evaluated by the researcher were those from medical records.

Once the time frame of the study was determined, all of the appropriate clinical records were obtained and evaluated. A copy of each secluded patient's face sheet was made and the additional data added to the face sheet. The above procedure was also followed with the non-secluded sample. Altogether, 120 clinical records were reviewed and evaluated. The data was entered and verified at the Michigan State University Computer Laboratory.

Using program records, such as the clinical record of the psychiatric program, created some problems for the reseacher. First of all, there was a problem of incompleteness. There was not easy access to data about patient characteristics. This was particularly true with job and occupational information, as well as information about previous psychiatric treatment. Either the information was not available, or it was placed in rather obscure parts of

the record. Another problem was that catagories of information desired by the researcher, were not readily available, and on occasion had to be inferred. An example was the variable "patient demographic living area". This was determined by the researcher's knowledge of the catchment area, but it did create some margin for error.

A different problem that emerged in data collection was the communication procedure regarding the seclusion usage reporting form. It was discovered that some incidents of seclusion were inadvertently not reported beyond the clinical record. This meant that some copies of the individual seclusion report forms did not reach the medical records department, or the building supervisor. Quarterly reports to the state DMH office are based on the records from medical records. Also, this meant that the building supervisor did not have the records available in order to ascertain whether or not appropriate procedures were followed by staff. This exclusion of seclusion incidents did present the potential for a 5% to 10% error in underreporting incidents of seclusion.

Weiss (1972) summed up the problem with using program records and agency files:

> If the participants do not supply certain items of information or if the staff fails to enter data, (often) nobody checks on the missing items and follows up. . . . (An evaluator) cannot rely on data on file

> for a complete count. Agencies sometimes change record keeping procedures. If this happens during the period under study, it can vitiate all attempts at before-after comparisions. . . . Agency records are often based on the reporting of practitioners, and when they know that they are being "judged" by the data in the records, they may intentionally or unintentionally bias their accounts. (pp. 54-55)

The researcher experienced all three problem areas when collecting the data. Information was incomplete, as noted above. Reporting procedures did change in the seclusion report process, where after the training program R.N.'s became fully responsible for initiating the seclusion process. Finally, the researcher believes some of the seclusion reports were biased when staff reported the reasons for seclusion.

The Research Design

From the description of the setting and subject selection it can be ascertained the research was conducted in a naturalist setting, using available subjects. Subjects were not manipulated by the researcher, but by the available treatments and dynamics in the environment of the admitting unit. The study was retrospective in nature, in that the researcher was looking back on events which had already taken place. There was no random assignment to treatment groups; there was random selection of the non-secluded

group. Secluded patients were all first-time secluded persons the designated time period of the study.

The design, based on the above description, is quasi-experimental. Because this was a field study, random assignment to treatments was not possible. Further, the study is an interrupted time-series design. Cook and Campbell (1979) described the concept:

> A time series is involved when we have multiple observations over time. The observations can be on the same units, as when particular individuals are repeatedly observed; or they can be on different but similar units. . . . The purpose of the analysis is to infer whether the treatment had any impact. If it did, then we would expect the observations after the treatment to be different from those before it. That is, the series would show signs of an 'interruption' at an expected point in time. (p. 207).

In this study the "interruption" was the staff training program. The subjects were different, but over the course of study similar.

The resulting design was a one-group pre-test-post-test time series design, or the one-group interrupted time series design. This design has inherent internal validity problems, and inferring causation is questionable. But Borg and Gall (1971) have stated that the "additional measurements enable the researcher to rule out maturation

and testing effects as sources of influence on shifts from pretest to posttest." (p. 395)

In this study, the dependent variable was incidents of seclusion involving first-time secluded patients, and it was this variable that was tested statistically. Other measures were examined, including all incidents of seclusion and over-all time in seclusion for first-time secluded people; the total incidents of seclusion during the time of the study; and percentages which reflected incidents of seclusion in relation to monthly admissions and in relation to the average monthly census of the admitting unit.

Data Analysis

The primary objective of this research was to investigate what factors in the psychiatric unit contributed to the incidence of seclusion. Patient characteristics were examined; psychiatric treatment effects were studied; and the impact of staff training was researched.

All of the hypotheses were initially tested and analyzed by the t-test for interval data and the chi-square for catagorical data. Crossbreaks were used to study and test relationships between two variables while controlling for the effects of a third variable. This process allowed the researcher "to observe and control for differences in degree of relationships at different levels of a control variable (thus) unmasking 'spurious' relationships." (Isacc & Michael, 1981, p. 163) A probability level of $p<.05$ was

required for consideration of statistical significance in all of the analyses.

Summary

The methodology used in the study was discussed in this chapter. The Caro Regional Mental Health Center in Caro, Michigan was the setting, and the research was designed and implemented there. Seclusion room usage at the psychiatric acute care/admitting unit was the focus of the research. The subjects were 52 first-time secluded patients and 58 randomly selected non-secluded patients. They were patients who were admitted to the acute care unit during a period covering December, 1986 to October, 1987. 90% had received pervious psychiatric treatment; 45% were never married; 90% were involuntary. The average income of both groups of people was $5,500 or less. 55% were males; 70% were white and 22.5% were black. Staff who participated in a training program held May 4-8, 1987 also were studied. The primary treatment variables were discussed, including patient characteristics, psychiatric treatment modalities, the training program, and the seclusion process. The research design was reviewed, and the statistical procedures used in analyzing the data were described.

CHAPTER IV

RESULTS

The major purposes of this study were (a) to investigate whether staff decisions to seclude patients at the Caro Regional Center psychiatric admitting unit were biased by patient characteristics such as age, sex, race, socio-economic status, diagnosis or admission legal status; (b) to examine whether various psychiatric treatment modalities had an effect on the incidence of seclusion; and (c) to determine if a staff training program for regular staff at the admitting building made any difference in the incidence of secluding patients. The findings presented in this chapter are based on the analysis of data gathered from clinical records of first-time secluded patients and non-secluded patients over a 10-month period. Also, some staff data will be reviewed and discussed, as well as data related to all incidents of seclusion during the 10 month period.

This chapter is a presentation of the results of the statistical analyses that addressed the research hypotheses and related questions posed in Chapter I. The chapter is divided into the following sections: Hypotheses Investigating Differences Between Characteristics of

Secluded and Non-secluded Patients; Hypotheses Investigating Differences Between Various Psychiatric Treatment Modalities in Relation to Seclusion Room Usage; and Hypotheses Investigating the Impact of Staff Training on Seclusion Room Usage. An alpha level of $p < .05$ was required for consideration of statistical signifcance in all analyses.

Hypotheses Investigating Differences Between Characteristics of Secluded and Non-secluded Patients

Ho 1: There are no significant differences in patient characterists when comparing secluded and non-secluded patients.

Ha 1: There are significant differences in patient characteristics when comparing secluded and non-secluded patients.

Table 4: Sample Characteristics of Secluded and Non-secluded patients.

Variables	Secluded N=52	Non-secluded N=58	P (a=.05)
Sex			N.S.
Male	30	30	
Female	22	28	
Race			N.S.
White	35	45	
Black	11	11	
Other	6	2	
Age (mean)	36.7	37.0	N.S.
Height (mean)	5 ft. 8 in.	5 ft. 6 in.	S
Weight (mean)	166 lbs.	160 lbs.	N.S.
Stature (lbs./inch)	2.45 lbs.	2.45 lbs.	N.S.
Education (mean)	11.8 yrs.	11.2 yrs.	N.S.
Marital Status			S
Never married	29	22	
Not currently married	20	22	
Married	3	14	

Table 4, continued

Variables	Secluded N=52	Non-Secluded N=58	P (a=.05)
Previous Treatment			S
No	2	10	
Yes	50	48	
Year Treatment Began (mean)	Aug. 1977	Feb. 1978	N.S.
Previous Hospitalizations at CRC (mean)	2.4	2.5	N.S.
Diagnosis			S
Schrophrenic	26	14	
Manic	19	9	
Depression	5	12	
Non-psychotic	2	14	
Organic		4	
Not known		5	
Treatment Received			S
Milieu	24	14	
Medication only	16	32	
Work & Meds	12	12	
Military			N.S.
Non-veteran	45	49	
Veteran	7	8	
Living Area			N.S.
Inner City	8	12	
City	25	18	
Suburban	5	3	
Rural-small town	14	25	
Living Status			N.S.
Independent	19	27	
Semi-independent	21	20	
Dependent	12	11	
Job Status			N.S.
Employed	3	4	
Homemaker	4	9	
Unemployed	17	15	
Disabled	26	26	
Retired	2	3	
Income (mean)	$3738	$5323	N.S.
Last Year Employed (mean)	August, '83	Feb. '84	N.S.
Legal Status			N.S.
Voluntary	10	19	
Involuntary	42	39	

The data related to testing the null hypothesis are presented in Tables 4 through 8, and Figures 1 and 2. The results indicated there was significant difference in five of the 20 variables tested statistically. An examination of Tables 6 and 8 indicates the significant differences in characteristics of secluded and non-secluded patients were as follows: height, marital status, previous psychiatric treatment, diagnosis, and treatment received.

PATIENTS SECLUDED FOR THE FIRST TIME FROM 12-1-86 TO 10-10-87

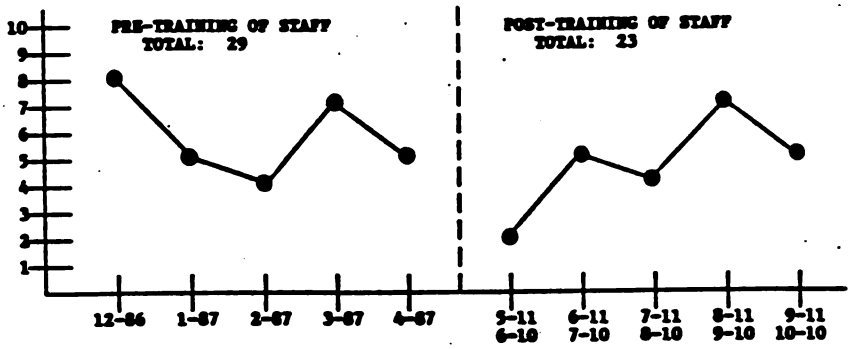

FIGURE 1

Training period was from 5-1-87 to 5-10-87. Multiple admissions are not counted more than once.

INCIDENTS OF SECLUSION INVOLVING FIRST TIME SECLUDED PATIENTS FROM 12-1-86 TO 10-10-87

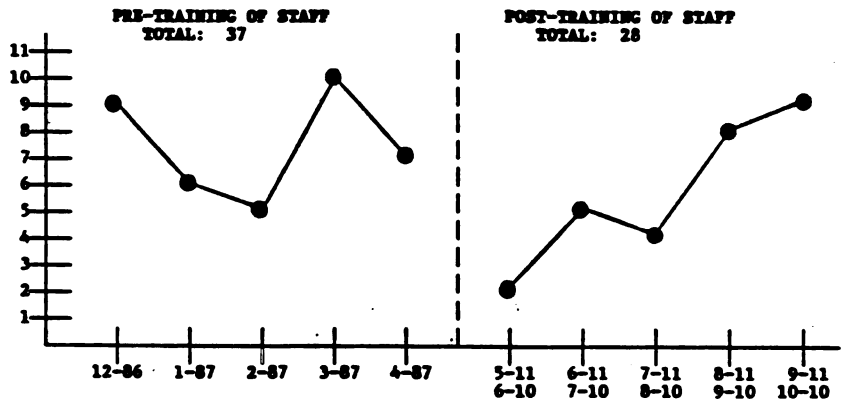

FIGURE 2

Training period was from 5-1-87 to 5-10-87. Excludes one patient secluded 18 times in Dec. 86 and 3 times in Jan. 87. Multiple admissions were not counted.

PATIENTS SECLUDED 12-1-86 TO 10-10-87

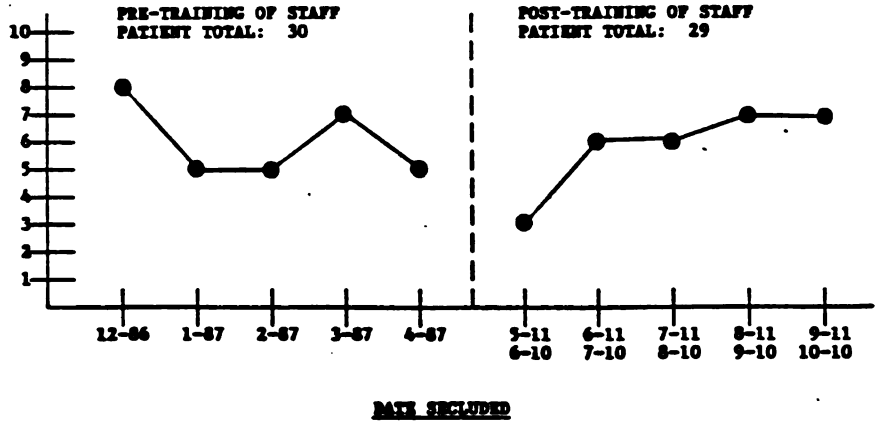

FIGURE 3

Training period was from 5-1-87 to 5-10-87. Includes all patients hospitalized more than once during the 10-month study.

INCIDENTS OF SECLUSION 12-1-86 TO 10-10-87

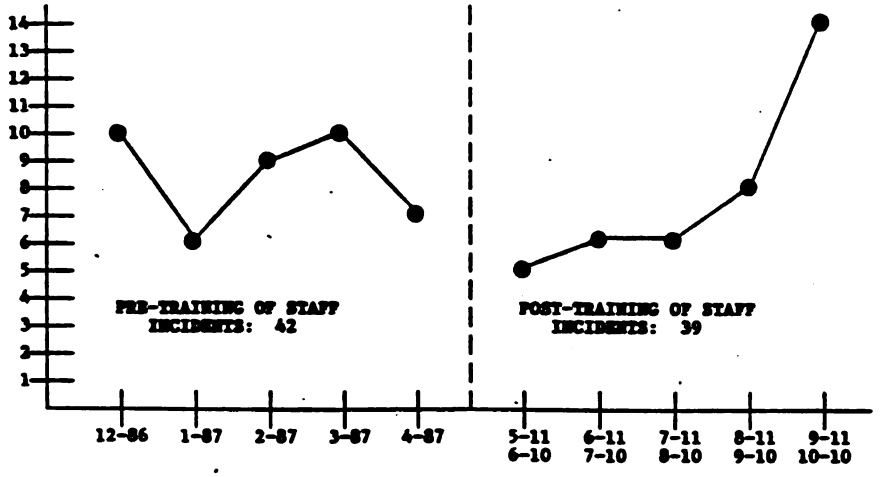

FIGURE 4

Training period was from 5-1-87 to 5-10-87. Excludes one patient secluded 18 times in Dec. 86 and 3 times in Jan. 87. Includes all patients hospitalized more than once during the 10 month study.

Table 5: Results of t-test Investigating Differences Between First-Time Secluded Patients and a Random Sample Group of Non-Secluded Patients

Variable	Group	Numbers	Mean	SD	t	df	p
Age	Group 1	52	36.7	12.7	-0.15	108	.817
	Group 2	58	37.0	12.3			
Height	Group 1	52	67.96*	3.9	2.17	108	.032
	Group 2	58	66.40*	3.7			
Weight	Group 1	52	166.35	30.7	1.11	108	.268
	Group 2	58	159.98	29.3			
Stature	Group 1	52	2.45**	0.46	0.53	108	.595
	Group 2	58	2.41**	0.41			
Education	Group 1	51	11.80	2.33	1.42	106	.158
	Group 2	57	11.16	2.4			
Income	Group 1	47	$3738	$2914	-1.93	91	.056
	Group 2	46	$5323	$4785			
Last Year Worked	Group 1	33	83.67	4.08	-0.66	68	.514
	Group 2	37	84.30	3.96			
Year Treatment Began	Group 1	37	77.59	6.9	-0.30	84	.763
	Group 2	47	78.14	9.2			
Number Hospitalized	Group 1	52	2.4	2.6	-0.21	108	.833
	Group 2	58	2.5	3.1			
C-5 Census	Group 1	52	16.2	2.15	-0.87	108	.386
	Group 2	58	16.5	1.98			
MI Census	Group 1	52	100.2	6.19	-0.49	108	.624
	Group 2	58	100.7	5.97			

Group 1 = Secluded patients
Group 2 = Non-Secluded patients
* Measure is in inches
** Measure is pounds per inch

Table 6: Results of Significant t-Tests Investigating Characteristic Differences Between Secluded and Non-Secluded Patients

Variable	Group	Number	Mean*	D	t	df	p
Patient Height	Secluded	52	67.96	3.9	2.17	108	.03
	Non-Secluded	58	66.40	3.7			

* measured in inches

Table 7: Results of Chi-Square Tests Investigating Differences Between First-Time Secluded Patients and a Random Sample Group of Non-Secluded Patients

Variable	Chi-Square	df	p
Sex	0.394	1	.5303
Race	2.931	2	.2309
Marital Status	7.869	2	.0195
Military Experience	0.008	1	.9308
Living Area	5.230	3	.1557
Living Status	1.135	2	.5669
Job Status	2.166	4	.7052
Occupation	3.353	3	.3402
Legal Status	2.584	1	.1079
Previous Treatment	5.062	1	.0245
Diagnosis	28.881	5	.0001
Treatment	7.660	2	.0217

Table 8: Results of Significant Chi-Square Tests Investigating Characteristic Differences Between Secluded and Non-Secluded Patients

Variable	Chi-Square	df	p
Previous Treatment	5.06	1	.0245
Diagnosis	26.88	5	.0001
Marital Status	7.87	2	.0195
Treatment	7.66	2	.0217

One variable, previous treatment, was an anomaly. Before a Yates correction, it was significant (p=.0245). After a Yates correction, it was not (p=.0519). Examination of chi-square cells indicated those who had not been previously hospitalized tended not to be secluded. 10 out of 12 who had not been previously treated were part of the non-secluded sample.

A comparison of income levels between secluded and non-secluded patients was close to statistical significance. An examination of Tables 4 and 5 show secluded persons had an average income of $3,438.20; non-secluded patients $5,322.83. The difference between the two groups was $1,584.53. The t-test was not statistically significant (p=.058); but in practical terms, significant, especially with the income levels being compared.

The results indicated there were significant differences in some patient characteristics when comparing

secluded and non-secluded patients. Therefore, the null hypothesis was rejected.

Hypotheses Investigating Differences Between Various Psychiatric Treatment Modalities and Their Effect on Seclusion Room Usage

Ho 2: There are not significant differences in psychiatric treatment variables when comparing secluded and non-secluded patients.

Ha 2: There are significant differences in psychiatric treatment variables when comparing secluded and non-secluded patients.

The data related to the testing of Hypothesis 2 are presented in Table 9. The results indicated there were significant differences in treatments in relation to whether or not a person was secluded. The most significant form of treatment was Milieu. This was determined by doing a chi-square of treatment by secluded, controlling for milieu. Tables 4 and 6 indicate a test result with $p=.0007$. An examination of the descriptive data shows 46% of individuals secluded received milieu treatment alone; 55% of non-secluded patients were on medication treatment alone. Other significant chi-square results were legal status status by treatment, and diagnosis by treatment.

Diagnosis and treatment have a close relationship because schizophrenia and bi-polar disorders most often require medication treatment. Also, most schizophrenic and manic patients came to the hospital involuntarily. This generally meant that initially only mileau treatment was received by these patients, thus creating a higher

vulnerability to being secluded during the first days of treatment. Based on all of these results, the null hypothesis was rejected.

Table 9: Results of Chi-square tests investigating differences between treatment modalities and other related variables.

Variables	Chi-Square	df	p
Treatment by secluded/ non-secluded	7.660	2	.0217
Legal Status by treatment secluded/non-secluded	8.395	2	.0150
Diagnosis Controlling for treatment (milieu) secluded/non-secluded	16.904	3	.0007
Diagnosis Controlling For Treatment (meds) secluded/non-secluded	5.635	3	.1308
Diagnosis Controlling For treatment (work and meds) secluded/non-secluded	1.477	3	.6876
Diagnosis by Treatment	20.816	10	.0224
Dianosis by Treatment schizophrenia/manic	1.896	2	.3873

Hypotheses Investigating the Impact of Staff Training on Seclusion Room Usage

Ho 3: Comparing the pre-training secluded group with the post-training secluded group, there are not differences in the relative influence of variables associated with seclusion.

Ha 3: Comparing the pre-training secluded group with the post-training secluded group, there are differences in the relative influence of variables associated with seclusion.

The data related to the testing of Hypothesis 3 are presented in Figures 1-4 and Tables 10-14. This hypothesis considers whether a staff training program makes a difference in factors related to seclusion room usage. Figures 1 and 2 examine graphically the descriptive data from the perspective of first-time secluded patients. Figure 2 excluded incidence data of one patient secluded 21 times over a two month period. Figures 3 and 4 present graphically data that represents all patients secluded, and all incidents of seclusion during the study time period.

Tables 10-14 present the results of the statistical tests of significance. The results depicted in Table 10 indicate there was no difference in various conditions related to seclusion. The criteria tested were: the average number of days after admission a patient was secluded; the average length of time secluded, the average time per incident secluded, and the per patient average number of incidents secluded. This data did not include one patient who was secluded 21 times over the December, '86 - January, '87 period of the study. Similar data including

this patient is shown in Table 11. Whether or not that particular patient was included in the data tested made little difference. The null hypothesis, based on these tests, was not rejected.

Table 10: Results of t-Tests Investigating Differences in Incidents, Length, Days After, and Average Time For Patients Secluded Before Staff Training and After Staff Training.**

Variable	Group	Number	Mean	SD	t	df	p
Days After Admission	Group 1	28	38.4	123.9	1.34	49	.187
	Group 2	23	3.7	8.2			
Length Secluded	Group 1	28	153.8*	167.8	1.17	49	.279
	Group 2	23	112.3*	75.7			
Incidents Secluded	Group 1	28	1.61	1.10	1.41	49	.164
	Group 2	23	1.26	0.45			
Average Time	Group 1	28	91.89*	84.98	0.17	49	.864
	Group 2	23	88.28*	59.10			

Group 1 = Pre-Training Secluded Patients
Group 2 = Post-Training Secluded Patients
*Variable is counted in minutes
**Excludes one patient secluded 20 times in December, 1986, and three times in January, 1987.

Table 11: Results of t-Tests Investigating Differences for Patients Secluded Before Staff Training and After Staff Training

Variable	Group	Numbers	Mean	SD	t	df	p
Age	Group 1	29	37.07	11.9	0.26	50	.794
	Group 2	23	36.13	13.9			
Height	Group 1	29	67.7*	3.8	0.63	50	.531
	Group 2	23	68.3*	4.1			
Weight	Group 1	29	169.05	33.6	0.71	50	.483
	Group 2	23	162.96	29.9			

Table 11: Continued

Variable	Group	Numbers	Mean	SD	t	df	p
Stature	Group 1	29	2.50**	0.52	0.95	50	.347
	Group 2	23	2.38**	0.36			
Education	Group 1	29	11.6	2.7	-0.78	49	.438
	Group 2	22	12.1	1.6			
Income	Group 1	27	$3589	2826.3	-0.40	45	.688
	Group 2	20	$3940	3091.1			
Last Year Worked	Group 1	18	83.6	3.1	-0.08	31	.933
	Group 2	15	83.7	5.1			
Year Treatment Began	Group 1	20	77.8	6.6	-0.15	35	.885
	Group 2	17	77.4	7.5			
Times Hospitalized	Group 1	29	2.2	2.44	-0.67	50	.508
	Group 2	23	2.7	2.74			
C-5 Census	Group 1	29	16.5	1.99	1.23	50	.225
	Group 2	23	15.8	2.32			
MI Census	Group 1	29	98.7	7.4	-1.97	50	.055
	Group 2	23	102.0	3.6			
Days After	Group 1	29	164.2	30.5	1.61	50	.114
	Group 2	23	8.2	1.7			
Length Secluded	Group 1	29	386.7	71.8	1.30	50	.201
	Group 2	23	75.7	15.8			
Incidents Secluded	Group 1	29	2.4	3.1	1.36	50	.179
	Group 2	23	1.3	0.5			
Staff Seniority	Group 1	29	8157***	7592	-0.55	50	.587
	Group 2	23	9775***	13481			
RN Seniority	Group 1	29	4977***	924	0.09	50	.929
	Group 2	23	3589***	748			

Group 1 = Secluded patients prior to staff training
Group 2 = Secluded patients after staff training
* Measure is in inches
** Measure is pounds per inch
*** Measure is in hours - 2080 hours equals one year

Table 12 shows the results of chi-square tests of significance, related to both patient and staff characteristics. The results indicated there were differences between the pre-training and the post-training groups of secluded patients. The differences were reflected in these patient catagories: patient race and treatment patients received while in the admitting unit. In terms of staff data, the following were statistically significant: work shift patient secluded; over-all staff I.D., R.N. I.D.; and R.N. sex. All the chi-square results are in Table 13.

Table 12: Results of Significant Chi-Square Tests Investigating Differences for Patients Secluded Before Staff Training and After Staff Training.

Variable	Chi-Square	df	P
Race	6.469	2	.0394
Treatment	6.139	2	.0464
Work Shift Secluded	11.275	2	.0036
Staff I.D.	25.496	15	.0437
R.N. I.D.	19.433	8	.0127
R.N. Sex	7.364	1	.0067

Table 13: Chi-Square Tests Investigating Differences for Patients Secluded Before Staff Training and After Staff Training

Variable	Chi-Square	df	p
Sex	0.170	1	.6796
Race	6.469	2	.0394
Marital Status	0.153	2	.9262
Military Experience	0.006	1	.9373
Living Area	3.804	3	.2834
Living Status	2.440	2	.2952
Job Status	1.099	4	.8944
Occupation	6.073	3	.1081
Legal Status	2.114	2	.3476
Previous Treatment	0.028	1	.8670
Diagnosis	0.958	3	.8115
Treatment	6.139	2	.0464
Day of Week	3.208	6	.7823
Work Shift	11.275	2	.0036
Reason Secluded	1.663	4	.7974
Staff I.D.	25.496	15	.0437
Staff Sex	2.525	1	.1120
Staff Race	0.809	1	.3685
Staff Classification	1.689	2	.4297
R.N. I.D.	19.433	8	.0127
R.N. Sex	7.364	1	.0067

Further data related to testing Hypothesis 3 are presented in Table 14. This analysis was required because there was a change in policy regarding who was responsible for initiating seclusion at C-5. After the training program took place May 4-8, 1987, R.N. nurses were required to assume responsibility for initiating all incidents of seclusion. Through a process of controlling for variables related to the sex and identity of the R.N. staff involved, it was determined that the effect of the training program was essentially on one male registered nurse, who was primarily the supervisory nurse for first shift. Based on this process, and because of previously discussed data, the null hypothesis was rejected, but conditionally. This conditional result will be further explained in the discussion.

Table 14: Results of Chi-Square Tests Investigating Differences Among Nurses Who Secluded Patients, Before and After Staff Training.

Variable	Chi-Square	df	P
Training by Shift controlling for R.N. Sex (male)	8.499	2	.0143
Training by Shift controlling for R.N. Sex (female)	2.844	2	.2412
Work Shift By R.N. Sex	9.183	2	.0101

Other Descriptive Data Related to Seclusion Usage

Figures 5-8 and Table 15 present other data of interest related to seclusion room usage. The graph in Figure 5 shows data that indicates average admissions per month, both before and after staff training. Figure 6 shows the percent of all patients secluded in relation to monthly admissions, both prior to and after the training program. This material was included in order to take into account all patients secluded and their respective incidents of seclusion in relation to admissions. Admissions prior to and after the training program were relatively constant, with a difference of plus three for the post training period. There was a decrease of 1.5% in the incidence of seclusion in the post-training program, as compared with the pre-training period.

The average daily census by month is depicted in Figure 7. The pre- and post-training program comparisons showed there was a .3% increase in census. Figure 8 shows the percent of all patients secluded during the same period covered by the previously discussed data. There was a .2% decrease of patients secluded during the post-training period, in comparison with the pre-training period.

Table 15 presents descriptive data about various criteria and conditions related to first-time secluded patients. Reasons for seclusion was of interest because those stated indicators were the justifications for a staff person effecting the seclusion process. 54% were related to

TOTAL ADMISSIONS PER MONTH AT ADMITTING UNIT(C-5) FROM 12-1-86 TO 10-10-87

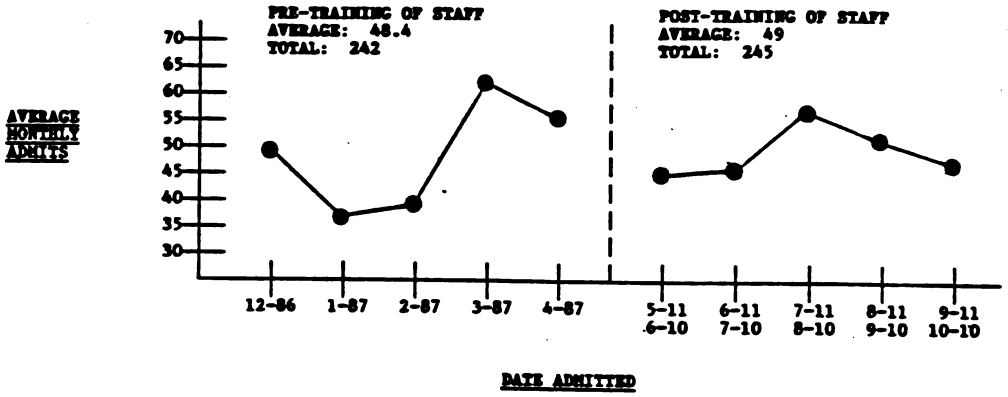

FIGURE 5

Staff training period was from 5-1-87 to 5-10-87.

MONTHLY % OF PATIENTS ADMITTED TO ACUTE CARE UNIT WHO WERE SECLUDED 12-1-86 TO 10-10-87

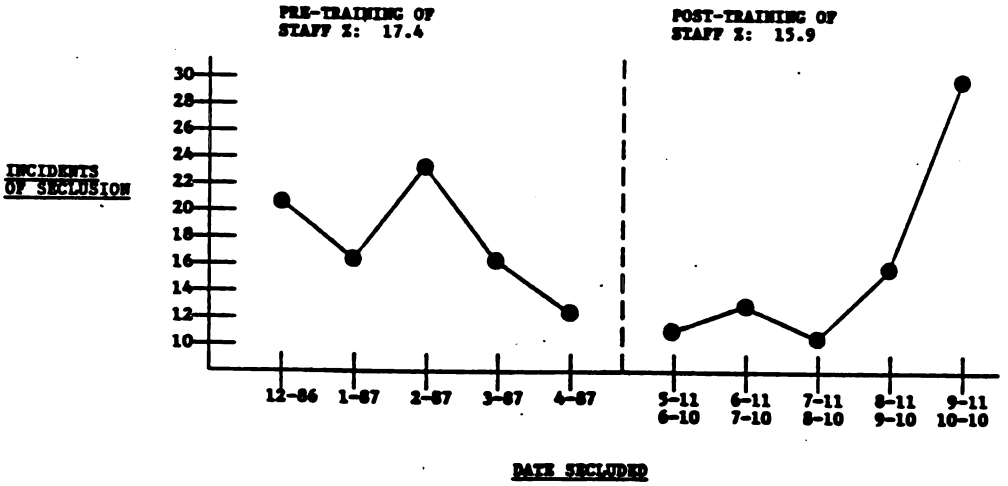

FIGURE 6

Staff training program from 5-1-87 to 5-10-87. Excludes one patient secluded 18 times in Dec. 86 and 3 times in Jan. 87. Includes all patients hospitalized more than once during the 10 month study.

AVERAGE DAILY CENSUS FOR PSYCHIATRIC ADMITTING UNIT (C-5) FROM 12-1-86 TO 10-10-87

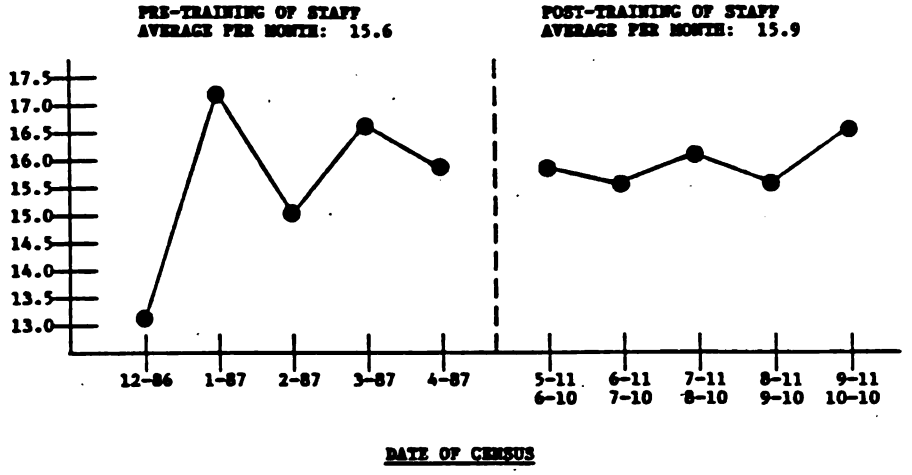

FIGURE 7

Training program was from 5-1-87 to 5-10-87.

% OF TOTAL PATIENTS SECLUDED AT C-5 IN RELATION TO AVERAGE DAILY CENSUS AT C-5 FROM 12-1-86 TO 10-10-87

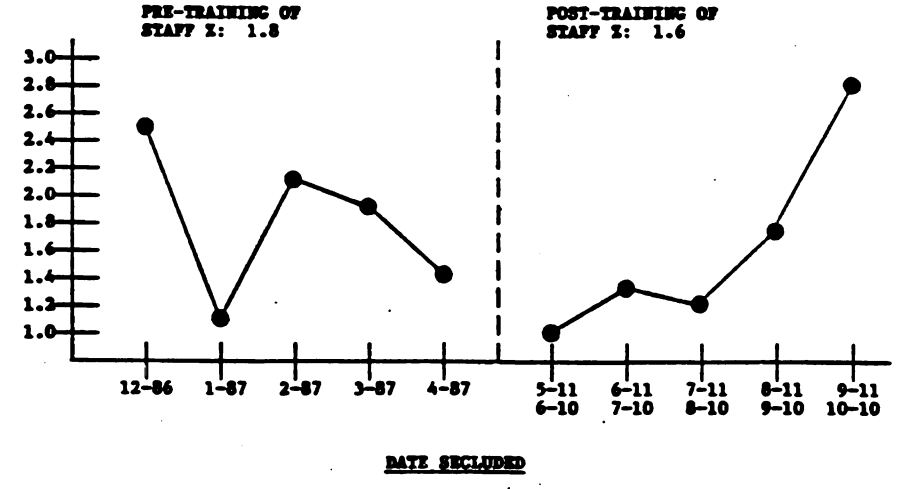

FIGURE 8

Staff training was from 5-1-87 to 5-10-87. Excludes one patient secluded 18 times in Dec. 86 and 3 times in Jan. 87. Includes all patients hospitalized more than once during the 10 month study.

threat of injury to staff; 26% to verbal agression. 71% of first-time secluded patients were secluded once during the reported admission. 75% of incidents of seclusion took place during the first and second shifts, with first accounting for 40% and second 35%. This data was tested for statistical significance, and found not significant. The same holds true for the time-of-week data. (See Table 13.)

Table 15: Criteria and Conditions Related to First Time Seclusion.

Variables	N=52
Reason for Seclusion	
Threat of injury to self	1 (2%)
Threat of injury to peers	6 (12%)
Threat of injury to staff	28 (54%)
Property Destruction	3 (6%)
Verbal Aggression	14 (26%)
Time of Week	
Weekday	33 (63%)
Weekend	19 (37%)
Time of Day (work-shift)	
First (6:30 a.m.-2:30 p.m.)	21 (40%)
Second (2:30 p.m.-11:00 p.m.)	18 (35%)
Third (11:00 p.m.-6:30 a.m.)	13 (25%)
Days After Admission (Mean)***	8.7
Incidents (Mean)***	1.5
Time in Seclusion (minutes) (Mean)***	135
Incidents of Seclusion	
Once	37 (71%)
2-3	12 (23%)
More than 3 times	3 (6%)
Admitting Unit Ave. Census*	16.2
Total MI Census**	100.7

*Bed Capacity = 20
**Bed Capacity = 110
***Excluded one patient secluded 21 times

Summary

The findings in this chapter were based on the analysis of data drawn from 110 clinical records of patients who were at the admitting unit of the psychiatric program at the Caro Regional Mental Health Center, Caro, Michigan. These data were used in analyzing the three major hypotheses and related questions of the study.

Based on *t*-tests and chi-square tests conducted on Hypothesis 1 investigating differences between secluded and non-secluded patients, the researcher concluded there were differences in the following areas:

1. Diagnosis, whereby secluded patients had a higher probability of being schizophrenic and bi-polar; non-secluded patients tended to be non-psychotic, depressed, personality disorders and organic.

2. Marital status, whereby secluded patients had a higher probability of never having been married, and non-secluded patients tended to be married or divorced/separated.

3. Height, whereby secluded patients, on the average, were two inches taller than non-secluded patients; there were no significant differences between secluded and non-secluded patients in weight or stature.

4. Treatment received, whereby treatment received by secluded and non-secluded patients was different

(differences will be discussed under hypothesis 2).

5. Previous treatment, whereby secluded patients had a higher probability of being previously treated than did non-secluded patients.

Based on chi-square tests conducted on Hypothesis 2 investigating differences between secluded and non-secluded patients, the researcher concluded there were differences in the following areas:

1. Secluded patients had a higher probability of receiving milieu treatment alone than did non-secluded patients;

2. Non-secluded patients had a higher probability of being treated on a regular medication regimen than did secluded patients;

3. Being involved in the work activity program had little to do with whether a patient was secluded or not secluded.

Based on *t*-tests and chi-square tests conducted on Hypothesis 3 the researcher concluded there were differences in secluded patient characteristics when comparing pre-training and pos-training. Also some staff differences emerged. The differences were reflected in the following catagories:

1. Patient race, whereby Hispanics had a higher probability of not being secluded after the training; a higher percentage of Black patients were secluded after the

training program;

2. Treatment, whereby pre-training secluded patients had a higher probability of receiving milieu and/or work activity and medication; post-training secluded patients tended to receive medication alone;

3. Staff characteristics, whereby staff I.D., R.N. I.D., and R.N. sex were influenced by the training program. Also, the work shift to which an employee was assigned made some difference.

Review of additional data, but not tested statistically, showed that in relation to patient admissions per month, approximately 16.5% were secluded; compared to daily census data, approximately 1.7% of patients were secluded. Most secluded patients, 71%, were secluded once, 45% were secluded during the first 24 hours of admission. 75% were secluded during the 1st or 2nd work shift. 54% of the incidents of seclusion were because of threats to staff; 26% because of verbal aggression or general agitation.

CHAPTER V

SUMMARY, CONCLUSIONS, AND IMPLICATIONS

Introduction

The final chapter includes a review of the problem that was researched, the procedures used in conducting the study, delimitations of the project, the major findings, and a statement of conclusions. Finally, recommendations and implications for future research and practice are presented and discussed.

Summary of the Study

Review of the Problem

The problem in this study was threefold. First, the researcher investigated the effect patient characteristics had on the seclusion process. Previous studies have not been consistent in determining whether or not patient characteristics such as race, sex, age, diagnosis, or size had an impact on biasing staff decisions to seclude. Secluded and non-secluded patients were compared in order to ascertain if any differences existed.

Secondly, the research focused on treatment considerations in relation to the seclusion process. The

admitting unit of the psychiatric program offered a variety of treatment modalities, and the basic question was how different aspects of active psychiatric treatment impacted on the level of seclusion usage. Treatments of interest were milieu, medication, and work activity. All patients in the admitting unit experienced the milieu, but not necessarily the other forms of treatment.

A third problem area was the influence of a staff training program on the incidence of seclusion. All regular staff of C-5 participated in a one-week training program, and an evaluation was made to determine if this program changed how staff reacted to patients who were apparently not in control.

Over-all, as much as was possible, the researcher wanted to identify the key factors which contributed to the event of seclusion in instances when this form of behavior control was required.

Review of the Procedures

The researcher employed an interrupted time-series design, in a naturalist setting. This design is quasi-experimental, and was retrospective in nature. The researcher did not manipulate the variables studied. The design had problems with internal and external validity; but in spite of these issues, causation cannot be dismissed; but it cannot be strongly inferred either.

The subjects were 110 hospitalized in patients who were

housed at the acute-care admitting unit of the psychiatric program at the Caro Regional Mental Health Center. The secluded group was all first-time secluded patients from December 1, 1986 to October 10, 1987. The non-secluded group was a stratified random sample, by month, over the same time period as the secluded group. The staff involved in the study were regular and relief staff assigned to the admitting unit during the course of the study. All regular staff participated in a training program held in May, 1987. The psychiatric treatments considered were those commonly available to the patients who resided in the admitting unit. All of the data were gained from the clinical records of the patients involved in the study. Also, policy, procedures and law were reviewed.

Delimitations

When the researcher first considered the problem of seclusion room usage as a research project, it was assumed this was a subject that had been well considered. The review of the literature was completed, and it was discovered that in comparison with other areas of concern in psychiatric treatment, the subject apparently has had limited interest. In addition to that, empirical research has essentially been even more limited. It seemed appropriate then that the issue of seclusion be explored empirically in order to begin to understand some of the dynamics that have entered into the procedure, which in 20th

Century psychiatric treatment seems like an anachronism. Particularly essential in the delimiting process was the addition of the staff-training component, which gave the research task more power in terms of testing the hypotheses that eventually emerged.

There was the desire to move more aggressively into staff issues as far as seclusion room usage was concerned. But it could not at this time be accomplished. This limitation should not be viewed as an expression of "blaming the victim", which in this case is the patient secluded. The patient is currently the focus because his/her treatment is paramount.

Major Findings

This section provides a summary of the findings derived from the statistical analysis of data concerning factors related to seclusion room usage at the Caro Regional Center Psychiatric Admitting Unit. The data were generated by a retrospective review of 110 patient records, who were residents of the admitting unit from December 10, 1986 to October 10, 1987. The data were analyzed using *t*-tests, and chi-squares, with $p < .05$ being required to obtain statistical significance. Three major hypotheses were tested.

Null Hypothesis 1 regarding patient characteristics and seclusion usage was rejected because the *t*-tests and chi-

square tests yielded satistically significant results at the $p < .05$ level. Examination of the data indicated that five of the twenty patient characteristics studied had some kind of association with the seclusion experience. For the purposes of this hypothesis, patient height, marital status, previous psychiatric treatment, and diagnosis stood out. It was determined that previous treatment and marital status, in the context of the sample studied, were closely related to diagnosis.

Null hypothesis 2, which focused on the role of psychiatric treatment in relation to seclusion, was rejected because chi-square tests yielded statistically significant results at the $p < .05$ level. The data was examined, and it was revealed that milieu treatment alone was associated with being secluded; medication treatment alone was associated with not being secluded; work activity had no impact on either the process of seclusion or not being secluded.

Null hypothesis 3 focused on the effect of staff training on the incidence of seclusion. Chi-square tests and t-tests yielded statistically significant results at the $p < .05$ level, and therefore the hypothesis was rejected. But examination of the data placed reservations on this conclusion. First of all, there were no statistically significant changes in incidences of seclusion, number of times individual patients were secluded, length of seclusion, or average length of seclusion. These factors

were tested two ways: one with a patient who was secluded twenty-one times over a two month period; the second without this patient. Secondly, an examination of staff data which was statistically significant revealed that one male staff nurse was the primary reason for the data showing statistical significance.

Other information of interest that emerged from the research was that 54% of the patients were secluded because of an actual or perceived threat of injury to staff. Most patients, 71%, required one incidence of seclusion to control behavior necessary to maintain safety for the patient and others. Statistical testing showed there was no significance when comparing incidence of seclusion and the census of C-5. The average time spent in seclusion was two hours, fifteen minutes, though this figure was affected by some few patients who spent an excessive amount of time in the seclusion room. There were no statistically significant differences when comparing work shifts secluded; and also when comparing weekdays with weekends.

Conclusions and Discussion

This research discovered that seclusion was primarily a product of two factors: the patient's diagnosis, along with commensurate behaviors and psychological dynamics that are correlates of the psychiatric condition the patient had been experiencing; the other factor was the treatment the patient received while in residence at the admitting unit.

As a result of this study, the researcher is confronted with the question "What was missed and not accounted for". This question becomes even more imperative when a rather interesting happening is considered. The study had what could be called "an open window", which was that period of time before, during, and after the training program when regular staff were not in the admitting building. This period covered ten days. During that ten-day period, and three days after, no patients were secluded. So, for a thirteen-day period no patients were secluded. The dynamics of that fact, it seems to the researcher, are at least somewhat related to the question raised about what was missed.

When the study was begun, the investigator had some anticipations about what might come from the research; and the basis of those expectations came from the literature review as well as from clinical impressions.

First of all, in relation to patient characteristics, it was expected there would be many differences between secluded and non-secluded patients. For example, it was thought a bias would be apparent in decisions to seclude, which would tend toward young, male, black, urban, disabled, poor, involuntarily in the hospital, and psychotic. Also, it was thought secluded people would tend to be larger. There were actual differences between the secluded and non-secluded population, but with the exception of

characteristics related to diagnosis, the differences were not statistically significant.

For example, secluded patients were two inches taller and six pounds heavier, on the average, that non-secluded patients.*

There was an actual difference of $1600 in the income levels, and in the reality of most of the patients, that dollar amount could be most significant. On the racial issue, what the study did reveal was that the percentage of Black patients in the hospital went far beyond their population proportions in the catchment area. This raises a question about race and mental illness. Also, what the general data revealed was that people who end up at the Caro Regional Center fall way below the established poverty guidelines. This raises an issue about the relationship of poverty to mental illness.

As far as significant variables were concerned, the results were not unexpected -- schizophrenic and bi-polar patients had a greater vulnerability to being secluded than persons with other diagnoses. But not all of those patients ended up in seclusion. So what differentiates non-secluded and secluded psychotic persons? Is there a predictive relationship here? Or do other factors enter into finding

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* On this characteristic, it is natural to assume bigger people would end up secluded. In reality, they were. If a larger sample had been obtained, this variable could have been significant. It is the belief of the researcher that the size factor needs to be examined more extensively.

the answer to the original question that was asked, i.e. "what was missed"?

When dealing with the question about diagnosis as a predictor, the nature of the illness has to be considered. Schizophrenia is not one mental illness -- rather it is a family of illnesses. The behaviors related to the condition can vary, depending on what form the patient is experiencing. DSM-III (1980), the major diagnostic reference for American psychiatry, lists five different types of schizophrenia, each with a numerical rating to indicate the severity of the disorder. And even though each carries the general name of the disorder (schizophrenia), each catagory of the disease has its own unique fingerprint. Catatonic is the opposite of paranoid, to consider one contrast in this family of disorders.

The same holds true for bi-polar disorders. Most patients who are diagnosed as bi-polar, and have been secluded, fit criteria that describe a manic condition. But there are the differences between a hypo-manic and a hyper-manic. There are "pleasant" manics and "nasty" manics. Some have paranoid type delusions; others are grandiose. Also, a person can be diagnosed as having a bi-polar disorder, mixed. Sometimes a person can be diagnosed as being bi-polar, depressed -- but experiencing an agitated depression.

To further confuse the issue, the problem of diagnostic

certainty is confounded when a person is determined to be schizo-affective. All of this is stated to indicate that even though diagnosis can be an apparent predictor in terms of the seclusion experience, diagnostic uncertainties create the potential for significant confounding.

Treatment issues were the second area of concern considered by the researcher. It was predicted that an active treatment involvement would make a difference. Medication turned out to be the most powerful variable in terms of reducing seclusion room usage. The converse of this was that if patients were treated in the milieu alone, that increased the probability of the incidence of seclusion.

That medication made a significant difference is no surprise, though past research has been inconsistent in reporting that medication was an importnat variable in reducing seclusion. Because of the properties of medication in terms of controlling symptoms, it would be expected that medicine would play a part in calming people down enough that seclusion would not be a needed alternative.

This raises another issue, i.e. chemical restraint. Often, in most psychiatric facilities, including Caro, prn (pro re nata, as required or necessary) medication is administered in conjunction with secluding a patient. This practice has significant treatment, legal, and philosophical implications. Justification usually centers on the safety

of the patient and the environment; but the Youngberg and Olin cases raised troublesome issues, and this practice would fit in the framework of those issues.

As examined in this research, the work activity program had little impact on seclusion room usage. This result was unexpected. Some of the literature reviewed earlier suggested that structured activities within an acute-care residential psychiatric unit made a positive difference in the incidence of seclusion. It seemed logical to assume that an out-of-building program would have a similar impact. In this instance it did not. Was that because the concept had no validity in relation to behavior control? Or was it because of the way the program was put into effect in the admitting unit? Though there is no hard evidence to support this impression, it is the belief of the researcher that it was a systemic issue, and not a conceptual one.

One reason to consider a systemic hypothesis is that work activity, by policy, is not generally considered until 48 hours after admission. Over 70% of incidents of seclusion occurred within 36 hours of admission; and 37% of seclusion incidents occurred over the weekend, when the work activity program was not available. Another issue was related to intentioning. The belief has been that if a person is stable enough to participate in an out-of-building activity, then he/she should be seriously considered for a less restrictive residential setting in the psychiatric

program. But there was inconsistency in having people attend the work program in a timely way. In recent months that has changed, but at the time of the study some patients did not go to the program as soon as they might have been able.

From a treatment perspective, it would seem fitting to consider the possibility of implementing some kind of work activity program at the acute-care unit. More structured programming will mean less out-of-control behavior on the part of patients, which would reduce the need for seclusion as a means of behavior control. If patients can be involved in something outside of themselves, a result can be a facilitation of patients regaining self-control.

The final reason considered in this research was staff training, and whether the program would make a difference in the incidence of seclusion. Even though the null hypothesis was rejected, it was done so with reservation. Differences did exist in certain staff and patient characteristics, but in variables such as incidence, average time, and length of time in seclusion there was no statistical significance. There was a perceptible drop in the number of patients who were secluded, and in incidence of seclusion during the five week period following the beginning of the training program. As a part of this (as noted earlier) in the ten-day period when regular staff were not in the building, and three days following, there were no incidents of seclusion. Admissions

and census at C-5 were nominal during this period, though it was not known for research purposes what diagnoses admitted patients carried.

Concerning the effect of the training program, as stated earlier, one staff person was impacted both clinically and statistically, and can be viewed as an "outlier". There was a significant reduction in the incidents of seclusion when he was the supervisory nurse, no matter what shift he was working. During an interveiw, he stated he noticed not only a difference in himself but also in the staff for whom he was responsible. He observed a difference in how patients who were agitated or aggressive were dealt with. Because of the training program, he believed he was more sensitive to what was happening with patients who were in a state of crisis.

The training program had the purpose of teaching staff about the philosophy of the facility, and also to be more effective in assisting patients to regain self-control. The program was not specifically designed to teach people alternatives to seclusion usage; it had a broader purpose than that. But it seems logical to presume that within the larger purpose, some impact might have been felt in terms of reducing seclusion room usage.

One area that is often not emphasized in staff training is the importance of the relationship between staff and patient. The content of most programs will have sections on

communication, or methods that will enhance empathy; or there may be portions of the program that focus on understanding the dynamics of mental illness. But few programs touch on establishing an authentic person-to-person relationship between staff and patient.

If the primary purpose of care is to facilitate an experience whereby a patient can regain self-control and self-esteem, then an authentic relationship experience must exist between the care providers and the care receivers. This has been talked about for years in the context of therapy; but little has been stated concerning this in regard to staff, who provide 24-hour care. The central barrier that exists between patients and staff is the resentment that is generated when patients feel they are being over controlled, and when they believe that staff are using their power to enhance their own ego. These are issues and perceptions that are illusive and difficult to quantify, but central to meaningful treatment.

Finally, it could prove helpful to have a clearly stated outline of procedure and criteria which would easily be accessible to staff. Redmond (1980) presented an example of such an outline, which was developed by the Psychiatry Department of the University of Texas. Something similar that reflects Caro Regional Center philosophy could be helpful. The protocol stated:

Seclusion Room Criteria

Justification for Seclusion

1. Discharge diagnosis of psychosis (schizophrenia, manic depression, major affective disorders)
2. Patient (pt) was dangerous (combative, suicidal)
3. Other methods of control were tried first (anti-psychotic medication, one-on-one interaction between staff and pt)
4. Physician's order prior to use of seclusion room was written within 24 hours
5. Progress note on reasons pt was secluded

Patient Outcome

6. Pt in seclusion room on less than three consecutive days
7. No physical injury
8. No attempted suicide
9. No special incidents (e.g. injury to others, fires, possession of potentially lethal objects)
10. Progress note describing course in seclusion (to be monitored every 15 minutes)
11. Pt in seclusion room less than two hours (exception granted for patients who fall asleep). (p. 23)

It is the belief of the researcher that most of the variability unaccounted for can be found in all dimensions of the hypotheses tested in this study: what the patient brings; what the program brings in terms of the treatment environment and program; and what the staff brings in terms of values, attitudes, and experience. Therefore, the

following is offered as a means to move to more effective treatment and greater knowledge.

Implication for Future Research and Practice

There is a great need for further investigations on seclusion process, as well as the effects of the practice on patients who are secluded. There is a need to consider further issues related to patient characteristics and bias. Treatment programs and their impact on seclusion usage should be examined further. Staff training in psychiatric care in general, and how it relates in particular to the incidence of seclusion, needs to be studied more. This research is just one small step, especially in an emperical sense. More needs to be accomplished, making use of more sophisticated and powerful models so there can be movement beyond clinical impressions.

Implications for Future Research

Results of this research suggested specific areas as being particularly relevant for future study. Recommendations first come from the study, and then move into related questions that need examination.

1. Investigation is needed to determine why Black patients are being hospitalized in numbers that are greater than their representation in the general population.
2. Research is required to understand further the effects of distress related to poverty and how this impacts on the

occurance of mental illness.

3. Research is needed to examine more extensively reasons why patients are secluded.

4. Replication of this study using larger samples and a longer time frame.

5. Research is needed to explore the impact of staff training programs on changing attitudes in regard to providing the least restrictive alternative of behavior management to culturally different people.

6. Structured programing is important in treatment. More knowledge is needed on how this kind of programing reduced distress, agitation and confusion.

7. Chemical restraint is a relatively common practice. Its prevelence needs to be examined both from a legal and treatment standpoint.

8. There were many days when patients were not secluded. What was the difference between days patients were secluded and not secluded?

9. Replication of this study at the following kind of institutions: private acute-care unit; community based acute-care unit; similar state-related institution; university acute-care unit, long-term state hospital.

10. Research efforts should focus on examining the experiences of patients who have been secluded, and how those experiences affected them.

11. Research would be fitting on how staff view their

involvement in secluding a patient, especially perceived threats to their safety.

12. Staff burn-out is a serious problem, and it has an effect on how difficult and agitated patients are treated. Research needs to be done on the causes and impact of staff burn-out.

13. There is a need to compare the philosophies and practices of several institutions in order to ascertain differences in procedures and their effectiveness.

14. Some raise the question about the need for seclusion at all. Research programs need to be developed to explore this option.

Implications for Practice

1. Create a new protocol for seclusion reporting which does not require copying and will minimize redundancy in reporting.

2. Develop with staff a step-wise procedure which outlines clearly management options, from the least restrictive to most restrictive.

3. Hold periodic staff training programs on behavior management issues, using role-playing methods and other experiential modalities of training.

4. Periodically, use a particular incident of seclusion as a focus for a retrospective look at behavior management approaches. This method of learning is most effective immediately after the incident.

5. Create a staff training module which focuses on non-control relationships between staff and patient. Of particular importance is the inclusion of guidelines for being "non-parenty" in those situations which require some kind of intervention by staff.

6. In comprehensive staff training programs, include information about seclusion policy, vulnerable patients, prevention options and least restrictive alternatives.

7. In the admitting unit make available more structured treatment options, including timely involvement in work activity, planned outside activities, various group therapies, various activity therapies including exercise, recreation, music and crafts.

8. Involve the behavior management committee as a check and balance when seclusion goes beyond two hours; when a patient is secluded more than three times; and when seclusion and prn medication are used together.

9. Seclusion at the Caro Regional Center, with exception of the admitting unit, has been abandoned as a behavior management option. The usage of seclusion is minimal, in comparison with other institutions, private and public. Create a task force representative of administration, direct-care staff, professionals and former patients to develop optional behavior management techniques that would be used in difficult management situations.

It is the belief of the researcher that seclusion as a

behavior management methodology is outmoded and unnecessary. The procedure is a carryover from another time in psychiatric history. Patients who are not in control, need assistance in regaining control. It is the responsibility of treatment personnel to be more creative in developing new ways to assist agitated patients become more calm and less distressed. All too often, practitioners (including the writer) have used seclusion as an easy way out of difficult situations. Possibly, if the option was not available, then other ways would be found. Hopefully, this research will facilitate finding new ways.

APPENDIX A

MICHIGAN MENTAL HEALTH CODE

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MICHIGAN'S MENTAL HEALTH CODE

MICHIGAN DEPARTMENT OF MENTAL HEALTH

330.1742 Seclusion

Sec. 742. (1) A resident shall not be kept in seclusion except in the circumstances and under the conditions set forth in this section.

(2) A resident may be placed in seclusion temporarily only pursuant to subsection (5) and only if it is essential in order to prevent the resident from physically harming himself or others or in order to prevent the resident from causing substantial property damage. A resident may be placed in seclusion upon an authorization or written order only pursuant to subsection (3) or (4) and only if it is essential to prevent the resident from physically harming himself or others, or to prevent the resident from causing substantial property damage, or if seclusion would be of clinical or therapeutic benefit for the resident.

(3) A resident may be placed in seclusion pursuant to an order of a qualified professional person made after personal examination of the resident. Ordered seclusion shall continue only for that period of time specified in the order.

(4) A resident may be placed in seclusion pursuant to an authorization by a qualified professional person. Authorized seclusion shall continue only until a qualified professional person can personally examine the resident.

(5) Seclusion may be temporarily employed in an emergency without an authorization or an order. Immediately after placing the resident in temporary seclusion, a qualifed professional person shall be contacted. If, after being contacted, the qualified professional person does not authorize or order the seclusion, the resident shall be removed from seclusion.

(6) The governing body of the facility pursuant to standards of the department of mental health shall establish in writing the qualifications necessary to be considered a qualified professional person for purposes of this section, the maximum length of time ordered, authorized, and temporary seclusion may last, the frequency at which a secluded resident shall be examined, the persons qualified to make the required examinations, and other regulations which the governing body deems appropriate.

(7) A secluded resident shall continue to receive food, shall remain clothed unless his actions make it impractical or inadvisable, shall be kept in sanitary conditions, and shall be provided a bed or similar piece of furniture unless his actions make it impractical or inadvisable.

(8) A secluded resident shall be released from seclusion whenever the circumstance which justified its use ceases to exist.

(9) Each instance of seclusion, full justification for its use, and the results of each periodic examination shall be placed in the record of the resident.

APPENDIX B

DMH ADMINISTRATIVE RULES

ADMINISTRATIVE RULES

DEPARTMENT OF MENTAL HEALTH

STATE OF MICHIGAN

Part 4. Administrative Action for Mentally Ill Persons Requiring Treatment

Subpart 3. Admission Conditions

R 330.4025 Equality of Care

Rule 4025. A hospital shall not discriminate or give differential care to any individual admitted to that hospital based on the type of admission or income status of the individual. Patients shall receive the highest possible quality of care and treatment without regard to race, nationality, religious or political belief, sex, age, or handicap.

R 330.4028 Physical Inspection

Rule 4028. A patient shall be inspected by a physician or registered nurse upon admission and notation shall be made in the clinical record of bruises, scars, marks, and possible fractures or other injuries.

R 330.4031 Voluntary admission

Rule 4031. (1) An application for voluntary admission shall not be considered as lacking voluntariness because an individual has agreed to that action as a result of a probate court proceeding.

(2) The hospital director or his designee shall evaluate an individual's clinical suitability for informal or formal voluntary admission and shall include the following criteria in making the determination.

(a) The individual has a condition that the hospital director determines can benefit from the inpatient treatment that is provided by the hospital.

(b) Appropriate alternatives to hospitalization have been considered by the hospital, and with the consent of the individual, the community mental health program in the individual's county of residence.

(c) Adequate alternative treatment is not available or suitable at the time of admission as determined by the hospital, and with the consent of the individual, the

community mental health program in the individual's county of residence.

R 330.4035. Formal voluntary admission.

Rule 4035. (1) When an individual requests formal voluntary admission and the hospital director or his designee determines the individual to be clinically suitable for that form of admission, the hospital shall admit the individual and shall include the application as part of the case record.

(2) An individual under 18 years of age shall be admitted as a formal voluntary patient if deemed clinically suitable by the hospital director, upon the application of a parent, guardian, or in their absence, a person in loco parentis.

R 330.4045 Involuntary Admissions.

Rule 4045. (1) For the purpose of establishing the point at which hospitalization begins, 1 of the following conditions shall be met:

(a) An individual arrives at or is at a hospital and an application for hospitalization is completed and given to a hospital staff member with a completed certificate.

(b) An individual arrives at or is at a hospital under a court order for immediate hospitalization, other than an order to undergo an examination, after a petition has been filed with the court.

(c) An individual is at a hospital after giving written notice of an intention to terminate formal voluntary hospitalization and the director of the hospital or his or her designee has filed with the court an application for admission by certification and the required certificates.

(2) For the purpose of establishing when an individual may complete a reasonable number of telephone calls and when a preliminary hearing shall be convened if the person is not released, the time an individual is received for hospitalization by certification, or court-ordered immediate hospitalization, is any time the individual arrives at the hospital. A formal voluntary patient who is being admitted as an involuntary patient by application of a hospital director is considered received for hospitalization at the time application and certificates are filed with a probate court.

(3) When an individual is presented to a hospital, the hospital shall do all of the following:

(a) Require that the application for hospitalization,

if any, meet the requirements of section 424 of the act.

(b) Require that the certificate accompanying the application, if any, meet the requirements of section 400(K) of the act.

(c) Determine if the individual presented is clinically suitable for informal or formal voluntary hospitalization. If this determination is affirmative, immediately offer the individual the opportunity to apply for hospitalization as an informal or formal voluntary patient, and as many times thereafter as deemed appropriate by the hospital director until an order of hospitalization, alternative treatment, or discharge is received. If the individual is hospitalized as a voluntary patient, the hospital director shall inform the court and recommend whether dismissal of pending proceedings would or would not be in the best interest of the individual or the public.

(d) Allow the individual to complete not less than 2 phone calls. If the individual does not have sufficient funds on his or her person, calls shall be made at hospital expense with the condition that they be limited to persons who are willing to receive the calls. The hospital director or his or her designee may determine the appropriateness of a call or calls that are at hospital expense and may limit their length to a reasonable duration, but a call shall not be limited to less than 5 minutes.

(e) Provide to the individual, not more than 12 hours after hospitalization, a copy of the application for admission asserting that the individual is a person requiring treatment, a written statement that the individual will be examined by a psychiatrist within 24 hours of the hospitalization, and a written statement, in simple terms, explaining the right of the individual to request a preliminary hearing, to be present at the preliminary hearing, and to be represented by legal counsel, if the individual is certified as a person requiring treatment; a written statement, in simple terms, explaining the right of the individual to a full court hearing, to be present at the hearing, to be represented by legal counsel, to a jury trial, and to an independent evaluation; and a copy of each certificate executed in connection with the individual's hospitalization if available. Each certificate shall be delivered to the individual within 24 hours of either a certificate's completion or receipt of a certificate by the hospital from a source outside the hospital.

(f) If the individual is unable to read or understand the written materials, every effort shall be made to explain them to him or her in a language he or she understands, and a note of the explanation and by who made shall be entered in the case record.

(g) The admission officer, as soon as administratively

possible after receiving an individual by certification who has been certified as a person requiring treatment, shall do all of the following:

(i) Notify the probate court by phone.

(ii) Obtain, when available, the tentative date of the preliminary or full court hearing and the name and address of counsel appointed by the court.

(iii) Notify the patient of this information.

R 330.4047 Admission by certification.

Rule 4047. (1) A state hospital, as designated in R 330.4005, shall receive and detain for examination by a psychiatrist any individual presented to the hospital who is accompanied by a certificate and an executed application. A psychiatrist, either from the hospital staff or from outside the hospital, shall examine an individual not more than 24 hours after admission. The hospital director shall provide a room and other equipment necessary to provide a complete examination.

(2) A psychologist or physician who has examined a patient shall be permitted, by the hospital director, adequate time to be deposed or to testify, if so required at a probate court hearing regarding that patient.

R 330.4049 Examination upon application by peace officer or court order.

Rule 4049. (1) A state hospital, as desigated in R 330.4005, shall receive and detain an individual for examination if that individual is presented to the hospital by a peace officer who has executed an application for admission. The hospital shall also receive and detain for examination any individual ordered by the court to be examined. A psychologist or physician, either from the hospital staff or from outside the hospital, shall examine the individual within 24 hours. A psychiatrist, either from the hospital staff or from outside the hospital, shall examine the individual, if necessary, within 24 hours of the completion of the first certificate. The hospital director shall provide a room and other equipment necessary to provide a complete examination.

(2) A psychologist or physician who has examined an individual presented shall be permitted by the hospital director adequate time to be deposed or to testify, if so required, at a probate court hearing.

R 330.4051 Admission by petition.

Rule 4051. An individual shall be admitted to a hospital on a petition pending a hearing only upon order of immediate hospitalization by a probate court. The hospital

director shall have the individual examined within 24 hours of hospitalization. If the required examination has not been accomplished within 24 hours, the hospital director shall release the individual and document in the records the reasons the examination was not completed. The hospital shall notify the probate court.

Part 7. Rights of Recipients of Mental Health Services

Subpart 3. Additional Rights of Residents of Facilities

R 330.7139 Resident's right to access

Rule 7139. (1) A resident shall not be prevented from acquiring, at his expense, or from reading, written or printed material or from viewing or listening to television, radio, recordings, or movies available at a facility for reasons of, or similar to, censorship.

(2) Restrictions or limitations may be imposed if documented in written plans of service.

(3) Each instance of restriction or limitation and justification for its application shall be documented and placed in the record of the resident.

(4) Restrictions or limitations shall be removed when not essential to achieve objectives which justified their application.

R 330-7151 Safe, sanitary, and humane living environment.

Rule 7151. (1) A resident has the right to basic human dignity and privacy provided in a manner consistent with the care and treatment setting and is entitled to a humane living environment. Provision for the safety, sanitation and comfort of residents shall comply with standards established by the department and with the following requirements:

(a) A resident shall be appropriately dressed and permitted to have and wear his own clothing, which shall be inconspicuously marked with the resident's name. Exceptions shall be documented and justified. A resident who does not have suitable clothing of his own shall be provided an adequate allowance of appropriate and seasonal clothing.

(b) Clothing, both in amount and type, shall make it possible for residents to go out-of-doors in inclement weather and to go on trips and visits.

(c) Nonambulatory residents shall be dressed daily in their own clothing, including shoes, unless contraindicated in the written plan of services.

(d) A resident with a physical handicap shall be provided with appropriate clothing, in accordance with individual needs.

(e) A resident shall be provided suitable opportunities for social interaction with members of the opposite sex, with appropriate supervision, except where a written plan of service includes an essential restriction or limitation on these opportunities and the justification for the restriction or limitation.

(f) A resident shall be provided facilities and equipment for regular physical exercise. A resident shall be provided, in the absence of contrary medication considerations, an opportunity to be outdoors at regular and frequent intervals, with supervision as necessary.

(g) Residents in a multiresident room shall be allocated a minimum of square feet of usable floor space per resident and a clearance between beds according to standards of the department. Single rooms shall have a minimum of square feet of floor space according to standards of the department. A resident shall be provided, unless contraindicated in a written plan of service all of the following:

(i) A bed of proper size and height with adequate changes of linen, and other appropriate furniture.

(ii) The right to suitable decorate his room, or portion of a multiresident room.

(iii) Screens or curtains to provide for privacy within a multiresident room for adult residents.

(h) Water closets and bathing and toileting appliances equipped with appropriate devices shall be provided for use by the physically handicapped.

(i) There shall be 1 toilet for each 8 residents, with separate stalls to ensure privacy, kept clean and free or odor. Toilet paper shall be available in each water closet.

(j) Water closets, bathtubs, and showers shall provide for individual privacy.

(k) There shall be 1 lavatory for each 6 residents with soap and towels or drying mechanisms available. On lavatory shall be accessible to, and usable by, residents in wheelchairs.

(l) There shall be 1 tub or shower for each 10 residents. A tub or shower area shall be divided by curtains, doors, or partitions to provide for privacy.

(m) A resident shall be provided 40 square feet of day activity room space. Day activity rooms shall have outside windows and shall be adequately furnished, and shall approximate normal patterns of home living. Recreational and leisure time supplies and equipment shall be provided. Corridors and chapels with fixed pews shall not be counted as day room space.

(n) Dining room areas shall have a minimum of 15 square feet per resident as provided for in the department standards. Dining rooms shall be separate from kitchens and shall be furnished with comfortable chairs and tables with washable surfaces.

(o) Special equipment shall be provided for geriatric and nonambulatory residents to assure safety and comfort, including appropriate devices on toilets and wheelchairs. Provision shall be made for nonambulatory residents to communicate their needs to staff.

(p) A facility shall have a system of linen supply which insures that linen is available at all times for the proper care and comfort of residents, that there is adequate space and equipment for handling clean and soiled linen, and that there are frequent changes of bedding and other linen, not less than once every week. Soiled bedding shall be changed immediately. Soiled linen shall be removed from the living unit daily. Clean linen and clothing shall be stored in clean, dry, dust-free areas.

(2) A facility shall be in compliance with the sanitation, health, and environmental safety codes of state and local authorities having primary jurisdiction over the facility.

(3) A facility shall have a system of maintenance service which insures that the facility is being kept in a continuous state of repair and operation in accordance with the needs of the health, comfort, safety, and well-being of the residents.

(4) A facility shall maintain a sanitary environment in keeping with pertinent public health standards and utilizing practices, including.

(5) The holding, transferring, and disposal of waste and garbage shall be done in a manner that will not create a nuisance, nor permit the transmission of disease, nor create a breeding place for insects or rodents.

(6) Handwashing facilities shall be available in, or adjacent to, bathrooms, water closets, and kitchens.

(7) There shall be adequate insect screens on windows and doors when those windows and doors are opened for ventilation.

(8) There shall be adequate janitorial equipment and storage space in each unit of the facility.

(9) A facility shall have a pharmacy, or contract for pharmaceutical services with a pharmacy, licensed and subject to, and conducted in accordance with, existing statutes, rules, and procedures.

(10) A resident shall receive prompt and adequate medical treatment for physical ailments and for the prevention of illness or disability which meet standards of the medical community.

R 330.7158 Medication

Rule 7158. (1) Medication shall be administered only at the order of a physician.

(2) Medication use shall conform to medication use guide-lines adopted by the department, which guidelines shall, at a minimum, conform to federal standards and nationally recognized peer review organization standards. The medication use guideline adopted by the department on psychotropic medication shall allow a provider to select between standards on dosage levels recommended by 1 or more nationally recognized organizations or those of the manufacturer of the medication.

(3) Medication shall not be used as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment.

(4) Telephone orders for medication shall be accepted only in emergency situations. In psychiatric hospitals, centers for developmental disabilities, and mental retardation service facilities, emergency telephone orders shall be received, recorded, and signed by a registered nurse, and countersigned by a physician within 24 hours. The receiving, recording, signing, and countersigning of emergency telephone orders in other facilities shall be by such personnel and within such time periods as is specified by licensing or certification requirements or standards applicable to the type of facility.

(5) Orders for medication shall be effective only for the specific number of days indicated by the prescribing physician.

(6) Orders for schedule 2 controlled substances shall expire after 3 days unless otherwise provided for in the guidelines established pursuant to subrule (2) of this rule, and stop order procedures for other medications shall be adopted, printed, and made available by the facility for review and approval by the authorized regulatory agencies.

(7) The administration of a psychotropic medication shall be reviewed at least once every 30 days to determine the appropriateness of continued use.

(8) Medication shall be administered by or under the supervision of residential facility personnel who are qualified and trained pursuant to Act No. 368 of the Public Acts of 1978, as amended, being #333.1101 et seq. of the Michigan Compiled Laws.

(9) The administration of medication shall be recorded in the resident's medical record.

(10) Medication cards or other approved systems shall be used in the preparation and administration of medication in psyhiatric hospitals and centers for developmental disabilities.

(11) Nursing units in psychiatric hospitals and living units of centers for developmental disabilities shall be equipped with adequate medication areas which provide appropriate and sufficient space for dosage preparation and setup. Administration shall be in accordance with Act No. 368 of the Public Acts of 1978, as amended, being #333.1101 et seq. of the Michigan Compiled Laws, and rules promulgated by the Michigan board of pharmacy.

(12) Medication errors and adverse drug reactions shall be immediately reported to a physician and the facility director and shall be recorded in the resident's clinical record.

(13) Only medication that is authorized in writing by a physician shall be given to residents upon leave or discharge.

(14) Medication that is given to residents upon leave or discharge shall be in compliance with state rules and federal regulations pertaining to labeling and packaging.

R 330.7171 Resident health, hygiene, and personal grooming.

Rule 7171. Provision for resident health, hygiene, and personal grooming shall include assisting and training residents to exercise maximum capability in personal grooming practices, including bathing, toothbrushing, shampooing, hair grooming, shaving, and care of nails. In addition, a resident shall be provided with all of the following:

(a) Toilet articles.

(b) A toothbrush and dentifrice.

(c) An opportunity for shower or tub bath at least once every 2 days, unless medically contraindicated.

(d) The services of a barber and a beautician on a regular basis.

(e) If a male, the opportunity to shave daily.

R 330.7185 Mental health services in a facility.

Rule 7185. A resident has a right to those mental health services suited to his condition which the governing body of a facility is required or has elected to provide. Provision of services may be limited as provided by these rules. Mental health services suited to a resident's condition and in accordance with the written plan of service shall include:

(a) Diagnosis and treatment to disturbances, intellectual deficienceies, biological defects, illnesses, and injuries.

(b) Protection against communicable disease and personal injury.

(c) Minimum restriction on movement.

(d) Habilitation or rehabilitation which maximizes ability to cope with as normal an environment as possible and which develops and realizes potential abilities.

(e) Treatment in the shortest practicable time.

R 330.7191 Orientation and in-service training.

Rule 7191. (1) A staff training program shall be provided and include orientation for new employees, as well as basic skill training. A summary of the content and provision of training shall be made available at the request of the director of the department.

(2) Staff shall be provided regularly scheduled in-service training to update and improve skills and competency, including training in pertinent aspects of civil admission and discharge procedures. A summary of the content and provision of training shall be made available at the request of the director of the department.

(3) A facility shall maintain records of resident-staff ratios, supervisory structure, and orientation and training programs.

R 330.7195 Change of type of treatment.

Rule 7195. (1) A resident shall remain in a facility's progressive treatment and care program until sufficiently rehabilitated for release to the community, until a discharge is required by law, or until the resident has, in

the judgment of the facility director, received the maximum benefit from the program. Justification for a change from 1 type of treatment and care to another within the program shall be in writing and made part of a resident's plan of service and case record. Types of treatment and care shall be designated by a facility director based on professional standards, resident to staff ratios, and frequency of professional consultation.

(2) A resident shall be informed when it is determined that he is ready for another type of treatment and care, release, discharge, or has received maximum benefit from the program.

R 330.7199 Plan of Service

Rule 7199. (1) A plan of service shall be developed by an interdisciplinary team of mental health professionals for each resident and shall be included in the record of the resident.

(2) Mental health professionals involved in the care of a resident shall work together to develop an integrated plan of service.

(3) One mental health professional who is a member of the treatment or habilitation team shall be responsible for the development, coordination, and implementation of an individual plan of service, record progress and changes, initiate changes or reviews, when necessary, and incorporate in the plan restrictions or limitations of rights placed on the resident. The first plan of service shall be aproved, signed, and recorded in the medical record by the mental health professional responsible for the plan within 5 working days after admission or after completion of the comprehensive examination, whichever occurs first.

(4) An individualized plan of service shall contain, when applicable, all of the following:

(a) A statement of the nature of specific problems or disabilities and specific needs.

(b) Evaluation of strengths as well as weaknesses.

(c) Evaluation of the degree of physical disability and the plan for remedial or restorative measures.

(d) Evaluation of the degree of mental disability and the service plan for appropriate measures to be taken to relieve treatable conditions and distress and to compensate for nonreversible impairment.

(e) Evaluation of capacity for social interaction and a plan for appropriate measures to increase adaptive capacity.

(f) Evaluation of environmental and physical limits required to safeguard health and safety.

(g) Determination of the least restrictive treatment or habilitation setting necessary to achieve the purposes of admission.

(h) A statement of, and rationale for, intermediate and long-range goals, specifiying the manner in which the facility can improve the resident's condition with a projected timetable for attainment.

(i) Proposed staff involvement with the resident in order to attain goals, including a minimum number of individual contacts and consultations planned between the resident and professional staff and the expected minimum number of hours of the consultations in each 30-day period.

(j) The frequency and extent of physical examination.

(k) Criteria to be met for release or discharge, and the prognosis for placement.

(l) Notation of therapeutic tasks, labor, personal house-keeping, recreation, or other scheduled activities to be performed, including those as a condition of residence in a small group living arrangement and a rationale for these in relation to goals.

(m) An estimated date for release or discharge, with a proposed date for development of a plan of service needed after release or discharge, including participation of community mental health services.

(n) Drug regimens by type, dosage, and frequency, changes in medication or dosages, and notation of effects and behavior changes.

(o) Dates for reviews at intervals of at least every 90 days, and by whom the review shall be done, including provision for a written assessment of progress toward goals and reasons for progress or lack of progress.

(p) Documentation of a restriction or limitation of rights and any restraint or seclusion.

(q) Record of surgery; electro-convulsive therapy; other procedures intended to produce convulsions or coma; experimental procedures; family planning services, including sterilization and abortion; and guardianships, legal, and other protective services.

(5) A plan of service of a resident through the age of 25 shall consider the chronological, maturational, and developmental level of the resident and provide for developmental, educational, and training needs and for contact with family members.

(6) A written plan of service and subsequent reviews shall be easily identifiable as distinct and separate written entries into a case record or separate forms which

become part of the record.

(7) Progress notes in a resident's record which indicate that a plan of service is being implemented and which document that a program plan is being carried out shall include both of the following:

(a) Notes recorded by mental health professionals involved in the treatment or habilitation of the resident.

(b) Notes recorded at intervals appropriate to the type of treatment, but not less often than once a week.

(8) A treatment or habilitation team shall include all of the following persons:

(a) One or more physicians.

(b) Two or more of the following:

(i) Registered nurses.

(ii) Certified social workers.

(iii) Psychologists.

(iv) Vocation, occupational, or recreational therapists.

(v) Mental health counselors.

(vi) Other members of the facility staff, including non-professional staff who work directly with the resident.

(9) Residents shall be informed, either verbally or in writing, or their clinical status and progress.

(10) A plan of service shall specify either the intervals for informing a resident in a manner appropriate to the resident's clinical condition or that this is a responsibility of the person in charge of the plan.

(11) A resident shall be given the required information not less than once a month, and more frequently if a short-term resident, unless waived by the facility director. The waiver and statement of the reasons for a waiver shall be placed in the record of the recipient.

(12) The record of the resident shall include the date and time the resident was informed, a brief summary for the information given, and a note of the resident's response.

(13) A facility shall allow a resident to request a report, and a requested report shall be given to the resident or a person chosen by the resident within 10 days. A requested report to the resident shall satisfy the current obligation of the facility to inform the resident. A report may be given to a relative, guardian, or other person when not requested by a resident only in a manner consistent with the disclosure of confidential information as specified in secions 748 and 750 or the act and R 330.7051.

(14) A clinical status and progress report shall include, unless in the judgment of the person in charge of implementing a plan of service disclosure would be detrimental to the resident, all of the following:

(a) Current diagnosis and evaluation of physical and mental condition.

(b) Assessment of progress, including whether an involuntary resident continues to meet the criteria for admission, whether treatment goals are being met, and, if the goals are not being met, the reasons for failing to meet the goals.

(c) The length of time residence is expected to continue.

(d) Information about medication, including the type, dosage and effects.

(e) Scheduled court proceedings which concern admission or discharge.

(f) Restrictions or limitations currently imposed, an explanation of reasons, the duration of restrictions or limitations, and when they shall be reviewed.

(g) Interim results or effects, when appropriate, relating to experimental procedures in which the resident is participating.

(h) Other information requested by a resident or deemed advisable by the resident's physician or person in charge of implementing the plan of service.

(15) Information which remains unchanged since a previous report need not be repeated unless a resident inquires or it appears likely the resident does not recall prior disclosure and would benefit by the repetition.

(16) When information is withheld, the reason it is considered detrimental to a recipient shall be placed in the record of the recipient. A resident who inquires about information being withheld, or about whether information is being withheld, shall be told if a determination has been made. Procedures of the facility shall allow a resident to obtain a review of this determination by the director.

(17) A plan of service shall not contain privileged information of communications.

(18) Copies of a current plan of service, or portions thereof, may be given to the following entitles:

(a) Individuals not on the staff of the provider who are involved in release planning for the resident, if the resident, or a person empowered on the resident's behalf, consents or if required by statute.

(b) A probate court in connection with a hearing in civil admission or discharge.

(c) A probate court in connection with admission or transfer of a prisoner.

(d) A criminal court in connection with a determination of incompetency to stand trial if pursuant to court order or subpoena or if the resident, or a person empowered on the resident's behalf, consents.

R 330.7205 Chemotherapy and physical treatment.

Rule 7205. (1) Use of psychotropic chemotherapy shall be subject to restrictions, as follows:

(a) Unless the individual consents or unless administration of chemotherapy is necessary to prevent physical injury, as described below, to the individual or to others, psychotropic chemotherapy shall not be administered to:

(i) A resident who has been admitted by medical certification or by petition until after a final adjudication.

(ii) A defendant undergoing examination at the center for forensic psychiatry or other certified facility to determine competency to stand trial.

(iii) A person acquitted of a criminal charge by reason of insanity while undergoing examination and evaluation at the center for forensic psychiatry.

(b) Consent shall meet the requirements of an informed consent.

(c) Chemotherapy may be administered to prevent physical injury after signed documentation of the physician is placed in the record of the resident and when acts of a resident or other objective criteria clearly demonstrate to a physician that a resident is presently dangerous to self or others.

(d) Initial administration of psychotropic chemotherapy may not be extended beyond 48 hours, unless there is consent. The initial period of treatment shall be as short as possible, shall be terminated as soon as there is little likelihood that the resident will quickly return to an actively dangerous state, and shall be the smallest possible dosage needed.

(e) Additional chemotherapy may be administered if a resident again is presently dangerous to self or to others following termination of a period of medication prior to final adjudication or during a period of examination or evaluation ordered by a criminal court.

(f) A governing body shall adopt policies and procedures regarding psychotropic chemotherapy which:

(i) Define psychotropic chemotherapy.

(ii) Establish objective criteria for determining

present dangerousness.

(iii) Provide for the medical staff to develop agreement on the minimal duration between commencing treatment and safe termination for different disorders.

(iv) Establish when and how documentation is placed in records of residents.

(2) Prior to final adjudication or during a period of examination or evaluation orderd by a criminal court, the medical staff of a facility may provide essential emergency physical treatment services requested or consented to by the resident or the individual empowered to give a consent. When the life of a resident is threatened and concent cannot be obtained, emergency essential physical treatment may be performed after the medical necessity has been documented and entered into the record of the resident.

R 330.7229 Resident labor.

Rule 7229. (1) A facility providing work and work training for residents or utilizing a resident's labor shall adopt procedures which complement both the therapeutic needs or residents and the basic human dignity to which a resident is entitled and is consistent with regulations and policies of the United States department of labor, other federal departments, and rules of the department.

(2) The labor of a resident, whether deemed therapeutic or not inconsistent with the resident's plan of service, shall require approval by the person in charge of the plan of service. Approval shall not be withheld unless reasons explaining how the labor is inconsistent with the plan of service are stated in the case record. Disapproval of labor by the person in charge of the plan may be reversed by the director of the facility. In approving labor, the person in charge of the plan may set limits. Resident labor shall not consume more than 6 hours of a resident's day, unless approved by the director of the facility. Labor shall not interfere with other ongoing treatment or habilitation programs suitable for the resident.

(3) A resident's right to compensation shall be protected by the facility when performing labor which results in an economic benefit to another person or agency other than the facility.

(4) Labor by a resident of a personal housekeeping nature or as a condition of residence in a small group living arrangement shall be in accordance with standards of the department.

R 330.7231 Freedom of movement

Rule 7231. (1) A facility's governing body shall ensure that freedom of movement of residents shall not be restricted more than is necessary.

(2) A resident shall have a right to the least restrictive conditions necessary to achieve the purposes of treatment and habilitation with due safeguards for safety of persons and property. To this end, a facility shall make every attempt to provide maximum freedom within the facility grounds, outside the facility grounds, and to move restraints from:

(a) More to less structured living.

(b) Larger to smaller facilities.

(c) Larger to smaller units.

(d) Segregation from the community to integrated community living.

(3) A facility shall ensure that residents are not transferred to settings which increase restraints on personal liberty unless the resident has committed or is expected to commit an act or acts which if committed by a person criminally responsible for his conduct, would constitute homicide or, felonious assault or is so dangerous a mentally disabled or retarded person that his presence in a facility is dangerous to the safety of other residents, employees, the community, or himself. Procedures for this determination shall be consistent with the applicable statutes, rules, policies, and procedures relating to transfers and appeals of transfer or shall provide substantially similar procedures which permit a resident to challenge such a move.

(4) A resident shall have the right to freedom of movement on the grounds, and in the buildings and areas, within the facility suitable for and designated for recreational or vocational activities or for social interaction when the freedom of movement does not impair the effective functioning of the vacility. Freedom of movement may be restricted on the basis of reasonable and lawful criteria. Policies and procedures may require a short period of restricted freedom or no freedom after initial admission.

(5) Any limitations on freedom of movement shall be clinically justified on a time-limited basis and entered into the resident's record. A limitation shall not exceed the justification for the limitation either in scope or duration.

(6) A resident shall be given the right to appeal restrictions on access which are substantial in scope or duration and the restrictions shall be reviewed with the plan of service. Polciies and procedures shall specify the scope and duration of restrictions which entitle a resident to an appeal. A restriction includes a refusal to grant a resident's request for a transfer to a setting on the same facility or other facility which provides greater access.

(7) A facility shall provide for a rational and fair manner in which a resident may request leaves and appeal denial of requests.

(8) Whenever there is a justified movement of a resident to a more restrictive setting, a justified denial of access, or an authorized security precaution, an assessment shall be made of whether it results in a substantial limitation on a resident's treatment or habilitation opportunities. The facility director shall take all feasible and prudent steps to minimize limitations on treatment or habilitation.

(9) A governing body shall establish the maximum duration of a movement to a more restrictive setting, denial of access or a security precaution which limits treatment or habilitation opportunities and a redetermination on new evidence.

R 330.7243 Restraint and seclusion.

Rule 7243. (1) As used in this rule:

(a) "Authorized professional" means a physicial when referring to physical restraints, and means a qualified professional person when referring to seclusion.

(b) "Drug-induced physical restraint" means the use of medication which is administered to a recipient for the sole purpose of preventing physical injury or substantial property damange when acts of the recipient or some other objective criteria clearly demonstrate that the recipient poses an immediate danger to himself or herself or others or is in danger of causing substantial property damange.

(c) "Medical restraint" means the use of physical restraint or drug-induced physical restraint to render a resident quiescent for medical reasons. Medical restraints shall be used only as specified in a written plan of service.

(d) "Physical restraint" means the use of mechanical or material appliances to restrict the activity of a resident.

(e) "Qualified professional person" means a mental health professional who is specifically authorized by a facility director pursuant to section 742(6) of the act.

(f) "Quiet room" means a room with a closed, unlocked door which limits both the movement of a resident and his or her contacts with others when placed in the room for temporary periods.

(g) "Seclusion" means the temporary placement of a resident in a room alone, monitored by staff, and with the door locked.

(2) For purposes of preventing a resident from physically harming himself or herself or others or for the purpose of preventing a resident from causing substantial property damange, the following measures, other than physical management, listed in order of increasing restrictiveness, shall be utilized, when appropriate, using the least restrictive measure possible:

(a) Quiet room.
(b) Seclusion.
(c) Short-term physical restraint.
(d) Drug-induced physical restraint.
(e) Other physical restraint.

(3) The order of preference set forth in subrule (2) of this rule is subject to limitations on the use of psychotropic chemotherapy before the final adjudication of a petition on the application for involuntary admission and during a period of examination or evaluation which is ordered by a criminal court.

(4) The governing body of a facility shall establish policies and procedures which define the use of physical restraint and seclusion and which designate the members of the staff who may impose temporary physical restraint or seclusion from an authorized professional.

(5) A record of each physical restraint and seclusion shall be available at all times for inspection by an authorized representative of the department.

(6) Emergency uses of physical restraint or seclusion that will place a resident in physical restraint or seclusion before a written order is obtained require that both of the following requirements are complied with:

(a) That written or telephones authorization from an authorized professional is obtained within 1 hour after the imposition of a temporary physical restraint or seclusion.

(b) That authorization is entered in the medical record.

(7) If physical restraint or seclusion is considered necessary, both of the following requirements shall be complied with:

(a) A written order shall be obtained from an authorized professional who has examined the resident within 8 hours of the temporary or authorized physical restraint or within 2 hours of seclusion. An authorized physical restraint or seclusion may follow a temporary physical restraint or seclusion.

(b) The type of physical restraint or conditions of seclusion, the duration of the restraint or seclusion, and clothing to be moved, if any, shall be specified in the order and shall be documented in the resident's medical record.

(8) A separate, permanent chronological record shall be kept for the purpose of listing specific instances of the use of physical restraint or seclusion and shall include all of the following;

(a) The name, age, and sex of the resident.

(b) The type of physical restraint or conditions of seclusion.

(c) Full justification for each application of physical restraint or seclusion, including why the measure is essential and why a less restrictive measure would not suffice.

(d) The name of the authorizing and ordering physician or qualified professional person.

(e) The name of the person instituting temporary restraint or seclusion.

(f) The date and time placed in temporary, authorized, and ordered physical restraint or seclusion.

(g) The date and time removed from temporary, authorized, and ordered physical restraint or seclusion.

(h) A notion of the steps taken during the period of physial restraint or seclusion, with regard to all of the following:

(i) Examination.

(ii) Opportunities for free movement.

(iii) Food.

(iv) Sanitary conditions.

(v) Clothing or other cover.

(vi) An opportunity to sit or lie down.

(vii) Toilet access.

(viii) Bathing.

(ix) Telephone calls made on behalf of a resident in seclusion or restraint.

(9) All orders for physical and drug-induced physical restraint shall automatically terminate 12 hours after they are given, and all orders for seclusion shall automatically terminate 24 hours after they are given.

(10) A new written order and documentation shall be obtained from a physican for physical restraint and from a qualified professional person for seclusion if further use of physical restraint is considered necessary after 12 hours or if seclusion is considered necessary after 24 hours.

(11) A resident in restraint or seclusion shall be evaluated and inspected by an authorized professional twice daily.

(12) A resident in restraint or seclusion shall be inspected at least once every 15 minutes by designated ward personnel.

(13) Documentation of staff monitoring and observation shall be entered into the medical record of the patient or resident.

(14) Inspection and documentation procedures for medical restraint shall be provided for in any order by a physician authorizing medical restraint.

(15) A resident in physical restraint or seclusion shall be provided hourly access to a toilet.

(16) A resident in physical restraint or seclusion shall be bathed as often as needed, but at least once every 24 hours.

(17) Physical restraint devices shall not be steel or other metal, unless required by conditions of a criminal arrest or conviction status.

(18) A resident in physical restraint shall be given the opportunity to sit or lie down and to move freely for not less than 15 minutes nor more than 30 minutes during each 2-hour period, unless medically contraindicated. Removal from restraint for more than 30 minutes shall result in termination of the order of restraint.

(19) A governing body shall establish the policies and procedures which specify criteria for all of the following, which procedures shall be followed unless contraindicated in the records:

(a) Using authorized or ordered seclusion for the clinical benefit of a resident.

(b) Removing the clothing of a secluded resident if clothing would be hazardous to life.

(c) Providing cover for a restrained resident.

(d) Providing food, sanitary conditions, and furnishings.

APPENDIX C

CRC SECLUSION POLICY

CARO REGIONAL MENTAL HEALTH CENTER

CARO, MICHIGAN

RESIDENT POLICY

SUBJECT: SECLUSION

DATE ISSUED: 7-1-86 (Revised) POLICY NUMBER: 02.25 PAGE: 1.

POLICY

1. SECLUSION OF RESIDENTS SHALL BE USED ONLY AS A LAST RESORT FOR THOSE RESIDENTS FOR WHOM A SPECIFIC DETERMINATION HAS BEEN MADE BY THE INTERDISCIPLINARY TEAM THAT THEY ARE DANGEROUS TO SELF OR OTHERS. THE USE OF SECLUSION AS A CONTAINMENT MEASURE TO AVOID SERIOUS INJURIES SHOULD BE DOCUMENTED AND INCLUDED IN THE INDIVIDUALIZED PLAN OF TREATMENT/TRAINING AS A SPECIFIC AND PRESCRIBED PROCEDURE.

2. RESIDENTS MAY BE SECLUDED ONLY UPON ORDER OF A PHYSICIAN.

3. SECLUSION ORDERS SHALL BE TIME-LIMITED AND SHALL NOT EXCEED TWENTY-FOUR (24) HOURS.

4. A SYSTEM OF SAFETY CHECKS AND RECORD KEEPING (See Procedure) SHALL BE MAINTAINED TO ASSURE ADEQUATE SUPERVISION AND CARE OF RESIDENTS WHO ARE SECLUDED.

5. COMFORT AND HYGIENE MEASURES SHALL BE PROVIDED THROUGHOUT THE PERIOD OF SECLUSION. (See Procedure)

6. SECLUSION REPORT FORMS SHALL BE FORWARDED TO THE ENTITLEMENTS, STATISTICS, COMMUNITY PLACEMENT OFFICE.

7. QUARTERLY STATEMENTS OF ALL SECLUSIONS SHALL BE REVIEWED AND SIGNED BY THE FACILITY DIRECTOR.

DEFINITIONS

1. Seclusion means the temporary placement of a resident alone in a room monitored by staff which the resident cannot leave due to its being locked, not having a doorknob inside, etc.

   a. Authorized Seclusion: Placement of a resident in seclusion as specified in the individualized plan of treatment/training. Written authorization must be obtained from the physician.

TECHNICAL APPROVAL APPROVED

CARO REGIONAL MENTAL HEALTH CENTER

CARO, MICHIGAN

RESIDENT POLICY

SUBJECT: SECLUSION

DATE ISSUED: 7-1-96 (Revised) POLICY NUMBER: 02.25 PAGE: 2

b. Emergency Seclusion: Emergency seclusion (not more than 1/2 hour) may be implemented at which time a physician's verbal order must be obtained.

PROCEDURE

1. Emergency Seclusion

   a. A dangerous resident may be ordered in seclusion by a supervisor. Telephone authorization from a physician must be obtained within one-half (1/2) hour after imposition of an emergency seclusion. This authorization is entered into the clinical record.

SECLUSION

1. A separate, permanent chronological record shall be kept for the purpose of listing specific instances of use of seclusion and shall include:

   a. The name, age, and sex of the resident.
   b. The conditions of seclusion.
   c. Full justification for seclusion, including why the measure is essential and why a less restrictive measure would not suffice.
   d. The name of the qualified professional person.
   e. The name of the person instituting emergency seclusion.
   f. The date and time placed in emergency or authorized seclusion.
   g. The date and time removed from emergency or authorized seclusion.

2. The need for the procedure shall be explained to the resident when he is being placed in seclusion or immediately following seclusion.

3. A resident in seclusion shall be observed not less than every 15 minutes by designated cottage personnel. Documentation of staff monitoring and observations shall be entered into the clinical record of the resident and shall describe the following:

   a. Meals, in keeping with physical needs, shall be served to the resident at appropriate times. Special precautions should be taken with regard to the use of glassware, dishes, or metal utensils. The amount and type of food and fluids shall be documented.

TECHNICAL APPROVAL APPROVED

CARO REGIONAL MENTAL HEALTH CENTER

CARO, MICHIGAN

RESIDENT POLICY

SUBJECT: SECLUSION

DATE ISSUED: 7-1-86 (Revised) POLICY NUMBER: 02.25 PAGE: 3

b. A resident in seclusion shall be provided with fluids (water, juice, etc.) at least every two hours.

c. A resident in seclusion shall be provided hourly access to toilet, or more often as appropriate.

d. A resident in seclusion shall be bathed as often as needed to ensure personal hygiene needs, but at least every 24 hours.

e. Telephone calls made on behalf of the resident shall be documented.

f. A resident in seclusion shall be given the opportunity to sit or lie down at least for 15 minutes during each two-hour period, unless contraindicated.

g. Since seclusion is to be used as a temporary measure for residents unable to control their own behavior, furnishings will normally not be provided. A resident is to be removed from seclusion to a more appropriate setting when behavioral control has been attained.

4. All orders for seclusion shall automatically terminate 24 hours after they are given. If continued seclusion is necessary, a physician must write and sign a new order after examining the resident.

5. A qualified professional person shall personally evaluate and inspect the recipient once during any period of seclusion that lasts beyond two hours and every two hour period thereafter.

6. A resident in seclusion beyond two hours shall be examined by a physician within 12 hours of imposition, and a written, signed note of the findings shall be placed in the clinical record by the physician. Residents placed in seclusion for 24 hours must be examined by a physician twice within the 24-hour period.

7. After removal from seclusion, the resident's behavioral reactions shall be observed and documented in the clinical record in accordance with the individual program plan.

8. Reports of Seclusion are to be completed and sent to the Entitlements, Statistics and Community Placement office.

TECHNICAL APPROVAL: APPROVED:

CARO REGIONAL MENTAL HEALTH CENTER

CARO, MICHIGAN

RESIDENT POLICY

SUBJECT: SECLUSION

DATE ISSUED: 7-1-06 (Revised) POLICY NUMBER: 02.25 PAGE: 4

REFERENCE: Department of Mental Health Administrative Rules, R.330-7203, February 1, 1903
Department of Mental Health Administrative Manual, Chapter 14, Section 220, Subject 0001, 5-8-78

TECHNICAL APPROVAL APPROVED

APPENDIX D

JCAH SPECIAL TREATMENT PROCEDURES

19. Special Treatment Procedures (SC)

		Circle One
SC.1	Designated special treatment procedures require clinical justification.*	1 2 3 4 5 NA
SC.1.1	Such treatment procedures include, but are not necessarily limited to, the following:	
	SC.1.1.1 The use of restraint;*	1 2 3 4 5 NA
	SC.1.1.2 The use of seclusion;*	1 2 3 4 5 NA
	SC.1.1.3 The use of electroconvulsive therapy and other forms of convulsive therapy;*	1 2 3 4 5 NA
	SC.1.1.4 The performance of psychosurgery or other surgical procedures for the intervention in or alteration of a mental, emotional, or behavioral disorder;*	1 2 3 4 5 NA
	SC.1.1.5 The use of behavior modification procedures that use painful stimuli;*	1 2 3 4 5 NA
	SC.1.1.6 The use of unusual medications and investigational and experimental drugs;*	1 2 3 4 5 NA
	SC.1.1.7 The prescribing and administering of drugs for maintenance use that have abuse potential (usually considered to be Schedule II drugs) and drugs that are known to involve a substantial risk or to be associated with undesirable side effects;* and	1 2 3 4 5 NA
	SC.1.1.8 Research projects that involve inconvenience or risk to the patient.*	1 2 3 4 5 NA
SC.1.2	The rationale for using special treatment procedures is clearly stated in the patient record.*	1 2 3 4 5 NA
SC.1.3	When appropriate, there is evidence in the patient record that proposed special treatment procedures have been reviewed before implementation by the head of the professional staff and/or his or her designee.*	1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page vii.

		Circle One
SC.1.4	The plan for using special treatment procedures is consistent with the patient's rights and the facility's policies governing the use of such procedures.*	1 2 3 4 5 NA
SC.1.5	The clinical indications for the use of special treatment procedures are documented in the patient record.*	1 2 3 4 5 NA
SC.1.6	The clinical indications for the use of special treatment procedures outweigh the known contraindications.*	1 2 3 4 5 NA
SC.2	The facility has written policies and procedures that govern the use of restraint or seclusion.*	1 2 3 4 5 NA
SC.2.1	The use of restraint or seclusion requires clinical justification.*	1 2 3 4 5 NA
	SC.2.1.1 Restraint or seclusion is used only to prevent a patient from injuring himself or others or to prevent serious disruption of the therapeutic environment.*	1 2 3 4 5 NA
	SC.2.1.2 Restraint or seclusion is not used as punishment or for the convenience of staff.*	1 2 3 4 5 NA
	SC.2.1.3 The rationale for the use of restraint or seclusion addresses the inadequacy of less restrictive intervention techniques.*	1 2 3 4 5 NA
SC.2.2	To ascertain that the procedure is justified, a physician conducts a clinical assessment of the patient before writing an order authorizing the use of restraint or seclusion.*	1 2 3 4 5 NA
	SC.2.2.1 The assessment and the order are documented in the patient record when the procedure is implemented.*	1 2 3 4 5 NA
SC.2.3	Each written order for restraint or seclusion is time limited and does not exceed 24 hours.*	1 2 3 4 5 NA
SC.2.4	In an emergency, restraint or seclusion may be utilized by trained, clinically privileged staff.*	1 2 3 4 5 NA
	SC.2.4.1 The clinical assessment of the patient and the order for the use of emergency restraint or seclusion are documented in the patient record when the procedure is implemented.*	1 2 3 4 5 NA
	SC.2.4.2 The emergency implementation of restraint or seclusion does not exceed one hour, at which time a physician staff member's oral order is required if restraint or seclusion is to be continued.*	1 2 3 4 5 NA
	SC.2.4.2.1 The physician's order is entered in the patient record as soon as possible, but not more than 24 hours after implementation of the order.*	1 2 3 4 5 NA
SC.2.5	PRN orders are not used to authorize the use of restraint or seclusion.*	1 2 3 4 5 NA
SC.2.6	All uses of restraint or seclusion are reported daily to the head of the professional staff and/or his or her designee.*	1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page vii.

		Circle One
SC.2.7	The head of the professional staff and/or his or her designee reviews daily all uses of restraint or seclusion and investigates unusual or possibly unwarranted patterns of utilization.*	1 2 3 4 5 NA
SC.2.8	Staff who implement written orders for restraint or seclusion have documented training in the proper use of the procedure for which the order was written.*	1 2 3 4 5 NA
SC.2.9	Restraint or seclusion is not to be used in a manner that causes undue physical discomfort, harm, or pain to the patient.*	1 2 3 4 5 NA
SC.2.10	Appropriate attention is paid every 15 minutes to a patient in restraint or seclusion, especially in regard to regular meals, bathing, and use of the toilet.*	1 2 3 4 5 NA
	SC.2.10.1 There is documentation in the patient record that such attention was given to the patient.*	1 2 3 4 5 NA
SC.3	The facility has written policies and procedures that govern the use of electroconvulsive therapy and other forms of convulsive therapy.*	1 2 3 4 5 NA
SC.3.1	The written informed consent of the patient for the use of electroconvulsive therapy or other forms of convulsive therapy is obtained and made part of the patient record.*	1 2 3 4 5 NA
	SC.3.1.1 The patient may withdraw consent at any time.*	1 2 3 4 5 NA
	SC.3.1.2 When required, the written informed consent of the family and/or legal guardian for the use of electroconvulsive therapy or other forms of convulsive therapy is obtained and made part of the patient record.*	1 2 3 4 5 NA
	SC.3.1.2.1 The family and/or guardian may withdraw consent at any time.*	1 2 3 4 5 NA
	SC.3.1.3 In cases dealing with children or adolescents, the responsible parent(s), relative, or legal guardian and, when appropriate, the patient give written, dated, and signed informed consent for the use of electroconvulsive therapy or other forms of convulsive therapy.*	1 2 3 4 5 NA
	SC.3.1.3.1 The family and/or guardian and, when appropriate, the child or adolescent patient may withdraw consent at any time.*	1 2 3 4 5 NA
SC.3.2	Electroconvulsive therapy or other forms of convulsive therapy are not administered to children or adolescents unless, prior to the initiation of treatment, two qualified psychiatrists who have training or experience in the treatment of children and adolescents and who are not affiliated with the treating program have examined the patient, have consulted with the responsible psychiatrist, and have written and signed reports in the patient record that concur with the decision to administer such therapy.*	1 2 3 4 5 NA
	SC.3.2.1 The records of patients under the age of 13 contain documentation that such examinations and consultations were carried out by qualified child psychiatrists.*	1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page vii.

		Circle One
SC.7	The facility has written policies and procedures that govern the prescribing and administering of drugs for maintenance use that have abuse potential (usually considered to be Schedule II drugs) and drugs that are known to involve a substantial risk or be associated with undesirable side effects.*	1 2 3 4 5 NA
SC.7.1	Drugs that have abuse potential are prescribed and administered for maintenance use only when the following criteria are met:	
	SC.7.1.1 A physician member of the professional staff has reviewed the patient record and has recorded the reasons for prescribing the drug(s) in the patient record:*	1 2 3 4 5 NA
	SC.7.1.2 The prescribed drug is listed in the facility's formulary;* and	1 2 3 4 5 NA
	SC.7.1.3 Prior to the administration of the drug, the patient and, when required by law, the patient's parent(s) or guardian are informed orally and in writing and, if possible, in the patient's native language, of the benefits and hazards of the drug.*	1 2 3 4 5 NA
SC.8	The facility has written policies and procedures that protect the rights of patients involved in research projects that involve inconvenience or risk to the patients.*	1 2 3 4 5 NA
SC.8.1	The policies and procedures require a statement of the rationale for a patient's participation in any research project that involves inconvenience or risk to the patient.*	1 2 3 4 5 NA
SC.8.2	The written informed consent of the patient who will participate in the research project is obtained and made part of the patient record.*	1 2 3 4 5 NA
	SC.8.2.1 The patient may withdraw consent at any time.*	1 2 3 4 5 NA
	SC.8.2.2 When required, the written informed consent of the family and/or legal guardian is obtained and made part of the patient record.*	1 2 3 4 5 NA
	SC.8.2.2.1 The family and/or guardian may withdraw consent at any time.*	1 2 3 4 5 NA
	SC.8.2.3 In cases dealing with children or adolescents, the responsible parent(s), relative, or legal guardian and, when appropriate, the patient give written, dated, and signed informed consent.*	1 2 3 4 5 NA
	SC.8.2.3.1 The family and/or guardian and, when appropriate, the child or adolescent patient may withdraw consent at any time.*	1 2 3 4 5 NA
	Overall compliance: special treatment procedures	1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page vii.

APPENDIX E

CRC SECLUSION STUDY

SECLUSION STUDY REPORT

October 1, 1986 -- December 31, 1986

COTTAGE 5	TOTAL EPISODES	65	
	TOTAL HOURS	115.5	
	AVERAGE HOURS PER EPISODE	1.78	
	TOTAL PATIENTS	21	(5 patients account for 40 episodes; 1 patient accounting for 25 episodes)

SEX: FEMALES - 27 (8)
MALES - 38 (13)

RACE: WHITE - 35 (18)
BLACK - 7 (1)
OTHER - 3 (2)

COUNTY:

OAKLAND	25 (1)	SAGINAW	3 (2)
ST. CLAIR	11 (3)	LAPEER	3 (2)
BAY	9 (1)	HURON	3 (4)
MIDLAND	5 (2)	MACOMB	1 (1)
SAGINAW	6 (3)	TUSCOLA	1 (1)

REASON FOR SECLUSION:

1. Aggression to peer	12
2. Aggression to staff	33
3. Aggression to self	0
4. Property destruction	3
5. Threatening behavior	10
6. Patient request	0
7. Overt agitation	6
8. Other	0

LEGAL STATUS:

1. ALV	5
2. MED CERT	3
3. COURT ORDERED EXAM	7
4. POLICE PETITION	1
5. COURT ORDERED ADMIT (not forensic)	3
6. FORENSIC	0
7. CONDITIONING ORDER	2
TOTAL	21

DIAGNOSIS:

295.3	4	296.4	2	303.9	1
295.6	9	296.6	1		
295.7	1	296.8	1		
296.2	1	301.8	1		

TOTAL 21

AVERAGE AGE: 33.24 MEDIAN AGE: 32 MODE: 26

SECLUSION STUDY REPORT

January 1, 1987 - March 31, 1987

COTTAGE 5	CENSUS	93		
	TOTAL EPISODES	29		
	TOTAL HOURS	52.4		
	AVERAGE HOURS PER EPISODE	1.81		
	TOTAL PATIENTS	10 (2 patients - 4 episodes; 1 patient - 3 episodes; 3 patients - 2 episodes)		
SEX	FEMALES	15 (8)	AVERAGE AGE	(32.5) 35.14
	MALES	14 (10)	MEDIAN AGE	(32.5) 33
			MODE AGE	(27, 33) 33
RACE	WHITE	16 (11)		
	BLACK	9 (4)		
	HISPANIC	3 (2)		
	ORIENTAL	1 (1)		
COUNTY	OAKLAND	4 (1)	MIDLAND	5 (2)
	BAY	1 (1)	GLADWIN	1 (1)
	SAGINAW	8 (6)	SANILAC	1 (1)
	TAPER	2 (2)	TUSCOLA	2 (1)
	ST. CLAIR	5 (3)		

REASON FOR SECLUSION

1) Aggression to peer	2
2) Aggression to staff	15
3) Aggression to self	1
4) Aggression to property	2
5) Threatening behavior	4
6) Patient request	1
7) Overt agitation	4

LEGAL STATUS

1) Adult Formal Voluntary	3 (3)
2) Medical Certification	11 (6)
3) Court Ordered Examination	5 (2)
4) Police Petition	3 (3)
5) Court Order	2 (2)
6) Forensic Order	1 (1)
7) Continuing Order	4 (1)

DIAGNOSIS

295.30	13 (7)
295.34	1 (1)
295.62	2 (2)
296.40	6 (3)
296.44	5 (3)
296.50	1 (1)
V71.09	1 (1)

SECLUSION STUDY REPORT

April 1, 1987 - June 30, 1987

COTTAGE 5	CENSUS	93	
	TOTAL EPISODES	16	
	TOTAL HOURS	25.8	
	QUIET ROOM	1	
	QUIET ROOM HOURS	9.2	
	AVERAGE HOURS PER EPISODE	1.9	
	TOTAL PATIENTS	13	(1 patient - 3 episodes; 2 patients - 2 episodes)
SEX	FEMALES	8 (5)	AVERAGE AGE 39.6
	MALES	9 (8)	MEDIAN AGE 39.5
			MODE AGE 22, 58
RACE	WHITE	10 (8)	
	BLACK	6 (4)	
	HISPANIC	1 (1)	
	ORIENTAL	0	
COUNTY	MIDLAND	1 (1)	
	SANILAC	1 (1)	
	SAGINAW	9 (8)	
	TUSCOLA	2 (1)	
	ST. CLAIR	4 (2)	

REASON FOR SECLUSION

1) Aggression to peer	1
2) Aggression to staff	5
3) Aggression to self	0
4) Aggression to property	0
5) Threatening behavior	2
6) Patient request	0
7) Overt agitation	8

LEGAL STATUS

1) Adult Formal Voluntary	1 (1)
2) Medical Certification	7 (4)
3) Court Ordered Examination	1 (1)
4) Police Petition	4 (4)
5) Court Order	1 (1)
6) Forensic Order	0 (0)
7) Deferred Order	2 (1)

DIAGNOSIS

295.90	4 (2)
295.92	2 (1)
296.40	1 (1)
296.44	4 (3)
296.50	1 (1)
296.60	1 (1)
296.70	1 (1)
298.90	1 (1)
301.40	1 (1)
304.90	1 (1)

SECLUSION STUDY REPORT

October 1, 1987 - December 31, 1987

COTTAGE 5

TOTAL EPISODES	25
TOTAL HOURS	90.3
AVERAGE TIME IN SECLUSION	1.21
TOTAL PATIENTS	19

SEX	FEMALES	9 (one - three times; one - four times; two - two times)
	MALES	10
RACE	BLACK	7
	WHITE	12

REASON FOR SECLUSION

1) Aggression to peers	1
2) Aggression to staff	13
3) Harmful to self	1
4) Harmful to property	1
5) Threatening behavior	7
6) Patient request	0
7) Overt agitation	2
8) Other	0

COUNTY	Bay	2
	Genesee	2
	Lapeer	1
	Sanilac	1
	Saginaw	8
	St. Clair	5
	Tuscola	2

LEGAL STATUS

1) Adult Formal Voluntary	1
2) Medical Certification	7
3) Court Ordered Examination	4
4) Police Petition	5
5) Court Order	1
6) Forensic Order	1

DIAGNOSIS

295.30	1	296.40	5
295.34	2	296.44	1
295.64	2	296.70	2
295.65	1	301.83	1
295.70	3	V71.09	1

APPENDIX F

CRC TREATMENT GOALS

OUR GOALS

The staff of Caro Regional Mental Health Center are committed to providing appropriate training and treatment and competent and humane care to all our residents and patients. We endeavor to meet or exceed all applicable standards of the various state agencies involved in our operation and to achieve and maintain relevant certification and accreditation. The facility is accredited by the Joint Commission on Accreditation of Hospitals, and the program for the developmentally disabled is certified as an Intermediate Care Facility for the Mentally Retarded.

We endeavor to create and maintain a physical environment which is as normal as possible and which is conducive to the development of appropriate behavior and social coping skills.

We endeavor to create and maintain a social and psychological environment which reinforces appropriate behavior and provides for the acquisition, retention or resumption of social skills required for coping with the demands of living in a less restrictive environment.

In the belief that the mentally ill and the developmentally disabled are entitled to live in as normal a setting as their condition permits, we work closely and cooperatively with the Community Mental Health System to ensure that only those people whose needs cannot be met in the community are admitted to--or remain at--the facility, and we support efforts to improve and expand community services which are currently inadequate.

We recognize the importance of the family as a support system for our residents and patients and endeavor to include them in our efforts as much as possible.

BUILDING PATTERNS OF SUCCESS

A Residential Treatment Philosophy

Whether admitted because of a developmental disability or mental illness, the people we serve have had difficulty in coping with the demands of daily living, and social coping skills are inadequate. Most have developed behaviors and attitudes resulting from failures--failure to meet expectations of parents, community, peers, or themselves. They have met defeat so regularly that it has become a pattern of behavior. Since success is not anticipated, they have difficulty being motivated to achieve.

The difference between success and failure is often a difference of expectations. Children and adults alike learn from success--learn to have confidence, learn to try new things, learn to like themselves and others, learn to grow physically, mentally and emotionally. It is our goal to help people build a pattern of success in their daily lives and experiences. We aim to create an environment which is appropriate to their needs and abilities. We try to make the environment as normal as their disabilities permit, but within that concept to provide structure and support necessary for them to achieve success at their developmental and functional level.

Our evaluations are directed to identify strengths and abilities and to determine readiness for experiences which will improve social, mental, emotional and physical functional abilities. By providing a variety of experiences in a variety of settings, we create opportunities for the individual to succeed, and to begin to develop a PATTERN OF SUCCESS. We avoid, as much as possible, a remedial approach which emphasizes the areas of weakness. Instead, we employ a habilitative approach which provides opportunities to function in areas where there are demonstrated skills, and to emphasize those strengths that will aid in the acquisition of new skills. Ours, we hope, is a humanistic, positive approach to the whole person.

It is our intent that Caro be more than a Hospital, as we strive to create a residential treatment facility which will provide therapeutic experiences in all aspects of life. The living units are as much like homes as the design of the buildings and the needs and characteristics of the residents will permit. Meals are prepared and served in the living units, privacy in sleeping areas is provided, personal laundry is done in the buildings, alternative living and activity areas are available.

Every activity of daily living is considered a possible learning opportunity. Residents and patients are expected to be as responsible as their condition permits for their personal care, for their own living areas, for assisting in normal household chores, and for meal preparation, service, and clean-up.

Direct care staff are provided to assist residents and patients in developing independent living skills and learning to be responsible for themselves, rather than to foster dependence through provision of care and control. The staff on the morning shift assist residents/patients in meeting their responsibilities for getting up, getting dressed, making their bed, having breakfast, and getting to "work" on time, whether "work" be school, an activity center, or other assignment. Staff accompany residents/patients to the various locations, where they direct activities, so that it is not possible to "stay home" for the day. Day care is provided in the Hospital unit for anyone too ill to attend activities. The emphasis for the day shift is on those social behaviors and attitudes normally associated with going to work and keeping a job, rather than on the acquisition of specific vocational skills.

The afternoon shift has primary responsibility for the acquisition of residential living skills and the appropriate use of leisure time. Freedom of movement and freedom of choice regarding use of leisure time is provided as consistent with clinical condition and treatment needs. Staff are expected to motivate participation, and share planning and implementation of activities with the residents and patients.

PSYCHIATRIC SERVICES

Any review of the history of Mental Health services illustrates the fact that there are both similarities and differences in the needs of the mentally ill and the developmentally disabled. At certain times and in certain places all persons with "mental problems" who could not function adequately within the social framework were housed and "treated" together. The inadequacy of this approach led to the effort to recognize the distinctions between those who were mentally ill and those who were mentally retarded or suffering from other developmental disabilities, and the creation of separate service delivery systems depending on the "primary diagnosis." The use of the term "primary diagnosis" itself recognizes that there are individuals with symptoms of both classifications, and, perhaps, indicates that behaviors and treatment needs do not always differentiate one group from another. While diagnostic procedures available today are adequate to differentiate mental illness from mental retardation in most cases, the criteria utilized often relate to the etiological basis or time of onset of the symptoms rather than clear differences in behaviors or treatment needs. Furthermore, it is increasingly evident that the incidence of mental illness in those of limited intellectual capacity is, perhaps, greater than in those without such limitations.

Currently, the medical aspects of mental illness receive prominent, if not exclusive, consideration in most psychiatric facilities, with great reliance on medication as the preferred treatment approach. The rapid increase in the number of psychiatric units located in general hospitals is an indication of the validity of this observation. A short average length of stay is viewed as an indication of effective and appropriate treatment, while the constantly increasing rate of readmission gets significantly less attention. The Caro program is designed to affect both the length of stay and the recidivism rate, and both are considered in evaluating effectiveness of treatment. The medical aspects of mental illness receive prominent, but not exclusive,

consideration in the treatment of all psychiatric patients. Since the symptoms of mental illness are behavioral, and admission to the service is invariably a result of demonstrated inability to cope with the demands of living in the social environment of the family and/or community, an interdisciplinary approach to assessment, diagnosis and treatment is utilized.

PSYCHIATRIC TREATMENT PROGRAM

The Psychiatric Treatment Program provides adult inpatient psychiatric treatment services to residents of a ten county catchment area. Close associations are maintained with the community mental health service boards serving the catchment area, and those boards are involved in all admissions and discharges. Patient treatment is highly individualized and individual treatment plans are developed and implemented by three interdisciplinary teams assigned to the program. Each patient is evaluated by a psychiatrist at least one time per week. In addition, all other resources and support services at Caro Regional Mental Health Center are available as appropriate to meet the needs of the individual patient.

The overall goal of the program is to provide effective inpatient psychiatric treatment to residents in the catchment area, helping the patients to develop, maintain or restore their social functioning to the best of their ability to enable them to live as normal and productive a life as is possible.

There are three program areas located in four residential buildings containing a total of 109 certified beds, assigned to the Psychiatric Treatment Program. Each area is staffed on a 24-hour basis and is supervised by a registered nurse. Each patient is assigned a level of supervision, which is reviewed at least weekly:

Level I - patient's freedom of movement is limited only by facility policy;

Level II - program staff must know the patient's whereabouts at all times;

Level III - patient must be within view of staff during waking hours and regularly checked during sleeping hours.

Smoking is permitted in each residential building in designated areas only.

PSYCHIATRIC ADMISSIONS

Admissions to the Psychiatric Service are controlled by the Michigan Mental Health Code, Act 258 of 1974, Chapter 4, Civil Admission and Discharge Procedures: Mental Illness. Caro Regional Mental Health Center is the designated State hospital for ten counties served by eight Community Mental Health Services Boards, i.e., Bay-Arenac, Lapeer, Midland-Gladwin, Huron, Saginaw, Sanilac, Tuscola, and St. Clair.

The facility is licensed and accredited by JCAH as an Adult Psychiatric Hospital. Persons under age 18 will not be admitted but referred to the appropriate designated Children's Psychiatric Hospital. Patients requiring forensic evaluations are not admitted, since the Department of Mental Health maintains the Center for Forensic Psychiatry to perform this function. Patients who require electroconvulsive therapy will not be admitted since this procedure is not available at Caro.

Persons whose mental faculties have simply been weakened as an aging process will not be admitted for long-term care. An aged person may be admitted for a short period of time for treatment of a behavioral problem but must be returned to a community-based program as soon as possible.

By law, substance abuse detoxification and treatment is a responsibility of the Department of Public Health, and these services are not available at Caro. Persons who have a substance abuse problem will only be admitted if they are determined to be mentally ill and require treatment for the mental illness.

Since the Mental Health Code places primary responsibility for services for the mentally ill with the Community Mental Health system, we encourage all referring agencies to contact the appropriate Community Mental Health Board for screening services. If patients are presented for admission without the knowledge of the CMH staff and admission is legally required, then the staff of CRMHC will notify the appropriate CMH staff at the earliest opportunity.

WOODSIDE
(Cottage 5)

This 21 bed residential building, housing both male and female patients, serves as the admissions unit for the program. The only seclusion room in the program is located here. Intensive 24-hour supervision is maintained for all patients due to their clinical needs and the building is locked at all times. Patients may be on any level of supervision. Sleeping and lounge areas are separate by sex, but dining and activity areas are coeducational. As soon as the patient is deemed stable enough to participate in an out-of-cottage program, he/she is transferred to another residential building. This is the only building in the program in which meals are not prepared in the cottage. Most patients remain at Woodside for a very short time.

THE INTERDISCIPLINARY TEAM

It is the policy of Caro Regional Mental Health Center to utilize an interdisciplinary approach to diagnosis, evaluation, and individual program planning in which professional and other personnel participate with parents or guardians and, when possible, residents/patients as a team. Participants share information and recommendations, so that a unified and integrated habilitation program plan is devised. We urge family participation in all aspects of planning and implementation of programs.

A system of staff activity, program development, and documentation has been developed to insure an appropriate and adequate individualized habilitation plan for each person. This system is based on an interdisciplinary team evaluation of the resident/patient and the setting in which he/she functions, and the treatment habilitation plan is kept current by periodic review. It is the policy of this facility that the status of each resident be reviewed by the team on admission, at thirty, sixty, and ninety day intervals following admission, and at least annually thereafter. Periodic review of the patients in the psychiatric unit is dictated by legal requirements related to the admission status, and our policy is to meet or exceed review requirements of the law and relevant accrediting or certifying bodies.

There is one interdisciplinary team for each Unit in the program for the developmentally disabled, and three teams for the psychiatric unit. All clinical personnel function as members of a Team, and in the development of the Individual Treatment Plan, the following are invited/assigned to participate:

1. Resident/Patient Advocate (This may be the person himself, and/or the interested parent, relative or guardian.)
2. Staff of the Community Mental Health Board from the county of residence.
3. Staff of the Tuscola Intermediate School District as appropriate.
4. Assigned Resident Care Personnel.

Each team meets every Tuesday for purposes of review and evaluation of appropriateness and adequacy of individual treatment/training

programs. At these meetings, the entire treatment program (including medical, social, habilitative and/or training aspects) of the individual is subjected to the collective scrutiny of the group. This review process follows an established procedure and includes a standardized system of documentation of staff activity which becomes a part of the individual's permanent record.

Prior to the staff meeting, all relevant disciplines complete an independent evaluation of the resident, and their conclusions are presented at the meeting. Comparison of current and previous reports provides a base of information which is utilized to:

1. Assess progress toward treatment goals
2. Determine new and continuing goals and objectives
3. Formulate a treatment plan based on assessed needs
4. Determine suitability for alternative placement

Concurrently, the team is expected to evaluate and assess the various aspect of past program planning and implementation, and to analyze whether the successes and failures encountered with the particular individual are unique or indicative of a need for systems alterations.

For each person, a member of the team is designated as the Qualified Mental Health/Retardation Professional responsible for the particular resident's program. The "Q" formalizes the team action in a written plan of service, monitors the appropriateness and effectiveness of the plan by reviewing it and its documentation at least every thirty days, and ascertaining that all appropriate staff are aware of the plan and their responsibilities for its implementation. While the "Q" is expected to modify objectives to ensure current appropriateness, if it is determined that major revisions involving modifications of Goals are indicated, these recommendations are presented to the team for consideration at the next weekly meeting.

A PATTERN FOR WORKING

In the normal rhythm of life, most people leave their home during the day for some form of meaningful occupational activity. This requires some organization and planning, and to facilitate the acceptance of a normal rhythm to a day, all residents and patients who are clinically able leave the residential unit for one of several locations at 9:00 AM and participate in a therapeutically directed activity designed to replicate a work environment in terms of behavioral expectations rather than vocational performance expectations.

THE WORK ACTIVITY CENTER

Psychiatric patients and residents from Gardenview and Apple Gate are assigned to the Work Activity Center, where primarily arts and crafts activities are utilized to encourage acquisition of social and behavioral skills normally associated with work, e.g. task completion, following directions, cooperating with others, distinguishing work time from break time. The program is implemented by residential unit staff assigned to the day shift, assisted by occupational and recreational therapists, with professional staff from the psychiatric treatment teams monitoring effectiveness in terms of the individual's treatment needs.

Activities available include woodworking, textiles, ceramics, printing and grounds-keeping. Individuals may be assigned to other work experiences on an individual basis. Compensation is provided, based on performance.

APPENDIX G

PSYCHIATRIC GUIDELINES OF CARE

Caro Regional Mental Health Center

PSYCHIATRIC TREATMENT PROGRAM

GUIDELINES OF CARE

October 1987

INDEX:

INDIVIDUAL PROGRAMS:

1. All patients admitted to the Psychiatric Treatment Program will have a current Individual Treatment Plan (ITP):

   A. Patients newly admitted to the facility will have a preliminary ITP implemented at the time of admission and an initial ITP, normally developed by the psychiatrist, implemented within 72 hours of admission.

   B. All patients whose inpatient hospitalization exceeds 10 days will be scheduled for a complete interdisciplinary staffing review to develop a Master ITP.

   C. All patients admitted to the Psychiatric Treatment Program will receive the following assessments to assist the treatment team in developing an appropriate treatment plan: psychiatric, physical, nursing, social, nutritional*, activities, audiological* and, when appropriate, psychological. (* initial screening as part of admission PE.)

2. Upon admission, each patient will be assigned a Qualified Mental Health Professional (QMHP) who will be responsible for

writing the treatment plan developed by the team and for coordinating the patient's care while in the Psychiatric Treatment Program.

3. Each patient's treatment plan will be reviewed by their assigned treatment team approximately 30 days after admission and by the assigned QMHP every 30 days thereafter. If a change in treatment goals is indicated, the complete interdisciplinary team must formulate those changes; the QMHP may update objectives to meet treatment goals.

4. ITP's will be completely updated every six months.

5. A direct care staff person must participate in the formulation of each ITP. Information regarding the patient will be sought from each shift prior to such a staffing.

6. Patients admitted to the hospital ward for care are to have their ITP's reviewed and, if necessary, amended by Psychiatric Treatment Program staff to insure that the current needs of the patient are met while in the hospital setting. Ideally, this will be accomplished prior to the patient's admission to the hospital.

DOCUMENTATION:

1. All patients admitted to the Psychiatric Treatment Program for care will have pertinent information regarding their behavioral and emotional responses to the therapy offered, documented with date and time by direct care staff.

2. At Woodside (Cottage 5) each Resident Care Aide/Licensed Practical Nurse will be responsible for daily documentation on patients in their assigned group.

3. Summary documentation, regarding the patient's response to treatment plan goals/objectives and containing recommendations for revisions in the ITP, will be done weekly by the Psychiatrist, Nurse, Social Worker for the first two months and at least once a month thereafter.

4. Weekly summary documentation reflecting ITP goals/objectives will be provided weekly by assigned Resident Care Aide/Licensed Practical Nurse.

5. Each entry into the clinical record is to be legible and include the time, date, signature and title of the reporter.

6. Incident Reports and, if indicated, Administrative Report Forms (ARF's) are to be completed whenever a patient is observed to have an injury, is aggressed by another, exibits self-injurious behavior, is secluded or restrained in any way, etc., as per facility and Department of Mental Health policies.

7. Self-sticking labels may be used for progress reports by adjunct therapies, for progress reports originating in the Work Activities program, for reporting behavioral incidents (not requiring an Incident Report) away from the living unit, for reporting "Incidental Contacts" with family members/guardians, etc., and for reporting discussions held in staffings by the interdisciplinary treatment teams.

8. Only the Program Secretaries are allowed to purge a clinical record.

9. A verbal report of each patient's condition, behavior, etc., will be given to the staff of the oncoming shift by the staff of the off-going shift.

10. "Communication Books" are in each living unit and are for administrative purposes (e.g., work orders needed or completed, supplies information, census, staffing, etc.) and to refer personnel to specific clinical records only. Clinical notes are to be entered only into the clinical record. All staffing moves, including relief staff, etc., are to be recorded in the Communication Book.

DAILY ASSIGNMENT:

Nursing supervision will assure that every patient has an assigned direct care staff responsible and accountable for the patient's daily care as outlined in this Guidelines of Care.

MEDICATIONS AND TREATMENTS:

1. Only Registered Nurses and Certified Licensed Practical Nurses will pass medications.

2. Medication cabinets will be kept locked and the nurses will keep the keys on their person at all times.

3. When medications are returned to the residential building by Pharmacy, medication checks, involving comparing prescriptions, medication sheets, and the actual medication will be done by the Midnight Nurse on duty. If the medication must be started at 5 p.m., the preceding will be done by the nurse on duty when the medications arrive. The Midnight Nurse is responsible for assuring a once monthly medicine room inspection, completing the required form.

4. Treatments may be administered by the resident care staff under the supervision of the nurse on duty.

5. Temperature, pulse, respiration, and blood pressure will be done on an individual basis as determined by the patient's medical condition or as ordered.

6. Any physical condition being treated requires daily documentation reflective of condition/treatment (e.g., description of wound, condition of dressings, etc.).

NUTRITION:

1. All patients' diets will reflect information from the nutritional assessment.

2. Mealtimes in the psychiatric residential buildings are as follows:

		Woodside	All other buildings
Breakfast	Mon-Fri:	7:00-8:00 AM	7:00-8:00 AM
	Weekends:	7:30-9:00 AM	7:30-9:00 AM
Lunch	Mon-Fri:	11:30-12:00 PM	WAC Schedule
	Weekends:	11:30-12:00 PM	12:00-1:00 PM
Supper		5:00-5:30 PM	5:00-6:00 PM

*Coffee is available at 6:00 AM in all buildings.

3. Dietary consults will be ordered by the physician, who must review, initial and date all dietary recommendations before implementation. The QMHP is to receive a copy of the consultation.

4. Special dietary restrictions will be followed as approved by the Interdisciplinary Team or as ordered by the physician.

5. Meals are served family-style and staff are expected to participate and to serve as role models for appropriate mealtime behavior.

6. When patients are having lab work done, which requires fasting, their breakfast will be delayed and held until after the lab work is completed.

7. Staff will encourage patients to eat with different people at mealtimes and emphasize the development or refinement of the patients' social skills.

8. Patients will be expected to assist in setting and clearing the tables in all residential buildings. Patients at Pinegrove may assist in meal preparation when specified by their Individual Treatment Plan. Patients at Sugarbush and Spring Oak are expected to assist in the preparation of their meals. Applegate patients will prepare their own meals, with staff supervision.

9. Silverware and other related "sharps" will be counted by Domestic Service Aides after each meal and documented on the appropriate form.

PATIENT ACTIVITIES:

1. All patients admitted to the Psychiatric Treatment Program will be expected to participate in unit activities , unless determined otherwise by the patient's ITP.

2. Under normal conditions, patients admitted to the Psychiatric Treatment Program will remain at Woodside (C-5) Admissions Unit for 48 hours before they will be assessed for participation in the Work Activities Center program.

3. All patients residing at Pinegrove, Sugarbush, Spring Oak and Applegate, as well as selected patients at Woodside, are expected to actively participate in the Work Activities Center (WAC) program on a Monday-Friday basis. Specified therapeutic activities may take place at WAC, the WAC Annex, or in other designated areas of the facility, if indicated in the patient's ITP.

4. Patients at Pinegrove, Sugarbush, Spring Oak and Applegate will be encouraged to walk to the Work Activities Center (WAC) program, unless specified otherwise in the ITP or due to inclement weather.

5. Any restrictions on physical activity will be included in the ITP.

6. All patients with adaptive equipment will be assisted by staff in its use if necessary. The staff also will monitor the condition of the equipment.

7. All patient activities are to be selected with the criteria of appropriateness of activity, benefit to the patient and "normalization" being considered. Building-specific goals/objectives regarding socialization activities for all patients residing in the building must be posted in the building.

8. Off-ground activities must be approved by Activities Therapist, RN III, Program Coordinator or designee. Requests for such activities (and for any monies involved) must be on the Off-Grounds Trip Form and should be submitted for approval one week before the activity. Activities out of the immediate Caro area (25 miles round trip) require additional approval by the Facility Director.

9. All patients will be expected to be responsible for making their own beds and keeping their personal living area neat, unless specified otherwise in their ITP. Domestic Service Aides will be notified of any exceptions by the building

supervisor. Building-specific training goals/objectives for all patients residing in the building (e.g., development of personal domestic tasks skills which would be needed on discharge, such as laundry, general cleaning of personal or community areas) must be posted in the building.

10. Patients also will be expected to help keep the community living areas neat and clean.

11. Patients will be assessed by the Interdisciplinary Treatment Team for participation in available group therapies and the Alcoholics Anonymous Program.

PERSONAL CARE:

1. All patients will be responsible for their own personal hygiene.

2. All patients will be provided with their own toothpaste, toothbrush, deodorant, comb and/or hairbrush, soap, and access to razor and after-shave lotion (if indicated).

3. Personal toilet items are to be marked with the patient's name and are to accompany the patient should he/she be transferred, hospitalized, etc. Community razors or other shared personal items are prohibited.

4. For patients who lack the ability to maintain their own personal hygiene, the direct care staff will assist them to bathe at least three times weekly and to change clothes daily. Fingernails are to be checked after bathing and clipped as needed. Toenails are to be checked at least weekly, and the nurse notified if they are in need of trimming. Proper oral hygiene is to be performed at least two times per day.

5. Breast examinations are to be completed as per facility policy.

CLOTHING:

1. All patients are to be dressed to provide safety, comfort, warmth, body coverage and, where indicated, to enhance skill development. Clothing is to reflect accepted, contemporary style and be appropriate for the activity, season, etc. Nightwear will not be permitted in the dining room or the living room areas after bathing time in the AM or before bathing time in the PM.

2. All patients will be responsible for keeping their own clothing clean unless determined otherwise in their ITP. It is the responsibility of the direct care staff to assist patients who need help in laundering, mending their clothing, or maintaining a reasonably neat clothing storage area.

3. Direct care staff will account for patient's clothing and other personal property in accordance with CRMHC Resident Policy 02.56 "Personal Property."

4. Clothing is available at Woodside on a temporary basis for patients who are admitted without a change of clothing.

5. Clothing is also available for permanent use, on a limited basis, for patients who have no clothing or the resources to obtain any. Whenever possible, supervisors will arrange for these patients to obtain clothes from the facility supply prior to their leaving Woodside.

6. All patients' clothing is to be appropriately identified. Clothing is to be labeled/marked only in the facility Sewing Room.

7. Patients will be informed that the facility is not responsible for clothing or other belongings left in the patient's possession, unless the patient has been determined to be incapable of caring for his/her personal property.

8. Patients will not be permitted to sell, exchange, trade, barter or gamble any article of their clothing to another patient.

9. Patients transferred back to Woodside from other residential buildings should bring only three changes of clothing.

10. When patients are transferred from one residential living unit to another, their belongings shall be inventoried in their presence, if possible. The personal inventory record will be updated as needed. Any missing items are to be reported to the RN III via an ARF.

11. When patient's belongings are inventoried, particularly at the time of discharge, staff are to insure that the patient has only those clothing articles which are marked with the patient's name.

PERSONAL ITEMS:

1. All personal items that present a danger to the patient or others will be locked up. Items defined as "excluded" in CRMHC Resident Policy 02.56 fall into this category. Other items (e.g., pens, pencils, cosmetics, perfumes, after-shave, keys, etc.) will be evaluated on an individual basis. Knives, scissors, aerosols, nail files are to be locked up and used under staff supervision only.

2. Personal radios, cassette players, televisions, etc., will not be permitted in the residential living areas as they interfere with the therapeutic process. If given to the

patient for use out of the residential building, the item must be noted on the inventory sheet. When in the building they are to be kept in a safe deposit area.

3. All valuables will be sent home with relatives, locked in a safe deposit area or placed in the facility safe. For patients who decide to keep any valuables in their possession, staff are to inform them that the facility is not responsible for the safety of their valuables. Staff are to document a complete description of the valuables, kept by the patient, in the clinical record and that the patient was apprised of his responsibility.

MONEY:

1. The facility is not responsible for money kept by the patient in his/her possession.

2. Patients are encouraged to keep no more than five dollars ($5.00) in their possession.

3. Limitations or restrictions on the patient's use of money must be documented in the ITP and be implemented in accordance with facility policy.

4. Patient monies not in the possession of the patient will be deposited in the individual patient's account at the Cashier's office. No patient monies will be locked in the residential living units.

5. Patients are encouraged to withdraw no more than ten dollars ($10.00) at any one time for incidental personal use. Withdrawals may be made at the Social Skills Center or the Cashier's Office during regularly scheduled hours.

6. At the time of discharge of each patient, both the Resident Affairs Office and the Accounting Department are to be notified of the patient's discharge address to insure that any monies/personal belongings located after discharge can be forwarded to the patient.

FREEDOM OF MOVEMENT:

1. All patients admitted to the Psychiatric Treatment Program will be given a copy of the Freedom of Movement policy.

2. Patients in the Psychiatric Treatment Program will be assigned a supervision level by the RN III assigned to the residential building (or the RN II who is relieving for the RN III), which will specify any additional restrictions placed on their movement. These levels will be determined though consideration of, but not necessarily limited to, the following:

a. perceived danger to one's self;
b. perceived danger to others;
c. potential property destruction;
d. potential elopement;
e. adherance to ITP;
f. assessment of mental status; etc.

These levels will be reviewed at least weekly by the RN III and modified as necessary. Determination of the levels is not considered a Treatment Team decision, but input from Team members is encouraged.

3. The levels of supervision are as follows:

LEVEL I: The patient only need adhere to the general restrictions for all patients/residents of Caro Regional Mental Health Center.

LEVEL II: Patients must keep staff informed of their whereabouts at all times. They may go outside the building if accompanied by staff or alone with permission. Patients at this level may complete personal hygiene without supervision. They will be checked every 30 minutes while sleeping.

LEVEL III: Patients on this level must be within the staff's eyesight during waking hours. Patients may go outside the buildings only if accompanied by staff. Patients at this level, at times, may be restricted to their building due to their special needs. Staff may need to accompany patients during personal hygiene care, as directed by the RN III/RN II/RCAS VB, and will check on patients at least 15 minutes while sleeping. Patients on Suicide Alert or Self-Abuse Precautions will be assigned to this level.

LEVEL IV: Only patients on SUICIDE PRECAUTIONS to be determined in accordance with DMH Policy III-003-0003-H dated 7/22/86 will be assigned to this Level of Supervision, in accordance with CRMHC Policy 02.42:1.

4. Woodside (admissions unit) is a locked residential building. Pinegrove, Sugarbush, Spring Oak and Applegate are programmatically designed to be open buildings. However, this status is subject to change based on needs and characteristics of inpatients present.

LEAVES OF ABSENCE (LOA'S):

1. The initial LOA for all patients admitted to the Psychiatric Treatment Program must be approved by the treating psychiatrist.

2. Subsequent LOA's will be arranged and authorized in accordance with general facility policy.

BUILDING INSPECTIONS:

Residential building supervisors (i.e., RN II's, RCAS VB's), both AM and PM shift, are to inspect the residential living units a minimum of two times per week to insure proper cleanliness, compliance with accepted health standards and that appropriate supplies and equipment are available and in good repair.

APPENDIX H

JCAH THERAPEUTIC ENVIRONMENT

32. Therapeutic Environment (TH)

		Circle One
TH.1	The facility establishes an environment that enhances the positive self-image of patients and preserves their human dignity.*	1 2 3 4 5 NA
TH.2	The grounds of the facility have adequate space for the facility to carry out its stated goals.*	1 2 3 4 5 NA
TH.2.1	When patient needs or facility goals involve outdoor activities, areas appropriate to the ages and clinical needs of the patients are provided.*	1 2 3 4 5 NA
TH.3	The facility is accessible to handicapped individuals or the facility has written policies and procedures that describe how handicapped individuals can gain access to the facility for necessary services.*	1 2 3 4 5 NA
TH.4	Waiting or reception areas are comfortable, and their design, location, and furnishings accommodate the characteristics of patients and visitors, the anticipated waiting time, the need for privacy and/or support from staff, and the goals of the facility.*	1 2 3 4 5 NA
TH.4.1	Appropriate staff are available in waiting or reception areas to address the needs of patients and visitors.*	1 2 3 4 5 NA
TH.4.2	Rest rooms are available for patients and visitors.*	1 2 3 4 5 NA
TH.4.3	A telephone is available for private conversations.*	1 2 3 4 5 NA
TH.4.4	An adequate number of drinking units are accessible at appropriate heights.*	1 2 3 4 5 NA
	TH.4.4.1 If drinking units employ cups, only single-use, disposable cups are used.*	1 2 3 4 5 NA
TH.5	Facilities that do not have emergency medical care resources have first-aid kits available in appropriate places.*	1 2 3 4 5 NA
TH.5.1	All supervisory staff are familiar with the locations, contents, and use of the first-aid kits.*	1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page vii.

		Circle One
TH.6	Programs providing partial-hospital or 24-hour care services provide an environment appropriate to the needs of patients.*	1 2 3 4 5 NA
TH.6.1	The design, structure, furnishing, and lighting of the patient environment promote clear perceptions of people and functions.*	1 2 3 4 5 NA
TH.6.2	When appropriate, lighting is controlled by patients.*	1 2 3 4 5 NA
TH.6.3	Where possible, the environment provides views of the outdoors.*	1 2 3 4 5 NA
TH.6.4	Areas that are used primarily by patients have windows or skylights.*	1 2 3 4 5 NA
TH.6.5	Appropriate types of mirrors that distort as little as possible are placed at reasonable heights in appropriate places to aid in grooming and to enhance patients' self-awareness.*	1 2 3 4 5 NA
TH.6.6	Clocks and calendars are provided in at least major use areas to promote awareness of time and season.*	1 2 3 4 5 NA
TH.7	Ventilation contributes to the habitability of the environment.*	1 2 3 4 5 NA
TH.7.1	Direct outside air ventilation is provided to each patient's room by air-conditioning or operable windows.*	1 2 3 4 5 NA
TH.7.2	Ventilation is sufficient to remove undesirable odors.*	1 2 3 4 5 NA
TH.8	All areas and surfaces shall be free of undesirable odors.*	1 2 3 4 5 NA
TH.9	Door locks and other structural restraints are used minimally.*	1 2 3 4 5 NA
TH.9.1	The use of door locks or closed sections is approved by the professional staff and the governing body.*	1 2 3 4 5 NA
TH.10	The facility has written policies and procedures to facilitate staff-patient interaction, particularly when structural barriers in the therapeutic environment separate staff from patients.*	1 2 3 4 5 NA
TH.10.1	Staff respect a patient's right to privacy by knocking on the door of the patient's room before entering.*	1 2 3 4 5 NA
TH.11	Areas with the following characteristics are available to meet the needs of patients:	
TH.11.1	Areas that accommodate a full range of social activities, from two-person conversations to group activities;*	1 2 3 4 5 NA
TH.11.2	Attractively furnished areas in which a patient can be alone, when appropriate;* and	1 2 3 4 5 NA
TH.11.3	Attractively furnished areas for private conversations with other patients, family members, or friends.*	1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page vii.

		Circle One
TH.12	Appropriate furnishings and equipment are available.*	1 2 3 4 5 NA
TH.12.1	Furnishings are clean and in good repair.*	1 2 3 4 5 NA
TH.12.2	Furnishings are appropriate to the ages and physical conditions of the patients.*	1 2 3 4 5 NA
TH.12.3	All furnishings, equipment, and appliances are maintained in good operating order.*	1 2 3 4 5 NA
TH.12.4	Broken furnishings and equipment are repaired promptly.*	1 2 3 4 5 NA
TH.13	Dining areas are comfortable, attractive, and conducive to pleasant living.*	1 2 3 4 5 NA
TH.13.1	Dining arrangements are based on a logical plan that meets the needs of the patients and the requirements of the facility.*	1 2 3 4 5 NA
TH.13.2	Dining tables seat small groups of patients, unless other arrangements are justified on the basis of patient needs.*	1 2 3 4 5 NA
TH.13.3	When staff members do not eat with the patients, the dining rooms are adequately supervised and staffed to provide assistance to patients when needed and to assure that each patient receives an adequate amount and variety of food.*	1 2 3 4 5 NA
TH.14	Sleeping areas have doors for privacy.*	1 2 3 4 5 NA
TH.14.1	In rooms containing more than four patients, privacy is provided by partitioning or the placement of furniture.*	1 2 3 4 5 NA
TH.14.2	The number of patients in a room is appropriate to the goals of the facility and to the ages, developmental levels, and clinical needs of the patients.*	1 2 3 4 5 NA
TH.14.3	Except when clinically justified in writing on the basis of program requirements, no more than eight patients sleep in a room.*	1 2 3 4 5 NA
TH.14.4	Sleeping areas are assigned on the basis of the patient's need for group support, privacy, or independence.*	1 2 3 4 5 NA
	TH.14.4.1 Patients who need extra sleep, whose sleep is easily disturbed, or who need greater privacy because of age, emotional disturbance, or adjustment problems are assigned to bedrooms in which no more than two persons sleep.*	1 2 3 4 5 NA
TH.15	Areas are provided for personal hygiene.*	1 2 3 4 5 NA
TH.15.1	The areas for personal hygiene provide privacy.*	1 2 3 4 5 NA
TH.15.2	Bathrooms and toilets have partitions and doors.*	1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page vii.

		Circle One
TH.15.3	Toilets have seats.*	1 2 3 4 5 NA
TH.16	Good standards of personal hygiene and grooming are taught and maintained, particularly in regard to bathing, brushing teeth, caring for hair and nails, and using the toilet.*	1 2 3 4 5 NA
TH.16.1	Patients have the personal help needed to perform these activities and, when indicated, to assume responsibility for self-care.*	1 2 3 4 5 NA
TH.16.2	Incontinent patients are cleaned and/or bathed immediately upon voiding or soiling, with due regard for privacy.*	1 2 3 4 5 NA
TH.16.3	The services of a barber and/or beautician are available to patients either in the facility or in the community.*	1 2 3 4 5 NA
TH.17	Articles for grooming and personal hygiene that are appropriate to the patient's age, developmental level, and clinical status are readily available in a space reserved near the patient's sleeping area.*	1 2 3 4 5 NA
TH.17.1	If clinically indicated, a patient's personal articles may be kept under lock and key by staff.*	1 2 3 4 5 NA
TH.18	Ample closet and drawer space are provided for storing personal property and property provided for patients' use.*	1 2 3 4 5 NA
TH.18.1	Lockable storage space is provided.*	1 2 3 4 5 NA
TH.19	Patients are allowed to keep and display personal belongings and to add personal touches to the decoration of their rooms.*	1 2 3 4 5 NA
TH.19.1	The facility has written rules to govern the appropriateness of such decorative display.*	1 2 3 4 5 NA
TH.19.2	If access to potentially dangerous grooming aids or other personal articles is contraindicated for clinical reasons, a member of the professional staff explains to the patient the conditions under which the articles may be used.*	1 2 3 4 5 NA
	TH.19.2.1 The clinical rationale for these conditions is documented in the patient record.*	1 2 3 4 5 NA
TH.19.3	If the hanging of pictures on walls and similar activities are privileges to be earned for treatment purposes, a member of the professional staff explains to the patient the conditions under which the privileges may be granted.*	1 2 3 4 5 NA
	TH.19.3.1 The treatment and granting of privileges are documented in the patient record.*	1 2 3 4 5 NA
TH.20	Patients are encouraged to take responsibility for maintaining their own living quarters and for day-to-day housekeeping activities of the program, as appropriate to their clinical status.*	1 2 3 4 5 NA
TH.20.1	Such responsibilities are clearly defined in writing, and staff assistance and equipment are provided as needed.*	1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page vii.

		Circle One
TH.20.2	Descriptions of such responsibilities are included in the patient's orientation program.*	1 2 3 4 5 NA
TH.20.3	Documentation that these responsibilities have been incorporated in the patient's treatment plan is provided.*	1 2 3 4 5 NA
TH.21	Patients are allowed to wear their own clothing.*	1 2 3 4 5 NA
TH.21.1	If clothing is provided by the program, it is appropriate and is not dehumanizing.*	1 2 3 4 5 NA
TH.21.2	Training and help in the selection and proper care of clothing are available as appropriate.*	1 2 3 4 5 NA
TH.21.3	Clothing is suited to the climate.*	1 2 3 4 5 NA
TH.21.4	Clothing is becoming, in good repair, of proper size, and similar to the clothing worn by patients' peers in the community.*	1 2 3 4 5 NA
TH.21.5	An adequate amount of clothing is available to permit laundering, cleaning, and repair.*	1 2 3 4 5 NA
TH.22	A laundry room is accessible so patients may wash their clothing.*	1 2 3 4 5 NA
TH.23	The use and location of noise-producing equipment and appliances, such as television sets, radios, and record players, do not interfere with other therapeutic activities.*	1 2 3 4 5 NA
TH.24	A place and equipment are provided for table games and individual hobbies.*	1 2 3 4 5 NA
TH.24.1	Toys, equipment, and games are stored on shelves that are accessible to patients as appropriate.*	1 2 3 4 5 NA
TH.25	Books, magazines, and arts and crafts materials are available in accordance with patients' recreational, cultural, and educational backgrounds and needs.*	1 2 3 4 5 NA
TH.26	The facility formulates its own policy regarding the availability and care of pets and other animals, consistent with the goals of the facility and the requirements of good health and sanitation.*	1 2 3 4 5 NA
TH.27	Depending on the size of the program, facilities are available for serving snacks and preparing meals for special occasions and for recreational activities.*	1 2 3 4 5 NA
TH.27.1	The facilities permit patient participation.*	1 2 3 4 5 NA
TH.28	Unless contraindicated for therapeutic reasons, the facility accommodates patients' need to be outdoors through the use of nearby parks and playgrounds, adjacent countryside, and facility grounds.*	1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page vii.

		Circle One
TH.28.1	Recreational facilities and equipment are available, consistent with patients' needs and the therapeutic program.*	1 2 3 4 5 NA
TH.28.2	Recreational equipment is maintained in working order.*	1 2 3 4 5 NA
	Overall compliance: therapeutic environment	1 2 3 4 5 NA

*The asterisked items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page vii.

Comments and Recommendations

Provide specific documentation for each 2, 3, 4, or 5 rating.

APPENDIX I

CRC/DMH REPORT FORMS

[illegible] (11/77)

MICHIGAN DEPARTMENT OF MENTAL HEALTH

STATE FACILITY

STATISTICAL FACE SHEET

INPATIENT - OUTPATIENT

1. CASE NUMBER | OPTIONAL [illegible] | 2. [illegible] CODE

3. AGENCY [illegible] AGENCY [illegible]

4. OPENING DATE (Mo., Da., Yr.) | 5. SOC. SEC. NO.**

6. ACTION CODE: 0. [ ] Initial 1. [ ] Update 2. [ ] Reopen 3. [ ] Correction | 7. [illegible] (Complete if Action Code 1 or 2) (Mo., Da., Yr.)

8. BIRTH DATE (Mo., Da., Yr.) | 9. SEX: 1. [ ] M 2. [ ] F

10. LAST NAME | FIRST | INITIAL | 11. COUNTY OF RESIDENCE Code* | 12. CENSUS TRACT | 13. [illegible] Code*

14. NO. OF DEPENDENTS (by age): 0-5 | 13-17 | 6-12 | 18+

15. ETHNIC GROUP (Check One): 1. [ ] White 2. [ ] Black 3. [ ] Am. Indian 4. [ ] Hispanic 5. [ ] Asian 6. [ ] Other

16. MARITAL STATUS (Check One): 1. [ ] Never Married 2. [ ] Married 3. [ ] Widowed 4. [ ] Separated 5. [ ] Divorced 6. [ ] Remarried

17. EDUCATION

Highest Grade Completed

Years in special education (If blank skip to Item 18.)

Currently in special education? 1. [ ] Yes 2. [ ] No

Most recent special education program (check one)

1. [ ] Educable
2. [ ] Trainable
3. [ ] Severely Mentally Impaired
4. [ ] Severely & Multiply Impaired
5. [ ] Emotionally Impaired
6. [ ] Other Learning Disabilities
7. [ ] Other

18. EMPLOYMENT STATUS AT OPENING (Check One)

CURRENTLY EMPLOYED

1. [ ] Full-time
2. [ ] Part-time
3. [ ] Sheltered Employment

UNEMPLOYED

4. [ ] On lay-off
5. [ ] Looking for work (Available during past 4 weeks)
6. [ ] Not looking for work

NOT IN LABOR FORCE

8. [ ] Homemaker
9. [ ] Child
10. [ ] Student
11. [ ] Never worked - Non-student
12. [ ] Disabled
13. [ ] Retired
14. [ ] Other

19. SOURCE OF REFERRAL Code*

20. PREVIOUS MENTAL HEALTH SERVICES (most recent - last 5 years): 1. [ ] None 2. [ ] DMH Inpatient (Last 30 days) 3. [ ] Inpatient (all other) 4. [ ] Other 0. [ ] Unknown

21. [illegible] OBJECTIVE (Check One): 1. [ ] Psychosocial Adjustment 2. [ ] Crisis Resolution 3. [ ] Rehabilitation/Habilitation 4. [ ] Maintenance

22. CURRENT LIVING ARRANGEMENT Code*

23. CLIENTS ELIGIBLE FOR PURCHASE OF SOCIAL SERVICES (Title XX)

Current Assistance Recipient Program Code (From DSS M.A. Authorization Card)

Income Eligible - Scale 1. [ ] 2. [ ] (from DSS form 1980) Eligible Beginning Mo. Yr.

24. DIAGNOSIS: Primary - DSMS Code | Secondary - DSMS Code | Primary Description | Attending Physician Code | Physician Name

25. OPTIONAL USE

STATUS AT TIME OF CLOSING

26. HOW TERMINATED: 1. [ ] Withdrew 2. [ ] According to Plan 3. [ ] Other | 27. REFERRED TO Code* | 28. DATE OF CLOSING (Mo., Da., Yr.)

REMARKS

*CODES ON BACK OF FORM

REPORTING AGENCY COPY

**Client's response to this request for information is voluntary. The use of this information is for billing and statistical purposes only.

CMC-PRO-56
12/82 - IH

REQUESTED BY_____
(Name and Title)

DATE IN_____ TIME_____

DATE OUT_____ TIME_____

RELEASED BY_____
(Name and Title)

CONDITION OF SECLUSION _____

OR _____

TYPE OF PHYSICAL RESTRAINT _____

_____

Signed_____
(Authorized Professional)

JUSTIFICATION: _____

_____

_____

_____

Signed_____
(Authorized Professional)

15-MINUTE CHECKS BY COTTAGE PERSONNEL

Time	Comments	Signed

(Continued on page 2)

CARO REGIONAL MENTAL HEALTH CENTER
Caro, Michigan 48723

OBSERVATION REPORT OF ☐ SECLUSION ☐ RESTRAINT ☐ QUIET ROOM

(Indicate which)

PROFESSIONAL OBSERVATIONS

Time	Comments

Signed_____

Time	Comments

Signed_____

Time	Comments

Signed_____

Time	Comments

Signed_____

(Addressograph)

(Continued from page 1)

15-MINUTE CHECKS BY OUTLAW PERSONNEL

Time	Comments	Signed

15-MINUTE CHECKS BY OUTLAW PERSONNEL

Time	Comments	Signed

CARO REGIONAL MENTAL HEALTH CENTER

QUARTERLY SUMMARY OF SECLUSION, RESTRAINT AND QUIET ROOM USAGE

Months of ____________________

____
Marlin H. Roll, Ph.D., Director

Census (last day of 1/4):

DD __________ MI __________

		Area			
SECLUSION	Total Episodes				
	Total Hours				
RESTRAINT	Total Episodes				
	Total Hours				
QUIET ROOM	Total Episodes				
	Total Hours				

QUARTERLY SUMMARY OF SECLUSION, RESTRAINT AND QUIET ROOM USAGE

Months of ____________________

____
Marlin H. Roll, Ph.D., Director

Census (last day of 1/4):

DD __________ MI __________

		Area			
SECLUSION	Total Episodes				
	Total Hours				
RESTRAINT	Total Episodes				
	Total Hours				
QUIET ROOM	Total Episodes				
	Total Hours				

QUARTERLY SUMMARY OF SECLUSION, RESTRAINT AND QUIET ROOM USAGE

Months of ____________________

____
Marlin H. Roll, Ph.D., Director

Census (last day of 1/4):

DD __________ MI __________

		Area			
SECLUSION	Total Episodes				
	Total Hours				
RESTRAINT	Total Episodes				
	Total Hours				
QUIET ROOM	Total Episodes				
	Total Hours				

QUARTERLY SUMMARY OF SECLUSION, RESTRAINT AND QUIET ROOM USAGE

Months of ____________________

____
Marlin H. Roll, Ph.D., Director

Census (last day of 1/4):

DD __________ MI __________

		Area			
SECLUSION	Total Episodes				
	Total Hours				
RESTRAINT	Total Episodes				
	Total Hours				
QUIET ROOM	Total Episodes				
	Total Hours				

APPENDIX J

TRAINING SCHEDULE

Caro Regional Mental Health Center

PSYCHIATRIC UNIT INSERVICE

MAY 4-8, 1987

Monday, May 4, 1987

8:00 a.m.	Introduction to Training Program Dr. Marlin Roll, Ph.D., Facility Director Mr. Maurice Forrest, Personnel Director Mr. Rick Jenkins, ATA III, Union President
9:00 a.m.	"What is Mental Illness?" Mr. Avni Cirpili, R.N.
10:15 a.m.	Break
10:30 a.m.	Mental Illness, Continued
12:15 p.m.	Lunch
12:45 p.m.	Major Disorders Treated at CRMHC Dr. Diane List, Ed.D., Director of Psychology, M.I.
2:15 p.m.	Break
2:30 p.m.	Disorders, continued

Tuesday, May 5, 1987

8:00 a.m.	Communication Dr. Diane List, Ed.D. Mr. Avni Cirpili, R.N. Mr. Joseph Warack, RCA IIIB
10:00 a.m.	Break
10:15 a.m.	Communication, continued
12:00 noon	Lunch
12:30 p.m.	Documentation Mr. Raymond Bates, ACSW, Psychiatric Program Coordinator Mr. Kim Hopper, RCA VB
2:00 p.m.	Break
2:15 p.m.	Introduction to Psychotropic Medication Dr. Irene Reive, MD, Director of Psychiatry
3:30 p.m.	Levels of Accountability and CRMHC Philosophy Dr. Marlin Roll, Facility Director

Wednesday, May 6, 1987

8:00 a.m.	Staff-o-Genic Behaviors: Effects of Treatment Interventions Dr. Diane List, Ed.D. Mr. Avni Cirpili, R.N. Mr. Joseph Warack, RCA IIIB
10:00 a.m.	Break
10:15 a.m.	Staff-o-Genic, continued
12:00 noon	Lunch
12:30 p.m.	Staff-o-Genic, continued
1:30 p.m.	Physical Management Techniques Mr. Robert Walker, RCA IIIB Ms. Judy McCrumb, RCA IIIB
2:30 p.m.	Break
2:45 p.m.	Admission Procedures Mr. Raymond Bates, ACSW, Psychiatric Program Coordinator

Thursday, May 7, 1987

8:00 a.m.	Elopement Precautions Mr. Joseph Warack, RCA IIIB
8:30 a.m.	Medication Side Effects Dr. Irene Reive, MD, Director of Psychiatry
10:30 a.m.	Break
10:45 a.m.	Seclusion Room Procedures Mr. Avni Cirpili, R.N.
12:00 noon	Lunch
12:30 p.m.	Suicide Risks Dr. Diane List, Ed.D., Director of Psychology, M.I.
3:00 p.m.	Break
3:15 p.m.	Avoiding Job Related Burn-Out

Friday, May 8, 1987

8:00 a.m.	Side Effects of Medication Dr. Barry Binkley, MD, Staff Psychiatrist
9:00 a.m.	The Acute Care Admitting Unit Ms. Pam Reuter, R.N.
10:00 a.m.	Closing Comments Dr. Marlin Roll, Facility Director
11:00 a.m.	Staff Test

APPENDIX K

STAFF TRAINING EXAMINATION

NAME: _____

1. A patient states that he is God and can control the whole world. He is staying up at night pacing and speaking continually in a pressured manner. This person has the characteristics of an individual who has a:

   A. Schizophrenic Disorder
   B. Bipolar Affective Disorder
   C. Borderline Personality Disorder
   D. Organic Brain Syndrome

2. The components of the communication process include

   A. Body language of the speaker
   B. Tone of voice
   C. Eye contact with the audience
   D. All of the above

3. In working with a manipulative patient staff need to use all of the following interventions <u>except</u>:

   A. Explain to patient limits of acceptable behavior
   B. Be consistent
   C. Have one staff as the primary attendant, if possible
   D. Give patient several chances to improve their behavior before intervention occurs

4. Who can move a patient from one level to another:

   A. Direct care staff
   B. Social worker
   C. Registered nurse
   D. QMHP

5. When a patient is aggressive on the unit appropriate interventions would include all of the following <u>except</u>:

   A. Tell the patients not involved to leave the area
   B. Do what is necessary to show to the patient you are in control
   C. Avoid a situation where you or the patient have to "win"
   D. Request assistance from othe staff

6. All of the following are components of a suicide assessment <u>except</u>:

   A. Plan
   B. Availability of means
   C. Number of household members
   D. Gender and ethnicity

7. Which of the following is not generally exhibited by an individual who is diagnosed as having a Borderline Personality Disorder.

A. Patient expresses feelings of emptiness
B. Tend to be manipulative
C. Expresses hallucinatory thoughts
D. Are fearful of being alone

8. Mr. Efh has been up and down all shift. Several patients on the unit have complained that Mr. Efh has been bothering them. What is the proper order of interventions:

1. Physical management
2. Seclusion
3. Move to quiet/less stimulus area
4. Verbal redirection

A. 1, 2, 3, 4
B. 2, 4, 3, 1
C. 4, 3, 1, 2
D. 4, 1, 3, 2

9. Which of the following terms is not used to describe a types of delusion:

A. Dementia
B. Grandiose
C. Paranoid
D. Persecutory

10. When dealing with a patient verbalizing suicidal threats the most important consideration is:

A. A suicidal ideation is a suicidal thought
B. Threats of suicide should be considered seriously and appropriate interventions defined.
C. The patient should be placed on a level IV as soon as possible
D. Suicidal threats should generally be considered to be attention seeking behavior

11. When caring for an organically mentally ill person, your primary concern should be for their safety.

A. True
B. False

12. "Staffogenic" behaviors are defined as those behaviors exhibited by patients that are a direct result of maladaptive behaviors and attitudes by staff.

    A. True
    B. False

13. Understanding yourself, your thoughts, perceptions, values and behaviors is an essential part of being a good care-giver.

    A. True
    B. False

14. Agitated behavior is generally unpredictable and has no underlying cause.

    A. True
    B. False

15. One does not need to use simple directions when caring for a schizophrenic patient because schizophrenia is not a thought disorder.

    A. True
    B. False

16. When a patient is experiencing anxiety, it is most likely that he/she is actually feeling fearful.

    A. True
    B. False

17. Chronic patients cannot function outside of a hospital setting.

    A. True
    B. False

18. A patient on an Adult Formal Voluntary elopes. We are obligated to contact the police as soon as possible.

    A. True
    B. False

19. You can change a person's delusion by telling that person what they think is happening really isn't.

    A. True
    B. False

20. Wrist cutting is a highly lethal means of suicide. An individual attempting suicide using this method should be placed on 1:1 for at least 24 hours.

A. True
B. False

21. Side effects of anti-depressants include:
1. Drowsiness
2. Ataxia
3. Constipation
4. Hypotension
5. Weight gain

A. 1 and 3
B. 2 and 4
C. All of the above
D. None of the above

22. Individuals diagnosed as Bipolar Affective Disoder are generally characterized as having a disorder of:

A. Thought
B. Mood
C. Organicity
D. Personality

23. The daily documentation in the progress notes is often utilized in all of the following situations <u>except:</u>

A. To provide a basis for describing behavior that may be used to develop or confirm a diagnosis
B. To provide orders to other staff members about the appropriate treatment of a particular patient
C. To identify possible positive or negative side effects of medications
D. To indicate the extent to which the objectives in the treatment plan are being implemented

24. Based on the philosophy of treatment at Caro Regional Center the 3 R's are all of the following <u>except:</u>

A. Reinforce appropriate behavior
B. Redirect to appropriate activity
C. Refer patient to their Q.M.H.P
D. Remove the stimulus

25. All of the following statements about stress are true except:

A. Stress is always bad for an individual
B. Relationships are often a basis for stress
C. Stress too prolonged and severe can eventually cause physical symptoms
D. Stress can be caused by any significant life change - either positive or negative

26. When interacting with a patient who is suffering from an acute psychotic episode, staff need to:

A. Focus the patient on to reality as much as possible
B. Always be in control the patient's behavior in order to avoid confrontation situations
C. Expect the patient to be able to answer question and carry out tasks rationally and logically
D. Make sure that the seclusion room is empty and ready in case it needs to be used

27. Mrs. Jones received 10 mg of Haldol last evening. This morning she is complaining of feeling jittery and just can't sit still. The most likley problem is
1. She is just a hypochondriac
2. She is reacting to last night's dose of haldol with akethesia
3. She is nervous and tense because the Haldol effect has worn off

A. All of the above
B. 1 and 3
C. 2 and 3
D. None of the above

28. The philosophy at Caro Regional Center may best be described as:

A. Our responsibility is to realize that patients are incapable of deciding things for themselves and do for them what they cannot do for themselves
B. Recognizing that our role is to control patient behaviors to the best of our ability
C. Understanding that our expectations for patients (i.e. expecting them to act normal) will greatly influence their behaviors
D. Setting down the limits and rules on the unit and do what is necessary to have the patients comply

29. Patients may be admitted to Caro Regional Center involuntarily on the following types of orders <u>except:</u>

A. Court order examination
B. Police petition
C. Medical certification
D. Informal adult formal voluntary

30. When a patient is becoming agitated the most appropriate intervention may be:

A. Explain to them that they should calm down
B. Attempt to redirect them to a more appropriate activity
C. Ask them "Why are you getting upset?"
D. Reassure them that everything will be fine soon

31. One of the side-effects of anti-psychotic/neuroleptic medications is tardive dyskinesia.

A. True
B. False

32. Each stressful situation in a person life should be treated individually because past expriences of how the person has dealt with stress has little, if any, effect on this new stessful situation.

A. True
B. False

33. The philosophy at Caro Regional Center is based on the theory that the primary responsibility of staff is to control patient behaviors

A. True
B. False

34. The Michigan Mental Health Code defines a person as being mentally ill if they are suffering from a substantial disorder of thought or mood.

A. True
B. False

35. Mental health workers are always objective in their interpretation and diagnosis of mental illness regardless of their own personal and cultural backgrouds.

A. True
B. False

36. It is best to leave a patient who is withdrawn alone because these individuals are non-problematic and will eventually seek out staff when they are ready.

A. True
B. False

37. Mental illnesses are easily defined, easily identified disorders.

A. True
B. False

38. One of the recommended physical intervention techniques for a physically aggressive patient is the Russian Grab.

A. True
B. False

39. The need to draw the line and maintain the rules is the key to running a good unit.

A. True
B. False

40. Telling the patient that they shouldn't think about suicide is an appropriate intervention.

A. True
B. False

41. You have been assigned to Mr. Knn, a newly admitted patient to C-5. He is diagnosed as Schizophrenic and has the following symptoms: delusions of paranoia, little insight into his problem, refuses any medications, refuses to do any of his care, and has a past history of aggressive behavior. Briefly describe some of the possible interventions that you implement in caring for this patient.

42. Mental illness is very subjective in nature. Explain how two mental health professionals assessing the same patient can come up with two different conclusions.

43. List five alternatives to physical management.

44. Define each of the disorders listed below.

A. Schizophrenia

B. Bipolar (Manic/Depressive) Disorder

C. Borderline Personality Disorder

D. Organic Mental Disorder

45. In class we have discussed the concept of control several times. Is it appropriate to control a patients behaviors? Explain your answer.

NAME: _____

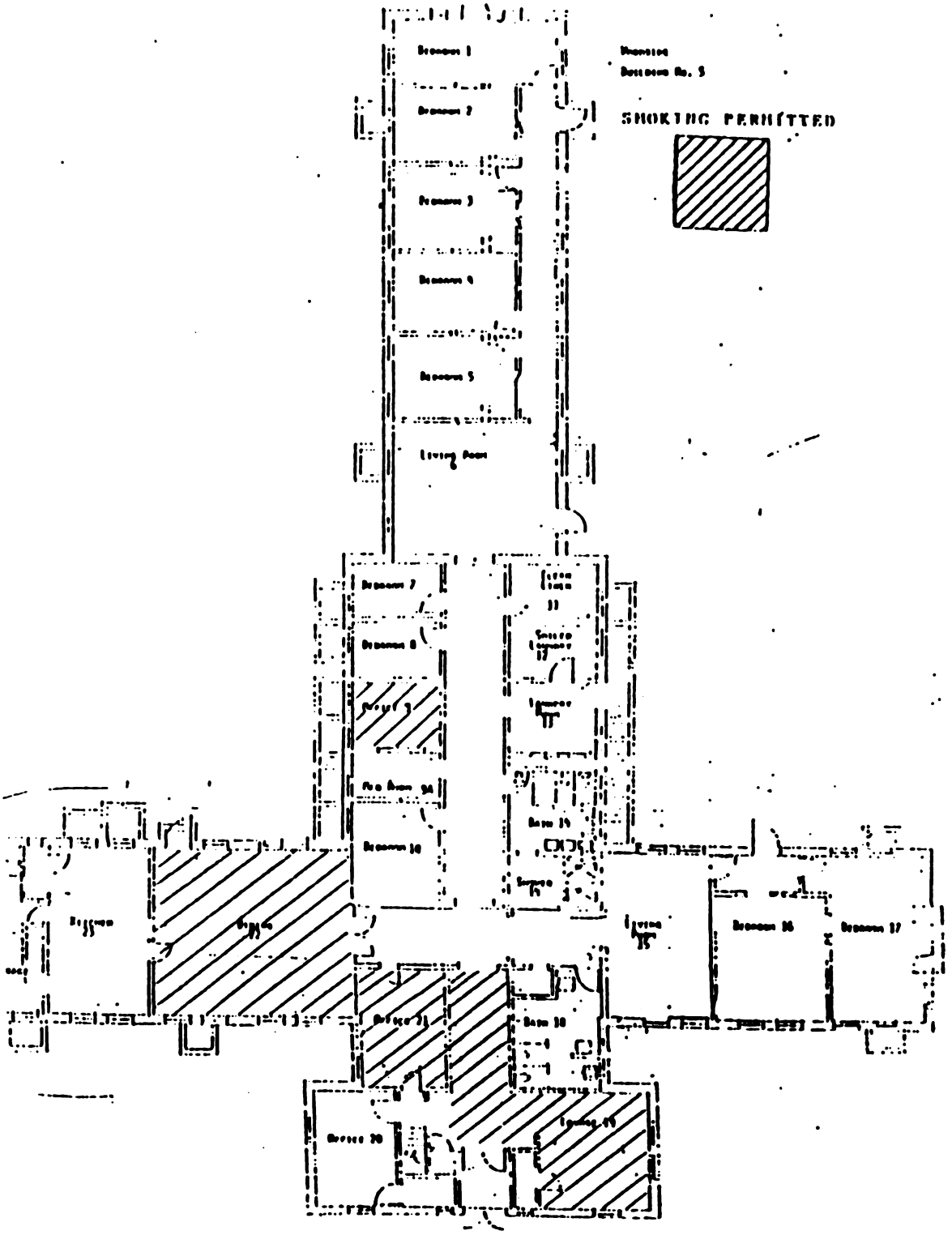
ANSWER SHEET

1.	A	B	C	D		21.	A	B	C	D
2.	A	B	C	D		22.	A	B	C	D
3.	A	B	C	D		23.	A	B	C	D
4.	A	B	C	D		24.	A	B	C	D
5.	A	B	C	D		25.	A	B	C	D
6.	A	B	C	D		26.	A	B	C	D
7.	A	B	C	D		27.	A	B	C	D
8.	A	B	C	D		28.	A	B	C	D
9.	A	B	C	D		29.	A	B	C	D
10.	A	B	C	D		30.	A	B	C	D

	TRUE	FALSE		TRUE	FALSE
11.	A	B	31.	A	B
12.	A	B	32.	A	B
13.	A	B	33.	A	B
14.	A	B	34.	A	B
15.	A	B	35	A	B
16.	A	B	36.	A	B
17.	A	B	37.	A	B
18.	A	B	38.	A	B
19.	A	B	39.	A	B
20.	A	B	40.	A	B

APPENDIX L

ADMITTING UNIT DIAGRAM



TECHNICAL APPROVAL _____ APPROVED _____

APPENDIX M

PERMISSION TO QUOTE LETTERS

STATE OF MICHIGAN

JAMES J. BLANCHARD
Governor

DEPARMENT OF MENTAL HEALTH
Thomas D. Watkins, Jr., Director

CARO REGIONAL
MENTAL HEALTH CENTER

Caro, Michigan 48723-0153
(517) 673-3191

OCT 3 1988

September 26, 1988

PERMISSION GRANTED
Ronald E. McMillan
Director, Publications
and Marketing
Date 10-14-88
Fee none

Send check payable to APA, attn: of
Publications & Marketing
The correct citation for this book is:

Editor-In-Chief
American Psychiatric Press
1400 K. Street, N.W.
Washington, D.C. 20005

TO WHOM IT MAY CONCERN:

I am in the process of completing a Dissertation for a Ph.D. in Counseling Psychology at Michigan State University. The title of my study is Seclusion Room Usage at a State Regional Mental Health Center. As a part of my first Chapter, I have a Section which defines various psychiatric terms. Fortunately, I had as a resource Psychiatric Glossary (1984) with appropriate credit given.

I would like permission to use parts of or all of the following definitions:

Agitation	Etiology
Bipolar Disorder	Hallucination
Deinstitutionalization	Incidence
Delusion	Mental Disorder
Depression	Moral Treatment
Dynamic Psychiatry	Occupational Therapy
Empathy	

Thank you for any consideration you can give me.

Sincerely,

Harry W. Wright

Harry W. Wright
Clinical Psychologist

STATE OF MICHIGAN
JAMES J. BLANCHARD
Governor

DEPARTMENT OF MENTAL HEALTH
Thomas D. Watkins, Jr., Director

CARO REGIONAL
MENTAL HEALTH CENTER

Caro, Michigan 48723-0154
(517) 673-3191

SEP 15 1988

September 13, 1988

John A. Talbot, M.D., Editor
Hospital and Community Psychiatry
1400 K Street, N.W.
Washington, D.C. 20005

Dear Dr. Talbot:

I am a Clinical Psychologist at the Caro Regional Mental Health Center, Psychiatric Unit, and a Ph.D. candidate in Counseling Psychology at Michigan State University. My dissertation topic is "Seclusion room usage at an acute care psychiatric unit of a state regional mental health center". Variables of interest are patient characteristics, various treatment modalities, and staff training. The focus is on how the above effect incidence of seclusion, especially on first time secluded patients.

I am writing to request permission to make use of part of an article published by Hospital and Community Psychiatry, June, 1985. The particular piece of interest was written by Soloff, Guthell, and Wexler, and was entitled "Seclusion and Restraint in 1985: A Review and Update". The parts I want to use are tables I and II, and I wish to adapt them to my study, and include the adaptation as a part of my literature review. I found the article to be very helpful, and I would appreciate having permission to make use of the material; of course, with fitting credit given.

Thank you for any consideration you can give me.

Sincerely,

Harry W. Wright

Harry W. Wright
Clinical Psychologist

cc: Gloria Smith, Ph.D.
Michigan State University

9/16/88

Permission granted provided permission is also obtained from the author. The address for Dr. Soloff given in the article is still current.

Teddye Clayton
Managing Editor

University of Pittsburgh

WESTERN PSYCHIATRIC INSTITUTE AND CLINIC

September 15, 1988

Harry W. Wright
Clinical Psychologist
Caro Regional Mental
Health Center
Lock Box A
Caro, MI 48723

Dear Mr. Wright:

You must obtain permission from the publisher to reproduce published data. (They hold the copyright.) You certainly may use our format to meet your own needs and cite us as a reference.

Sincerely,

Paul H. Soloff, M.D.
Associate Professor
of Psychiatry

PHS/mc

TRAINING PROGRAM SPECIALISTS

270 MICHELLE DRIVE - HOWELL, MICHIGAN 48843
(517) 546-8354

August 25, 1988

Harry W. Wright
Caro Regional Mental Health Center
Lock Box A
Caro, MI 48723

Dear Harry,

I understand that you are preparing a doctoral dissertation and wish to have permission to quote from a document I wrote. Permission is hereby granted to quote from a memorandum dated September 6, 1982, addressed to C. Richard Tsegaye-Spates, Ph. D., Bureau of Clinical and Medical Services, Department of Mental Health, Lansing, MI 48926, RE: Survey of Seclusion and Restraint, including the attached 3 page document titled "Survey of Restraint and Seclusion Use". This permission is extended to any and all use you wish to make of this material.

I am delighted that you are finding this material useful. Please let me know if you require further assistance.

Cordially,

Robert Orlando, Ph. D.

Dear Nancy,

This letter is to verify my granting permission for you to use the following list of materials and any material written by Dr. Martin N. Rall for your dissertation.

1) 5/21/88 testimony before the Michigan House Mental Health Committee
2) Undated memo to Charles Mathis, Dixie Corcoran, etc.
3) May 1, 1987 writing on "A Positive Approach to Behavior Management"
4) A 1985 unfinished article for publication
5) a 2/4/80 proposal on/for psychiatric services.

I am pleased to allow you to use these materials written by my late husband.

Sincerely,
Janice C. Rall
103 Briarcliff Drive
Cadillac, MI 49601
Sept 16, 1988

APPENDIX N

RESEARCH APPROVAL CORRESPONDENCE

STATE OF MICHIGAN

JAMES J. BLANCHARD
Governor

DEPARTMENT OF MENTAL HEALTH
Thomas D. Watkins, Jr., Director

CARO REGIONAL
MENTAL HEALTH CENTER

Caro, Michigan 48723-0153
(517) 673-3191

May 9, 1988

Office for Research and Graduate Studies
Room 230
Administration Building
Michigan State University
East Lansing, MI 48024

RE: UCRIHS review of research proposal by Harry Wright

Mr. Wright has proposed a review of patient records for data collection regarding seclusion room usage in this facility. This would not involve identification of any individual patient, either directly or indirectly. Since Mr. Wright holds a staff psychologist position at this facility, he has legal access to these records as a matter of course in performing his duties. The study would in no way affect the course of treatment of any of the patients.

We strongly support Mr. Wright in this effort, since we feel the information to be obtained might well have a positive effect on our continuing efforts to reduce/eliminate the use of seclusion in our treatment programs.

Sincerely,

Marlin H. Roll, Ph.D.
Facility Director

CARO, MICHIGAN

RESIDENT POLICY

SUBJECT:	RESEARCH			
DATE ISSUED:	3-4-83	POLICY NUMBER:	02.60	PAGE: 1

Whenever the facility initiates a research program, the proposed plan shall be submitted to the Facility Director for consideration. The plan shall include a detailed outline of the program which includes the benefits to be expected, potential risks and discomfort, and possible alternative services which might prove equally advantageous. The plan shall include a listing of all residents proposed for participation in the program as well as the staff conducting the investigation.

Provisions for consent must be outlined to insure confidentiality, privacy and informed consent.

Following the Facility Director's review, the plan shall be reviewed by the Resident Care Committee for adoption.

Final reports of projects are to be submitted to the Facility Director and Resident Care Committee.

REFERENCE: Administrative Rules, 1981, Rule 330.1015
JCAH Consolidated Standards, 1981 Edition, Research, pg. 47.

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

DEPARTMENT OF MENTAL HEALTH

LEWIS CASS BUILDING
LANSING, MICHIGAN 48913
THOMAS D. WATKINS, JR.
Director

March 22, 1988

Mr. Harry Wright, Psychologist
Psychiatric Unit
Caro Regional Psychiatric Hospital
Caro, MI 48723

Dear Mr. Wright:

Contrary to the information I gave you when we spoke by telephone on March 9, 1988, your dissertation proposal, as described, will not require review by the Department of Mental Health Technical Advisory Research Committee. Because your study does not involve direct contact with recipients of departmental services, approval to implement your study is at the discretion of the record holder who, in this case, is Dr. Roll, the facility director. You are responsible, however, for adhering to the confidentiality safeguards as specified in section 330.1748 of Michigan's Mental Health Code. Section 330.1750 concerning privileged communications may also be relevant.

If you have questions or require additional information, I may be reached at (517) 335-0129. I wish you well in the completion of your doctoral studies.

Sincerely,

Jenice L. Rhodes-Reed

Jenice L. Rhodes-Reed, Director
Research Unit

GLRR/kw

cc: Dr. Marlin Roll

MICHIGAN STATE UNIVERSITY

UNIVERSITY COMMITTEE ON RESEARCH INVOLVING
HUMAN SUBJECTS (UCRIHS)
202 ADMINISTRATION BUILDING
(517) 355-2186

EAST LANSING • MICHIGAN • 48824-1046

May 16, 1988

Harry W. Wright
6794 3rd Street
Cass City, MI 48726

Dear Mr. Wright:

Subject: "FACTORS WHICH INFLUENCE THE INCIDENCE AND DURATION OF SECLUSION ROOM USAGE IN A STATE REGIONAL PSYCHIATRIC FACILITY #88-166"

The above project is exempt from full UCRIHS review. I have reviewed this project and approval is granted for conduct of this project.

You are reminded that UCRIHS approval is valid for one calendar year. If you plan to continue this project beyond one year, please make provisions for obtaining appropriate UCRIHS approval prior to May 16, 1989.

Any changes in procedures involving human subjects must be reviewed by the UCRIHS prior to initiation of the change. UCRIHS must also be notified promptly of any problems (unexpected side effects, complaints, etc.) involving human subjects during the course of the work.

Thank you for bringing this project to our attention. If we can be of any future help, please do not hesitate to let us know.

Sincerely,

John K. Hudzik, Ph.D.
Chair, UCRIHS

JKH/sar

cc: G. Smith

APPENDIX O

DIAGNOSES OF PATIENT SAMPLE

DIAGNOSES OF PATIENT SAMPLE SECLUDED/NON-SECLUDED

Number	Diagnosis - DSMIII
	Schizophrenic Disorders
1	295.00 - Schizophrenic, Simple (ICD-9)
23	295.30 - Schizophrenic, Paranoid
20	295.60 - Schizophrenic, Residual
1	295.90 - Schizophrenic, Undifferentiated
	Psychotic Disorders not Elsewhere Classified
5	295.70 - Schizoaffective Disorder
1	298.90 - Atypical Psychosis
	Affective Disorders
3	296.20 - Major Depression, Single Episode
2	296.30 - Major Depression, Recurrent
20	296.40 - Bipolar Disorder, Manic
8	296.50 - Bipolar Disorder, Depressed
2	296.60 - Bipolar Disorder, Mixed
3	296.70 - Atypical Bipolar Disorder
1	296.80 - Atypical Depression
	Paranoid Disorders
1	297.10 - Paranoia
1	297.90 - Atypical Paranoid Disorder
2	298.30 - Acute Paranoid Disorder
	Anxiety Disorders
1	300.30 - Obsessive Compulsive Disorder
	Other Affective Disorders
2	300.40 - Dysthymic Disorder
	Personality Disorders
1	301.00 - Paranoid
1	301.83 - Borderline
	Substance Use Disorders
1	303.00 - Intoxication - Organic Disorder
1	303.90 - Alcohol Dependence, Unspecified
1	304.90 - Unspecified Substance Dependence

	Adjustment Disorder
2	309.00 - With Depressed Mood
1	309.24 - With Anxious Mood
2	309.28 - With Mixed Emotional Features
2	309.40 - With Mixed Disturbance of Emotions and Conduct
	Other Diagnoses
1	310.10 - Organic Personality Syndrome
1	294.80 - Atypical or Mixed Organic Brain Syndrome
3	311.00 - Depressive Disorder, not Elsewhere Classified (ICD-9)
4	V71.09 - No Diagnosis on Axis I

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BIBLIOGRAPHY

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Sense of Place