



Coming together—despite fear, trauma—to reduce restraint and seclusion

Recent dialogues increase understanding around mental health issues

“I don’t even know how many times I’ve been in restraints,” says Nicki Glasser. “I couldn’t talk about it for years, even in therapy. It’s really severe trauma.”

Actually, it’s re-traumatization. Like Glasser, many people come to inpatient psychiatric hospitals with a history of significant violent trauma. For them, being physically restrained against their will—or even witnessing others being restrained—triggers a flood of memories; sometimes people are further harmed, instead of helped.

“That’s why, for me, even after all these years, it’s still so hard to talk about,” says Glasser, Policy Coordinator for the Transformation Center, a nonprofit organization of people with mental health conditions who advocate for change in the mental health system.

Staff, too, experience significant trauma in administering and witnessing restraints (using a mechanical device to tie someone down) and seclusions (placing someone in isolation), says Ken Thompson, M.D., Medical Director for the Center for Mental Health Services, one of three branches of the U.S. Substance Abuse and Mental Health Services Administration (SAMSHA).

Thompson recalls his experience thirty years ago when he worked at an inpatient facility in Massachusetts: “There was a sense of accomplishment in being able to restrain someone without physically injuring anyone. But that sense was heightened by the fear that something could go wrong. It’s an intense circumstance with intense emotions.”

In the late 1990s, a federal investigation and Congressional hearings concluded that “restrained and secluded customers were traumatized and harmed and that many died as a result of these often violent procedures.” (*Psychiatric Services*, February 2008 Vol. 59, No. 2 p. 194)

In response, in 2003 SAMSHA created “A National Call to Action: Eliminating the Use of Seclusion and Restraint.”

As early as 2000, the Massachusetts Department of Mental Health (DMH) began to address restraint prevention. In both 2004 and 2007, SAMSHA announced the availability of eight three-year state infrastructure grants to increase the use of alternatives to seclusion and restraint. The DMH requested funding and received one of the grants in 2004.

In accordance with a stated goal to include input from patients, families, staff, and advocates (Commonwealth of Massachusetts Department of Mental Health Seclusion and Restraint Philosophy Statement, September 18, 2007), DMH subcontracted a portion of the grant to the Transformation Center. In its statement, DMH outlined three goals: preventing the need for restraint and seclusion, using early interventions that reduce the need for restraint and seclusion, and preventing negative consequences when restraint or seclusion cannot be avoided.

Although there was a shared desire to talk about this deeply complex and highly emotional issue between people with mental health conditions and their advocates, and senior clinical and administrative staff at DMH, ultimately the Transformation Center recommended that PCP facilitate dialogues with the two groups. Last summer, during those dialogues, Glasser was one of nearly fourteen participants who did talk about their personal experiences.

PCP’s charge was challenging: To help both mental health advocates and clinical staff share about these emotionally charged experiences and form the relationships needed to work together to reduce the use of restraint and seclusion.

“The chief concern was to avoid a situation where memories might be triggered and people feel emotions



- ▶ associated with the original trauma. We had to work to prevent harmful emotional experiences,” says PCP Vice President Bob Stains, who, along with Program Director Dave Joseph, facilitated the dialogues.

Creating Cultural Change

Thompson describes the institutional challenge around reducing the use of restraint and seclusion and how it is complicated by the fact that these are long-standing practices designed to keep people in hospitals and inpatient facilities from hurting themselves or others:

“Restraint and seclusion are part of the culture of these institutions and until now there have been minimal efforts to change that. So the barrier is that this is a huge cultural change. That’s fueled by the fact that staff feel unsafe if they don’t have these particular tools.

During a restraint, each person is assigned a limb and your job is to immobilize that one limb. And to avoid being bitten. That’s straight out fear. Staff don’t want to harm patients in any way. They go into this work to help people. But fear is a very powerful emotion and eliminating or controlling fear is very difficult.”

“The flip side is that patients have said that being restrained or secluded, or even witnessing these things, is one of the reasons they don’t want to go to a psychiatric hospital,” Thompson explains.

Much was at stake in these dialogues; there would be conversations about intense emotional experiences with numerous complicating factors, not least that the two disparate groups had never before discussed this issue from a personal perspective.

“They were entering uncharted territory,” says Stains. “Participants were concerned about not being fully seen, understood, accepted, or heard. So our work was to create a space where people could let go of these fears enough to participate.”

In order to do that, Stains and Joseph turned to a standard practice at the Public Conversations Project: in-depth preparation. They held several meetings with each group separately, at which they helped participants identify their fears about and their hopes for the dialogues.

“I hoped that we would be heard as human beings about our real experiences in life. Our community is so disenfranchised, discriminated against, oppressed, looked at as less than human or not the same. Something

different needed to happen so that we could experience understanding and connection,” says Glasser.

A core piece of the Public Conversations Project’s practice is thinking about how language impacts people, and the differences between what a speaker intends and how it impacts the listener, says Joseph: “We worked closely with participants to help them be aware of those differences and to ‘mind the gap’ by making very careful choices about their language.” As part of the preparation, participants used role plays to see if their words elicited caring and concern or disconnection.

After significant preparation in the groups’ separate meetings, Stains and Joseph were able to bring everyone together for a series of dialogues. In the end, both DMH staff and advocates had the opportunity to tell their stories, and listen to one another in a new way.

“There was a remarkable change in the way we were able to communicate with one another following the facilitated conversations,” says Bill Scott, Massachusetts Department of Mental Health Project Director for the Alternatives to Restraint and Seclusion Grant.

“Sometimes, when we were in meetings together, we felt misunderstood or, worse yet, judged even though we were all clearly committed to restraint elimination. Trying to find a safe, shared language was complicated by a long history of institutional practices that were not in keeping with the new desire to be inclusive and collaborative. The dialogues helped to shift our language and understanding of one another. We were each able to see the other as real people and equal partners.”

This shift was directly related to the pre-dialogue preparation, says Stains: “In situations like these, people often have a sense of what they want to say, but less a sense of how best to say it. The separate gatherings gave people a chance to work on speaking in ways that were more likely to be heard by people on the other side. So they entered the dialogues feeling much more prepared.”

“There was a different level of honesty,” says Glasser. “It felt very free of the normal sort of oppression and ‘us-them’ dynamics that usually drape over these meetings.

What surprised me was how much you could transform a relationship during a three-hour conversation. It opened the door to real talk about real issues.” ■