



DISABILITY RIGHTS NEW YORK

New York's Protection & Advocacy System and Client Assistance Program

In conjunction with
Mental Hygiene Legal Service,
First Judicial Department

INVESTIGATION REPORT:

USE OF RESTRAINTS ON PSYCHIATRIC PATIENTS AT BELLEVUE HOSPITAL CENTER

725 Broadway, Suite 450
Albany, New York 12207
(518) 427-6561 (fax)

25 Chapel Street, Suite 1005
Brooklyn, New York 11201
(718) 797-1161 (fax)

44 Exchange Blvd, Suite 110
Rochester, New York 14614
(585) 348-9833 (fax)

mail@DRNY.org • www.DRNY.org

(800) 993-8982 (toll free) • (518) 432-7861 (voice) • (518) 512-3448 (TTY)

Table of Contents

<u>EXECUTIVE SUMMARY</u>	1
<u>BACKGROUND</u>	2
<u>SCOPE OF INVESTIGATION</u>	4
<u>INVESTIGATION FINDINGS</u>	5
<i>Use of Restraints</i>	6
1. Finding: Bellevue underreports its use of restraints	6
2. Finding: Bellevue’s use of mechanical restraint is markedly higher than any other similarly populated public hospital in New York City	8
3. Finding: Bellevue uses mechanical restraints more frequently than seclusion, and uses seclusion more than other similarly populated hospitals	10
4. Finding: The use of mechanical restraints on individual Bellevue units varies significantly even controlling for unit demographics, with certain units utilizing mechanical restraints at unusually high rates	12
5. Finding: Bellevue’s use of mechanical restraints on its forensic units occurs at markedly higher rates than at other forensic hospitals in the state	14
6. Finding: One of Bellevue’s two adolescent units restrains patients at a higher rate than any other Bellevue unit and at a much higher rate than child/adolescent units at other hospitals	15
7. Finding: Bellevue’s restraint forms do not require the recording of essential details concerning restraint incidents and do not provide guidance for the use of less restrictive interventions before the imposition of mechanical restraints	16
<i>a. The Restraint/Seclusion Form fails to include essential</i>	

<i>details about the patient and the restraint incident.....</i>	17
<i>b. The Restraint/Seclusion Form should be restructured to require documentation of the use of specific de-escalation and debriefing techniques, which would reinforce that these techniques are mandatory whenever possible.....</i>	17
8. Finding: Bellevue’s mechanical restraint practices do not comport with recommendations by the New York State Office of Mental Health for reducing such use.....	18
9. Finding: Bellevue does not adequately document its use of intramuscular psychotropic medications as a form of restraint.....	20
<u>SUMMARY OF FINDINGS</u>.....	20
<u>RECOMMENDATIONS</u>.....	20
1. Bellevue needs to take immediate, affirmative steps to change how it uses mechanical restraint.....	21
<i>a. Bellevue should focus on de-escalation and less restrictive interventions, including the use of seclusion as an alternative to mechanical restraint.....</i>	21
<i>b. Bellevue should review its current training on the use of mechanical restraint, and ensure that it also teaches effective methods of reducing the frequency of restraint.....</i>	22
<i>c. Bellevue should improve its staff-to-patient ratios to ensure that adequate resources are in place to manage patients in crisis.....</i>	22
<i>d. Bellevue should require debriefing after the use of restraint to help prevent repeated use for individual patients.....</i>	22
2. The Restraint/Seclusion Form should be redesigned to include more patient-specific information and to require documentation of alternative de-escalation methods and less-restrictive forms of intervention.....	23

3. Bellevue should develop and implement a more effective data collection system that accurately tracks the use of restraint and seclusion and accounts for the concurrent use of chemical restraints.....23

CONCLUSION.....24

Index of Tables

Table A: Rates of Restraint per Bed (HHC Data).....	9
Table B: Total Seclusion Incidents (HHC Data).....	10
Table C: Total Mechanical Restraints and Seclusions by Unit (Bellevue Data).....	11
Table D: Total Incidents of Mechanical Restraint by Unit (Bellevue Data).....	13
Table E: Rates of Mechanical Restraint by Unit (Bellevue Data).....	13
Table F: Restraint Incidents and Rates for Bellevue Adolescent Units 21 W and 21 N (Bellevue Data).....	15
Table G: Restraint Incidents and Rates for Child/Adolescent Units at Bellevue and Metropolitan (Bellevue and Metropolitan Data).....	16

Index of Appendices

Appendix A: “Restraints/Calming Room,” Elmhurst Hospital Center (Last Revised August 2014).

Appendix B: “Use of Restraints,” Metropolitan Hospital Center Procedure Manual (Effective November 2014).

Appendix C: “Use of Restraint and Seclusion,” Bellevue Hospital Center (Last Reviewed December 2013).

Appendix D: “Restraint and Seclusion in Child and Adolescent Psychiatry,” Bellevue Hospital Center (Last Reviewed and Revised November 2013).

Appendix E: Operating Certificate, Bellevue Hospital Center Inpatient Treatment Program, New York State Office of Mental Health (March 22, 2014).

Appendix F: Bellevue Data

Appendix G: HHC Response to FOIL Request (May 13, 2016).

Appendix H: OMH Response to FOIL Request (October 7, 2015).

Appendix I: OMH Response to FOIL Request (December 7, 2015).

Appendix J: Metropolitan Hospital Center Response to Request for Restraint Data (October 5, 2015).

Appendix K: Therapeutic Holds Form and Flow Sheet, Bellevue Hospital Center.

Appendix L: Interdisciplinary Integrated Restraint Order and Monitoring Form for Violent/Self-Destructive Reasons, Metropolitan Hospital Center.

Appendix M: Bellevue Response to Report (December 2, 2016).

EXECUTIVE SUMMARY

Disability Rights New York (DRNY) is the designated federal Protection and Advocacy System for individuals with disabilities in New York State. DRNY has broad authority under federal and state law to monitor conditions and investigate allegations of abuse or neglect occurring in any public or private facility, including a psychiatric hospital, providing care, services, or treatment, to individuals with disabilities.¹

The Mental Hygiene Legal Service (MHLS) is the New York State agency responsible for representing, advocating, and litigating for individuals with mental illness. MHLS attorneys work in all hospitals in New York State that provide inpatient psychiatric care. Under Mental Hygiene Law §47.03(d), MHLS is entitled to any and all records or data pertaining to any psychiatric hospital that MHLS deems necessary for carrying out its functions.

Pursuant to their respective statutory authority, DRNY and MHLS investigated the use of mechanical restraints for individuals with mental illness at Bellevue Hospital Center (Bellevue), which is located in Manhattan and has 330 psychiatric beds and a psychiatric emergency program. This report summarizes and analyzes the data collected by DRNY and MHLS for the period of September 1, 2014 through August 31, 2015. Based on that data, DRNY and MHLS found that:

1. Bellevue underreports its use of restraints;
2. Bellevue's use of mechanical restraints is markedly higher than the use of restraints at any other similarly populated public hospital in New York City;
3. Bellevue uses mechanical restraints more frequently than seclusion and at a higher rate than other hospitals operated by the New York City Health and Hospitals Corporation (HHC);
4. The use of mechanical restraints on individual Bellevue units varies significantly, even when controlling for unit demographics, with certain units utilizing mechanical restraints at unusually high rates;
5. Bellevue's use of mechanical restraints on its forensic units occurs at markedly higher rates than the use of restraints at other forensic hospitals in the state;
6. One of Bellevue's two adolescent units restrains patients at a higher rate than any other Bellevue unit and at a much higher rate than child/adolescent units at other hospitals;
7. Bellevue's restraint forms do not require the recording of essential details surrounding restraint incidents and do not provide guidance for the use of less restrictive interventions before the imposition of mechanical restraints;

¹ See generally Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. §15041 *et seq.*; Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. §10801 *et seq.*; Protection and Advocacy for Individual Rights Act, 29 U.S.C. §794e; N.Y. Exec. Law § 558(b).

8. Bellevue's mechanical restraint and seclusion practices do not comport with recommendations by the New York State Office of Mental Health aimed at reducing the use of these emergency measures; and
9. Bellevue does not adequately document its use of intramuscular psychotropic medications as a form of restraint

This report includes recommendations from DRNY and MHLS (see page 21) based on the data and findings discussed below. DRNY and MHLS present this information as a way of encouraging all stakeholders – including HHC and the Office of Mental Health – to take the action necessary to ensure that the use of these non-therapeutic interventions at Bellevue and other hospitals is significantly reduced, if not eliminated.

DRNY and MHLS provided a copy of this report to Bellevue officials on September 23, 2016. The officials were invited to respond to the report's findings and recommendations or otherwise provide information for DRNY and MHLS to consider. Bellevue responded to this report by letter, dated December 2, 2016. This letter appears as Exhibit M in the attached appendix.

BACKGROUND

The physical restraint of patients may occur in psychiatric hospitals only when staff feel that the immediate safety of the patient, staff, or others on the unit is compromised by a patient's current dangerous behavior. Restraint is intended to be a short-term way of keeping the patient from injuring himself or others, and it should be ordered only after a sequence of less restrictive de-escalation techniques have been attempted.²

The physical restraints primarily discussed in this report are mechanical restraints, also known as four-point restraints or wrist-and-ankle restraints. They involve strapping the patient to a bed with all limbs secured.³

In addition to mechanical restraints, facilities also use seclusion (isolation rooms). Seclusion is defined as "the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving."⁴ A third tool regularly used by psychiatric facilities is chemical restraint, or the involuntary injection of psychotropic medications to manage a patient's behavior.⁵ Although mechanical restraints are the primary focus of this report, some observations concerning the use of seclusion and chemical restraints are included herein as well.

Policies governing the use of restraints exist at both the state and federal level:

² Federal regulations define a restraint as:

- (A) Any manual method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely; or
- (B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
42 C.F.R. § 482.13(e)(1)(i).

³ See 42 C.F.R. § 482.13(e)(1)(i)(A).

⁴ 42 C.F.R. § 482.13(e)(1)(ii).

⁵ 42 C.F.R. § 482.13(e)(1)(i)(B).

- *Federal law.* Federal directives mandate that physical and chemical restraints be used only “to ensure the physical safety of the [patient], a staff member, or others.”⁶ Restraints must be authorized by a physician’s written order, which must specify the duration and circumstances under which the methods may be used.⁷
- *U.S. Department of Health and Human Services.* HHS regulations provide that “[r]estraint ... may only be imposed to ensure the *immediate* physical safety of the patient, a staff member, or others *and must be discontinued at the earliest possible time.*”⁸ HHS regulations also require a finding in each instance that restraints are the least restrictive form of intervention and that all other less restrictive methods are ineffective.⁹ HHS policy further sets forth ongoing training requirements for staff who are responsible for using restraints within facilities.¹⁰
- *New York regulations.* New York regulations impose the additional requirement that the condition of a patient in restraints be monitored at least once every 30 minutes.¹¹

Additionally, each hospital included in this report has implemented its own unique set of policies and procedures for the use of mechanical restraints. But even among New York City’s public hospitals, all of which are operated by HHC, policies regarding the use of mechanical restraints differ dramatically.¹² Some hospitals’ restraint policies include comprehensive lists of the de-escalation techniques that should be attempted before ordering mechanical restraints, while the description of such de-escalation techniques in other hospital policies is less extensive.¹³ Some hospitals have a policy of following any restraint episode with a comprehensive debriefing process that includes the patient, the patient’s family (where appropriate), and all hospital staff involved within 24 hours of a restraint incident, while others do not.¹⁴

⁶ 42 U.S.C. § 290ii (b)(1).

⁷ 42 U.S.C. 290ii (b)(2).

⁸ 42 C.F.R. § 482.13 (e) (emphasis added).

⁹ 42 C.F.R. § 482.13(e)(2)(3).

¹⁰ 42 U.S.C. § 290ii-2(b).

¹¹ 10 NYCRR § 405.7 (b)(5). Additionally, the New York Office of Mental Health, which licenses inpatient psychiatric hospitals and units across the state, has also published its own policy on the use of restraint and seclusion, discussed *infra* at Finding 8.

¹² The use of seclusion also differs from hospital to hospital. For example, while Elmhurst Hospital (Elmhurst) does not use seclusion as an emergency intervention on any unit, the same is not true for other HHC hospitals, including Bellevue. See Appendix A, “Restraints/Calming Room,” Elmhurst Hospital Center (Last Revised August 2014) (“Elmhurst Restraint Policy”) at 3.

¹³ *Id.* at 5.

¹⁴ Appendix B, “Use of Restraints,” Metropolitan Hospital Center Procedure Manual (Effective November 2014), (“Metropolitan Restraint Policy”) pp. 9-10 as compared to Appendix C, “Use of Restraint and Seclusion,” Bellevue Hospital Center (Last Reviewed December 2013) (“Bellevue Restraint Policy”). It should be noted that Bellevue has a separate restraint and seclusion policy for children and adolescents. See Appendix D, “Restraint and Seclusion in Child and Adolescent Psychiatry,” Bellevue Hospital Center (Last Reviewed and Revised November 2013), (“Bellevue Child/Adolescent Restraint Policy”).

All of the hospital policies reviewed for this report, however, mandate that physical restraint only be used to protect a patient or others from injury secondary to imminently dangerous behavior. The policies also explicitly acknowledge that mechanical restraints have the potential to be harmful and should only be used after less restrictive methods have failed. For example, the policy at Elmhurst Hospital (Elmhurst) notes that physical restraint “is considered a serious intervention of last resort as it may potentially result in loss of dignity, violation of patient rights and in rare instances, death.”¹⁵ Similarly, Bellevue’s policy states that the administration recognizes that “the use of restraints has the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of an individual’s rights, feelings of isolation and even death.”¹⁶

At Bellevue, patients are placed in mechanical restraints with the help of a team consisting of at least five people, usually men, known as the “Crisis Management Team” (CMT). CMTs are comprised of rotating staff assigned from different units and likely unknown to the patient being placed in restraints. CMT members are responsible for exerting the manual holds deemed necessary to place a patient in mechanical restraints.¹⁷

Medical providers and advocates alike recognize that being placed in mechanical restraints can be a very traumatic experience for patients, especially those who are already in a heightened state of anxiety or agitation.¹⁸ The practice of mechanical restraint often works against the model of trauma-informed care,¹⁹ and mental health officials in New York State have advocated for other, less traumatic approaches to dealing with behaviorally challenging patients.²⁰ In recent years, there has been a movement among treatment providers to reduce the use of both mechanical restraints and seclusion in favor of more therapeutic approaches for individuals in crisis, such as de-escalation techniques aimed at reducing patient agitation.²¹ Many hospitals have implemented, or are attempting to implement, policies and procedures that aim to decrease or eliminate the use of restraints. But reviews of hospitals around the country have found that, despite the change in attitude about restraint among mental health professionals and advocates, restraint orders continue to be given at high rates.²²

¹⁵ Elmhurst Restraint Policy, Appendix A, p.1.

¹⁶ Bellevue Restraint Policy, Appendix C, at 1.

¹⁷ In the context of restraint, a “manual hold” is defined as any instance during which a patient is physically restrained by hospital staff, even in the course of another intervention.

¹⁸ G. Bonner et al., *Trauma for all: a pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK*, 9 *Journal of Psychiatric and Mental Health Nursing* 465 (2002).

¹⁹ Like the use of mechanical restraints, seclusion can prove physically and psychologically traumatic to patients and staff, but has been reported by patients to be less traumatic than mechanical restraint. *See e.g.* B. Christopher Frueh et al., *Special section on seclusion and restraint: Patients' reports of traumatic or harmful experiences within the psychiatric setting*, 56 *Psychiatric Services* 1123 (2005).

²⁰ *See* New York State Office of Mental Health, “Trauma-Informed Care: Positive Alternatives to Seclusion and Restraint” (October 27, 2012) *available at*: <http://www.omh.ny.gov/omhweb/dqm/restraint-seclusion/trauma.html>.

²¹ Peter L. Forster et al., *Staff training decreases use of seclusion and restraint in an acute psychiatric hospital*, 13 *Archives of Psychiatric Nursing* 269 (1999).

²² Eila Sailas et al., *Restraint and seclusion in psychiatric inpatient wards*, 18 *Current Opinion in Psychiatry* 555 (2005).

SCOPE OF INVESTIGATION

In the early months of 2014, MHLS attorneys at the Bellevue Field Office began to notice a significant increase in the use of mechanical restraints. Doctors testifying during judicial proceedings regularly referred to the use of these restraints when describing how the behavior of patients was being addressed. In August 2014, a child with autism was placed in mechanical restraints at least once a day for 36 out of the 43 days that she was hospitalized. In response to this case and others, MHLS began to investigate the overall use of restraints at Bellevue.²³

Initial findings raised significant concerns. Bellevue appeared to use mechanical restraints at a much higher rate than other acute care psychiatric services in Manhattan and the Bronx. To determine whether the rates of restraint used at Bellevue were indeed higher than at other public inpatient psychiatric hospitals in New York City, MHLS began to collect restraint data from Bellevue and other facilities, focusing on the period between September 2014 and August 2015. MHLS then contacted DRNY for assistance in processing and analyzing the collected data in order to formulate this report. The sharing of data between DRNY and MHLS was done in compliance with confidentiality protections under Mental Hygiene Law § 33.13, HIPAA, and 42 C.F.R. § 51.45.

INVESTIGATION FINDINGS

Bellevue has a total capacity of 360 patients: 330 beds spread across 13 units and a capacity of 30 in its Comprehensive Psychiatric Emergency Program (CPEP).²⁴ MHLS asked Bellevue to provide documentation of every instance of restraint or seclusion that occurred on any of its inpatient psychiatric units (including forensic and CPEP) from September 1, 2014 through August 31, 2015.²⁵ The information Bellevue provided showed the use of mechanical restraints on 1,328 separate occasions.²⁶ Additional data used in this report was obtained from HHC through the Freedom of Information Law (FOIL).²⁷ According to this information, physical restraint was utilized at Bellevue on 2,417 occasions during this period.²⁸

²³ Federal and state regulations require that the use of restraint (both chemical and physical) and seclusion be documented. 42 C.F.R. § 482.13 (e); 14 NYCRR § 526.4 (c).

²⁴ Appendix E, Operating Certificate, Bellevue Hospital Center Inpatient Treatment Program, New York State Office of Mental Health, (March 22, 2014). In order to be licensed as a CPEP, the program must meet certain specifications. These include, but are not limited to, providing psychiatric emergency services, crisis intervention, outreach and residence services and extended observation beds. 14 NYCRR § 590. Hospitals applying for CPEP certification must demonstrate a willingness and ability to provide psychiatric services to all persons but especially “ethnic minorities and poor and medically indigent persons.” *Id.* at § 590.5 (2).

²⁵ During the period under review, 3,682 patients were admitted to Bellevue’s civilian psychiatric units, not including its CPEP or its two forensic units, the latter of which are jointly operated with the New York City Department of Correction.

²⁶ In accordance with State and Federal privacy protections, none of the restraint forms collected are reproduced in this report or its appendices. Similarly, no other client-specific information is included. A monthly tally of the forms collected from Bellevue can be found at Appendix F, Bellevue Data.

²⁷ In addition to collecting data on the use of mechanical restraints, we also tracked the use of seclusion at Bellevue and other HHC hospitals during this same period.

²⁸ Appendix G, HHC Response to FOIL Request (May 13, 2016). While we cannot definitively explain the discrepancy between the numbers provided by Bellevue and those provided by HHC, it seems clear that some of the

Because Bellevue is the largest provider of acute care psychiatric services in New York City, DRNY and MHLS analyzed how Bellevue's *per capita* rate of restraint compared to the same rate of restraint in smaller HHC hospitals.²⁹ The analysis controlled for differences in population size by dividing the total number of restraints utilized within a given time period by the *total treatment capacity* of the hospital in question, as opposed to actual admissions. Admissions numbers for all psychiatric hospitals are reported quarterly to MHLS. Because Bellevue failed to include CPEP and forensic admissions in its tallies during this period, calculating a rate of restraint per admitted/treated patients was not possible.³⁰

Use of Restraints

Records confirmed that Bellevue uses mechanical restraints at a much higher rate than other public psychiatric hospitals in New York City. In particular, Bellevue's CPEP, forensic service, and one adolescent unit employ mechanical restraints more frequently than the remainder of the hospital, and at higher rates than comparable hospitals with CPEP, forensic, or adolescent populations.³¹ Hospital culture, staff-to-patient ratios, and insufficient training likely play a significant role in causing this difference.

1. Finding: Bellevue underreports its use of restraints.

In investigating the use of restraints, DRNY and MHLS utilized two mechanisms for obtaining data. First, relying on MHLS's statutory authority to require any psychiatric facility to produce records or data for MHLS review,³² MHLS asked Bellevue to provide the individual forms upon which it records each incident of restraint or seclusion. These forms, which were provided on a weekly basis, enabled MHLS and DRNY to monitor Bellevue's restraints usage in real time and to investigate on an individual basis any incidents that appeared particularly problematic. Second, after the conclusion of the period upon which this investigation was focused, MHLS made Freedom of Information Law (FOIL) requests to obtain complete restraints data for all public hospitals in New York City, as well as state-run facilities.

Troublingly, the data that Bellevue provided in real time, throughout the period between September 2014 and August 2015, massively undercounted both restraint and seclusion incidents, compared to the data acquired through our FOIL requests. According to the accounting provided

statistics contained in this report, which are based on the restraint forms provided by Bellevue, in fact undercount the full extent of mechanical restraint use. *See infra* at pp. 7-9.

²⁹ The HHC hospitals are: Bellevue; Metropolitan Hospital Center; (Metropolitan); Harlem Hospital Center (Harlem); Elmhurst; Coney Island Hospital (Coney Island); Queens Hospital Center (Queens); North Central Bronx Hospital (NCB); Kings County Hospital (Kings County); Jacobi Medical Center (Jacobi); Woodhull Medical Center (Woodhull); and Lincoln Medical Center (Lincoln). Appendix G, HHC Response to FOIL Request (May 13, 2016).

³⁰ Despite multiple requests, Bellevue failed to provide forensic admissions data or data concerning the total number of patients seen in the CPEP.

³¹ Bellevue also orders seclusion far more frequently than other hospitals, though mechanical restraints are much more commonly employed than seclusion.

³² MHL § 47.03 (d) provides that MHLS must be "granted access at any and all times to . . . all books, records or data pertaining to any such facility or place deemed necessary for carrying out its functions, powers and duties," and may require the officers or employees of any psychiatric facility to produce any information that MHLS requests.

by HHC pursuant to FOIL, Bellevue used mechanical restraints 2,417 times during this one-year period.³³ Yet the individual restraint forms provided by Bellevue in real time documented only 1,328 of these incidents, undercounting the number of incidents by more than 1,000. This suggests that Bellevue's documentation of restraint incidents is disturbingly erratic, at best.

The investigation also disclosed additional ways in which Bellevue appeared to be undercounting its use of restraints. For example, MHLS learned from OMH that, in 2014, in response to concerns raised by the Joint Commission,³⁴ all State-operated psychiatric hospitals were instructed to report the restraint necessary to place an individual into seclusion (i.e., hospital staff physically restraining an individual in order to transport him to seclusion) as a separate "manual restraint" incident.³⁵ Accordingly, State-operated hospitals record separate restraint incidents each time that a patient is physically restrained by hospital staff, even in the course of another intervention, such as seclusion. But, as noted above, Bellevue did not document *any* manual restraints used on adults within the investigation period.³⁶ In this respect, Bellevue is not alone. It appears that none of the other HHC hospitals included in this report are separately reporting the manual restraints required to place a patient in mechanical restraints or seclusion. It goes without saying that the reporting requirements should be uniformly imposed, and the Joint Commission should clarify what is required of every psychiatric hospital when reporting restraint and seclusion.

Even more problematically, Bellevue does not appear to be documenting its use of chemical restraints in any respect. The definition of "restraint" under both State and Federal regulations explicitly encompasses a psychiatric medication or pharmacologic measure that is administered to manage the patient's behavior, and the regulations also require that all such restraint usage be documented.³⁷ Although Bellevue's own policy, titled "Use of Restraint and Seclusion," notes that the use of chemical restraint is "prohibited," MHLS has observed that Bellevue, like other HHC hospitals, routinely uses medication to manage patients' behavior, both in conjunction with the use of mechanical restraints or seclusion, and as a separate form of intervention.³⁸ Such medications are administered via intramuscular injection (IM) on an emergency basis.

In response to the FOIL inquiry, HHC reported that Bellevue used IMs on 13,216 occasions between September 2014 and August 2015, but stated that it had "no data that separates emergency

³³ Appendix G, HHC Response to FOIL Request (May 13, 2016).

³⁴ The Joint Commission is an independent, not-for-profit organization that accredits and certifies health care organizations and programs in the United States. *See* www.jointcommission.org.

³⁵ *See* Appendix H, OMH Response to FOIL Request (October 7, 2015).

³⁶ Although the individual restraint forms provided by Bellevue in real time did not document any instances of manual restraints used on adults, it is not clear whether the overall total restraint numbers provided by HHC in response to our FOIL request might include some manual restraint incidents. Although we asked HHC to provide not only the total numbers of restraint and seclusion use, but also "the number of instances in which each possible type of intervention (manual restraint, 4-point restraint, 5-point restraint, chemical restraint wrist-to-belt restraint, and seclusion)" was utilized, HHC responded that it "do[es] not have data that breaks down restraint into the six categories in your request." Appendix G, HHC Response to FOIL Request (May 13, 2016). OMH, by contrast, was able to provide data for each type of restraint used within each of its facilities. Appendix H, OMH Response to FOIL Request (October 7, 2015).

³⁷ *See* 42 C.F.R. § 482.13 (e)(1-B), (4) (i); 14 NYCRR § 526.4(b) (1)(i)(c)(5)(i)(A).

³⁸ *See* Appendix C, Bellevue Restraint Policy at 2. *See* discussion on page 11 below.

injections from others.”³⁹ And although the 13,216 IM incidents seems high, an article published in late 2015 stated that, according to information provided by HHC, Bellevue used 95,959 emergency IMs of psychotropic medications in 2014 alone.⁴⁰ Given that these are overlapping time periods, the vast difference in these numbers is inexplicable.

Moreover, the restraint forms provided by Bellevue in real time did not include a single instance in which IMs were reported as restraints. And HHC’s FOIL response unequivocally stated that “we have no records that identify ‘chemical restraints.’”⁴¹ If Bellevue were properly reporting its use of emergency IM medication as a form of restraint, its total restraint usage would likely be far higher than currently reported.

2. Finding: Bellevue’s use of mechanical restraint is markedly higher than any other similarly populated public hospital in New York City.

A comprehensive review of the data collected establishes that, even accounting for the difference in size, Bellevue uses mechanical restraints at a much higher rate than other New York City psychiatric hospitals. Six HHC public hospitals, including Bellevue, have CPEPs that serve as a common point of entry for persons experiencing acute psychiatric distress. Many of Bellevue’s reported restraints incidents occurred within its CPEP. Bellevue reported 542 CPEP restraint incidents over the 12-month period, accounting for over 30 percent of Bellevue’s total mechanical restraint incidents.⁴² Yet, CPEP’s 30 beds⁴³ accounts for less than 10 percent of Bellevue’s total capacity.⁴⁴

It may be hypothesized that the acute condition of patients in a CPEP could contribute to a hospital’s usage of mechanical restraints. If so, then restraint usage at other hospitals that have CPEPs could serve as a useful point of comparison. But, according to the data provided by HHC, Bellevue’s use of mechanical restraints far outpaced that of any other New York City public hospital with a CPEP, even after controlling for hospital size, as set forth in Table A. Between September 2014 and August 2015, Bellevue used physical restraints on 2,417 separate occasions, according to HHC data. Bellevue’s rate of restraint was 6.7 restraints per bed, while the next highest hospital, Kings County, with 1,089 incidents for the year, used restraints at a rate of only

³⁹ Appendix G, HHC Response to FOIL Request (May 13, 2016).

⁴⁰ See “NYC Hospital Uses Forced Medication to Compel Bloodwork,” Ben Hatten, CityLimits *available at* <http://citylimits.org/2015/12/08/nyc-hospital-uses-forced-medication-to-compel-blood-work>. In its response to this report, Bellevue states that it provided erroneous data to the reporter and, accordingly, represents that the 95,959 figure is a “gross error.”

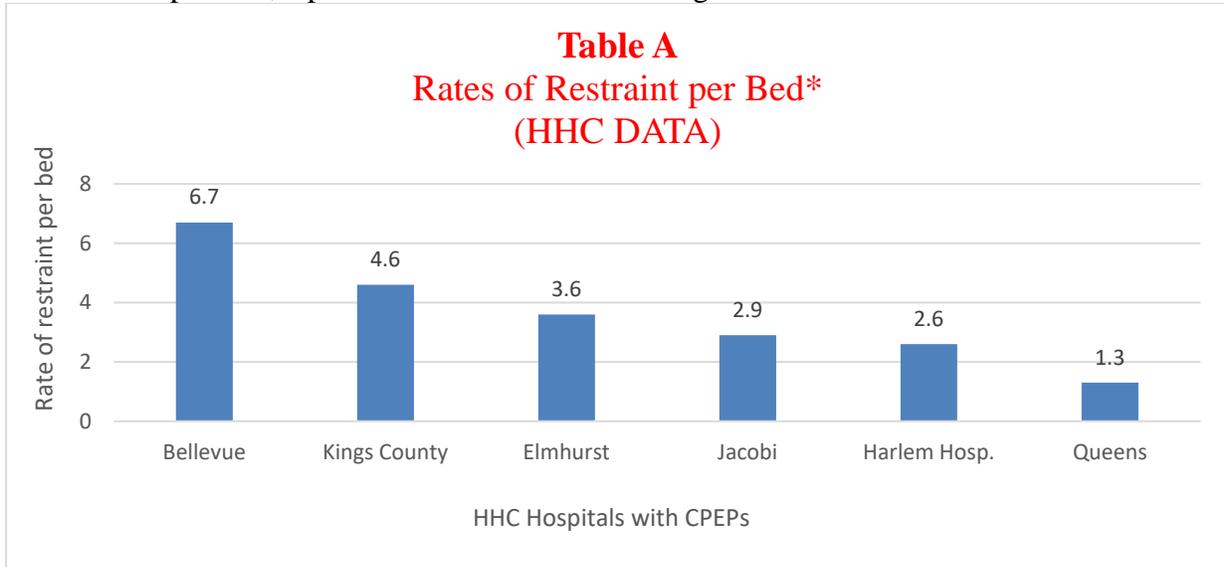
⁴¹ Appendix G, HHC Response to FOIL Request (May 13, 2016).

⁴² Appendix F, Bellevue Data. The restraint information collected from Bellevue does not include restraint (mechanical or manual) and seclusion forms from its Child/Adolescent CPEP. In discussing CPEP, this report does not include Child/Adolescent CPEP, which is a separate unit.

⁴³ In addition to regular psychiatric emergency services, a CPEP includes extended observation beds for patients who may require in-patient admission. For purposes of this report, total CPEP capacity, including extended observation beds, was considered as part of each hospital’s total treatment capacity.

⁴⁴ Because the Bellevue CPEP unit presumably treats many patients in psychiatric crises, it is important to examine the restraint practice in the CPEP separately. In doing so, it must be noted that providing trauma-informed care upon initial contact is of paramount importance, especially for those in crisis, and, even acknowledging that a large number of behaviorally challenging patients arrive at CPEP, the frequent use of mechanical restraint in this setting should be critically scrutinized.

4.6 per bed. At the low end within this group, Queens Hospital, with 120 incidents, utilized restraints at a rate of only 1.3 per bed. Notably, it appears that the rate at which public hospitals use restraints increases with size. Thus, it may be that the added pressures associated with operating a larger psychiatric service could directly result in an increased use of mechanical restraints on patients, a problem that should be investigated and addressed.



*Refers to rates of mechanical and manual restraint combined. See Appendix G, HHC Response to FOIL Request (May 13, 2016).

Importantly, the above numbers for the rate of restraint at Bellevue do not include the use of psychotropic medication as a chemical restraint because, in violation of federal and state regulations, Bellevue does not report the use of emergency psychotropic medication injections as a restraint incident.⁴⁵ Nonetheless, there is ample evidence suggesting that physically restrained patients at Bellevue are frequently given IM medication immediately before or after being placed in mechanical restraints. To determine whether this was the case, MHLS and DRNY reviewed the complete medication logs of a blind sample of Bellevue patients for whom mechanical restraint was reported over a one-month period. The sample, provided by Bellevue administration, included patients across every unit and the CPEP. These documents revealed that orders had been given for emergency IM medications nearly every time a patient was placed in mechanical restraints, yet these intramuscular injections were never reported as restraint incidents.

The data provided by HHC did not separate CPEP restraint from inpatient service restraint; however, even if Bellevue's CPEP numbers are excluded from its overall restraint totals, to enable a comparison with public hospitals that do not have CPEPs,⁴⁶ Bellevue's rate of restraint on its remaining units continues to be disproportionately high. According to the data provided by Bellevue, where CPEP restraint use could be separated out, there were 2.3 restraint incidents per bed between September 2014 and August 2015, excluding its CPEP. By comparison, Metropolitan, a public hospital without a CPEP, had a rate of restraint in the same period of only 0.6 restraints

⁴⁵ See 42 C.F.R. § 482.13 (e); 14 NYCRR § 526.4 (c)(13)(i). See Finding 1, *supra*, and Finding 7, *infra*.

⁴⁶ The HHC hospitals that do not have a CPEP are Coney Island, Lincoln, Metropolitan, NCB (North Central Bronx) and Woodhull.

per bed, averaging only 15 restraint incidents per month.⁴⁷ Had HHC provided data that categorized CPEP restraints separately, Bellevue's rate of restraint excluding CPEP would likely be much higher, given that there were over 1,000 more restraint incidents reported by HHC than by Bellevue.

Similarly, the rates of restraint for other public hospitals with no CPEP are also much lower than at Bellevue. For example, according to data provided by HHC, Woodhull, the facility with the second-highest restraint totals among non-CPEP hospitals, still reported just 536 incidents, or 3.9 restraint incidents per bed.

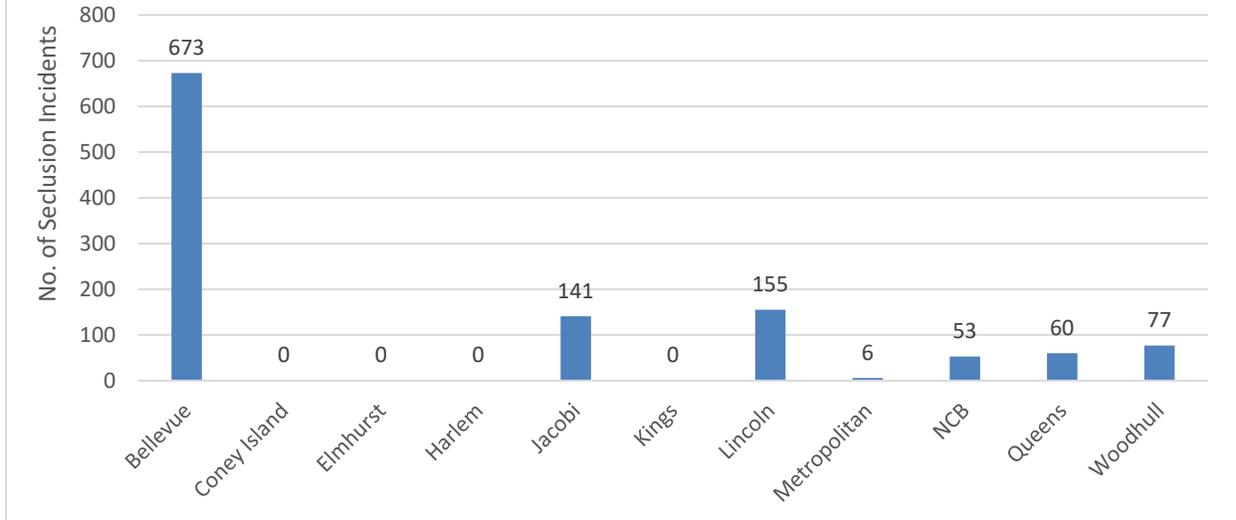
3. Finding: Bellevue uses mechanical restraints more frequently than seclusion, and uses seclusion more than other similarly populated hospitals.

While the above analysis demonstrates that Bellevue used mechanical restraints at a much higher rate than other public hospitals, the data acquired shows that Bellevue also utilizes seclusion at a higher rate than other HHC hospitals, as set forth in Table B. Notably, four of the hospitals in this group, Coney Island, Elmhurst, Harlem, and Kings County, do not use seclusion at all, and Metropolitan stopped using seclusion in January 2015.⁴⁸ Thus, the lower rates of restraint usage at other hospitals is not attributable to an increased use of seclusion; rather, compared to Bellevue, other HHC hospitals utilize fewer restrictive interventions overall. Additionally, based on the data provided by Bellevue, staff do not use seclusion as an intervention in the CPEP. Therefore, even if the data provided by HHC was separated into inpatient and CPEP categories, Bellevue's seclusion numbers would likely remain the same as those captured in the table below, as there would be no instances of seclusion in the CPEP.

⁴⁷ Over the 12-month period for which data was analyzed, Metropolitan reported 69 incidents of mechanical restraint and 36 incidents of manual restraint to MHLS. Appendix J, Metropolitan Hospital Center Response to Request for Restraint Data (October 5, 2015). During this same period, Bellevue reported 781 incidents of mechanical restraint outside of its CPEP. Bellevue did not report any instances of manual holds outside of its children's units. Appendix F, Bellevue Data. The hospitals' self-reported documentation of restraint incidents differed from the general restraint figures (manual and mechanical) provided by HHC: 174 incidents of restraint at Metropolitan and 2,417 incidents at Bellevue. Appendix G, HHC Response to FOIL Request (May 13, 2016).

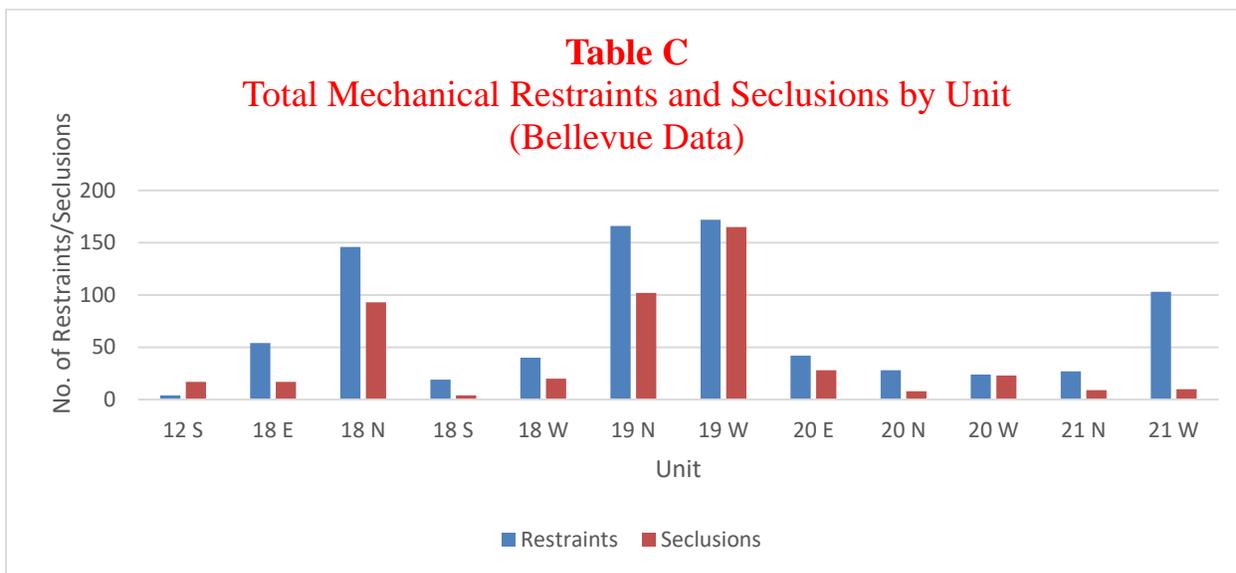
⁴⁸ See Appendix G, HHC Response to FOIL Request (May 13, 2016).

Table B
Total Seclusion Incidents
(HHC Data)



The data collected also demonstrates that despite using seclusion at a higher rate than other hospitals, Bellevue does not attempt seclusion as an alternative intervention before resorting to mechanical restraints. As shown in Table C, with only one exception, all units at Bellevue use mechanical restraints more frequently than seclusion and, in the data provided by Bellevue, rarely was an incident of seclusion documented before mechanical restraints were ordered.⁴⁹

Table C
Total Mechanical Restraints and Seclusions by Unit
(Bellevue Data)



⁴⁹ All analysis regarding separate Bellevue units rests on the individual restraint and seclusion forms provided by Bellevue in real time from September 2014 through August 2015. As noted above, these forms documented far fewer total restraint and seclusion incidents at Bellevue than reported by HHC during that period. According to the data provided by HHC, Bellevue seclusion occurred on 673 occasions as compared 2417 uses of restraint. *See* Appendix G. Thus, the rates of restraint on individual units are likely significantly higher than discussed herein.

To reduce mechanical restraint practice, seclusion should be considered, where appropriate,⁵⁰ as a less restrictive means of addressing a patient who cannot otherwise be de-escalated.⁵¹ Mechanical restraint should be the very last option for patients, rather than an immediate reaction to dangerous behavior. Even putting aside the traumatic effects on individual patients, the frequent use of mechanical restraints on any psychiatric unit can create an environment of fear that works against the goals of trauma-informed care.⁵² A recent study of adolescent psychiatric patients found that they “preferred the use of a seclusion room over bed restraint as confinement in situations in which they may have endangered themselves or their surroundings. They considered confinement by physical restraints to be more threatening than seclusion in a seclusion room.”⁵³ Resorting to seclusion after other de-escalation techniques have failed, but before ordering mechanical restraints, may assist in maintaining healthier milieus.

4. Finding: The use of mechanical restraints on individual Bellevue units varies significantly even controlling for unit demographics, with certain units utilizing mechanical restraints at unusually high rates.

The use of mechanical restraints at Bellevue varies widely from one unit to the next.⁵⁴ While some units reported 30 or more incidents of mechanical restraint during certain months, others reported only two or three. Each unit employed mechanical restraints more than seclusion, with some units using it nearly 10 times more than seclusion over the course of the year.⁵⁵

While some of these differences may be due to unit characteristics, such extremes in reporting cannot be explained by patient demographics alone. These disparities likely reflect, to some extent, a combination of insufficient staff-to-patient ratios, staff approach, and the level of behavioral challenges presented by specific unit populations. For example, on units with an older, gender diverse population, there may be less concern about immediate safety and potential escalation, and thus mechanical restraint may not be an immediately considered option when a patient presents challenging behavior. Thus, not surprisingly, the two all-male forensic units, 19N and 19W, which serve perhaps Bellevue’s most volatile population, have the highest number of inpatient restraints, as set forth in Table D. But, even when the forensic units are excluded, there is wide variation in rates of mechanical restraint use among units.

⁵⁰ Seclusion cannot be used for patients with a sole diagnosis of a developmental disability. It “may be used for persons with a dual diagnosis of a developmental disability, provided that such persons are under one-to-one constant visual observation while in seclusion ...” 14 NYCRR 526.4 (b) (5).

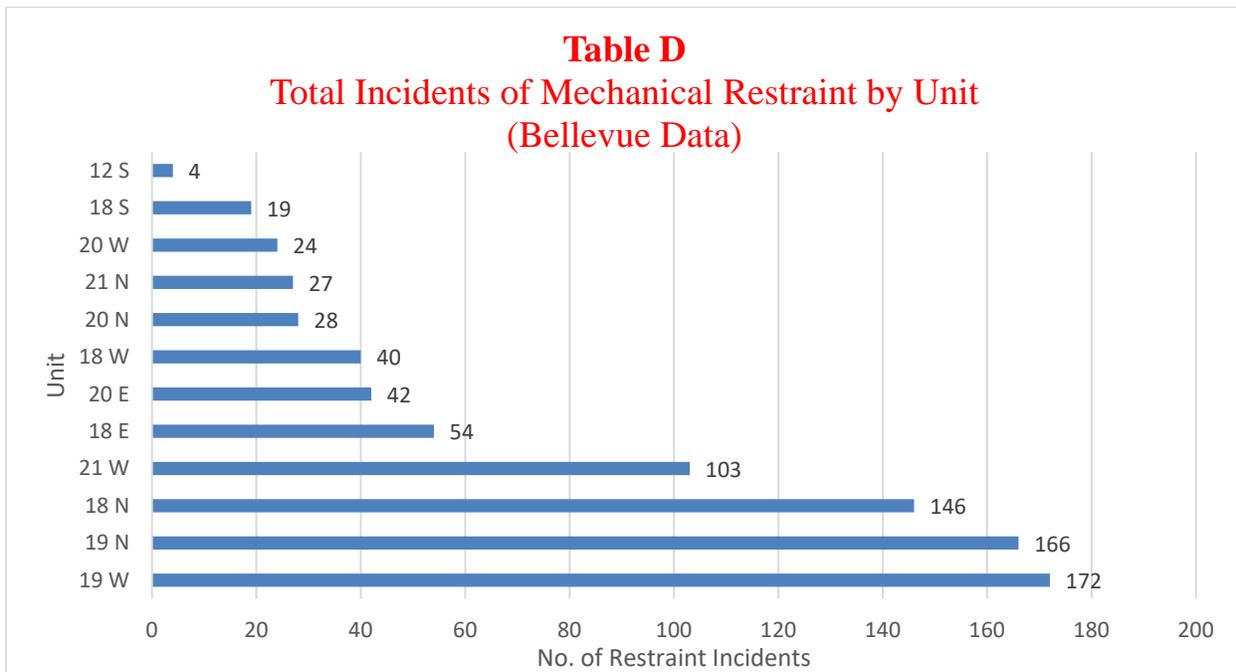
⁵¹ “Seclusion generally is less restrictive than physical restraint because the individual in seclusion can move around within the room or area.” *Restraint and Seclusion: Complying with Joint Commission Standards*, Joint Commission on Accreditation of Healthcare Standards (2002) at 3.

⁵² See Tilman Steinert et al., *Subjective distress after seclusion or mechanical restraint: one-year follow-up of a randomized controlled study*. 64 *Psychiatric Services* 1012,1016 (2014) (“this follow-up study ... provides some evidence that seclusion, a less restrictive alternative, may be associated with less psychological distress [than restraint]”).

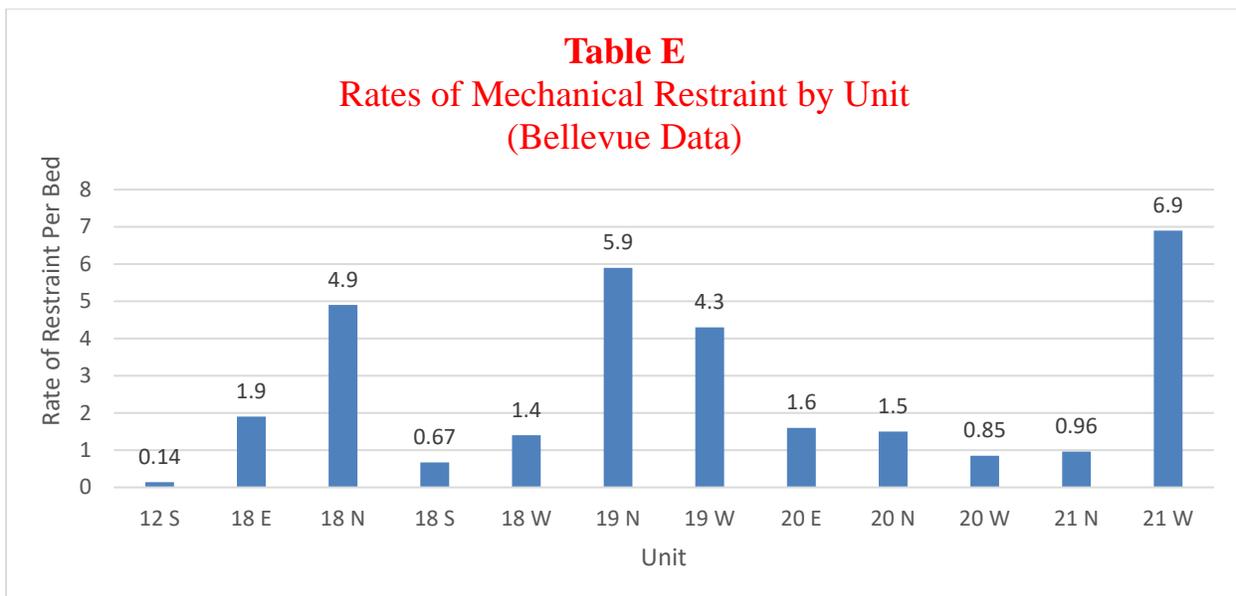
⁵³ Sergey Vishnivetsky, at. al., *Seclusion Room vs. Physical Restraint in an Adolescent Inpatient Setting: Patients’ Attitudes*, 50 (1) *Isr J Psychiatry Sci* 6, 9 (2013).

⁵⁴ As noted above, all data regarding the use of restraints and seclusion on individual units was provided by Bellevue, but the total number of restraints documented therein was less than half of the total number reported by HHC in response to our FOIL request. Therefore, the data for individual units likely significantly undercounts the total restraint usage on those units.

⁵⁵ Total Mechanical Restraints and Seclusions (Bellevue Data), *infra* at p.13.



A glaring example of this variation is found on the adolescent service. As seen in Table F, 21 West, an adolescent unit with a capacity of only 15 beds, had the highest rate of mechanical restraint in the entire hospital – 6.9 per bed – while 21 North, an adolescent unit that also has a capacity of 15, had a mechanical restraint rate of only 1.8 per bed.⁵⁶



⁵⁶ It should be noted that mechanical restraints are not used at all at the New York City Children’s Center, a long-term state hospital for children and adolescents. See Appendix I, OMH Response to FOIL Request (December 7, 2015). Use of mechanical restraints on adolescents is discussed further at Finding 6, *infra*.

Even comparing only the general adult psychiatry units at Bellevue, which are all similar in size and which all treat similarly diverse populations, the rates of mechanical restraint among units remain markedly different. Indeed, 18N's rate of mechanical restraint for the period of September 2014 - August 2015 is 4.9 incidents per bed, the highest of any non-forensic adult unit, and more than seven times the rate of 18S. This discrepancy in frequency of restraint use cannot be attributed to unit demographics, as both 18N and 18S are general adult psychiatry units.

5. Finding: Bellevue's use of mechanical restraints on its forensic units occurs at markedly higher rates than at other forensic hospitals in the state.

As previously stated, Bellevue's forensic units, 19N and 19W, have the highest total number of mechanical restraint and seclusion incidents in the hospital. Unit demographics undoubtedly play a role in these numbers. These units house only men, most of whom are transferred to Bellevue from Rikers Island, New York City's primary jail complex.⁵⁷ Incidents of violence occur so frequently at the main jail complex,⁵⁸ which likely affects unit milieu and treatment considerations, especially regarding how crises are addressed.⁵⁹

But even when compared with other hospitals that serve a comparable forensic population, Bellevue's rates of mechanical restraint are notably high. Bellevue's two forensic units had a rate of 5.9 and 4.3 mechanical restraint incidents per bed between September 2014 and August 2015. In the same time period, Kirby Forensic Psychiatric Center, with 190 beds, utilized four- and five-point restraints at a rate of 3.3 incidents per bed.⁶⁰ While a portion of Kirby's population consists of long-term patients, it also serves a significant population of inmates who, like those at Bellevue, have been transferred from Rikers Island. Other forensic facilities report even lower rates: for example, in 2013, Central New York Psychiatric Center had a restraint rate of approximately 1.1 per bed. To the extent that data was available for the female forensic unit at Elmhurst, the numbers indicate a drastically lower rate of mechanical restraint.⁶¹

Thus, even accounting for the relative volatility of the male forensic population, Bellevue's rate of mechanical restraint on its forensic units is unacceptably high.

⁵⁷ Inmates ages 16 and 17 are at times also treated on the forensic psychiatric service at Bellevue.

⁵⁸ See Mayor's Management Report, September 2015, The City of New York at 82 (available at: http://www1.nyc.gov/assets/operations/downloads/pdf/mmr2015/2015_mmr.pdf).

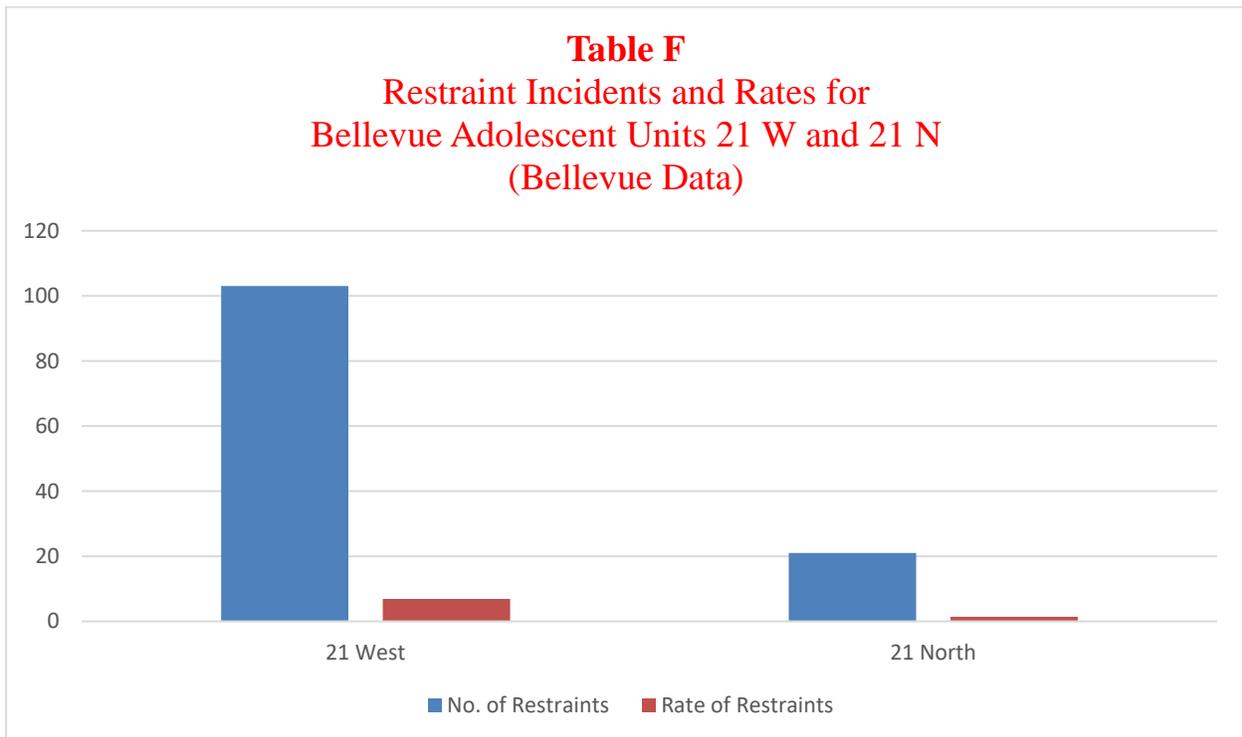
⁵⁹ This phenomenon has been reported by several different studies that examine the characteristics of individuals most likely to be restrained in inpatient psychiatric units. See e.g. William A. Fisher, *Restraint and seclusion: a review of the literature*. 151 American Journal of Psychiatry 1584 (1994).

⁶⁰ Appendix H, OMH Response to FOIL Request (October 7, 2015).

⁶¹ Although MHLS requested individual restraint forms for all units at Elmhurst pursuant to MHL § 47.03, none were provided. The number of restraints reported by Elmhurst did not include data for the entire year, and the hospital did not consistently provide unit-specific data.

6. Finding: One of Bellevue’s two adolescent units restrains patients at a higher rate than any other Bellevue unit and at a much higher rate than child/adolescent units at other hospitals.

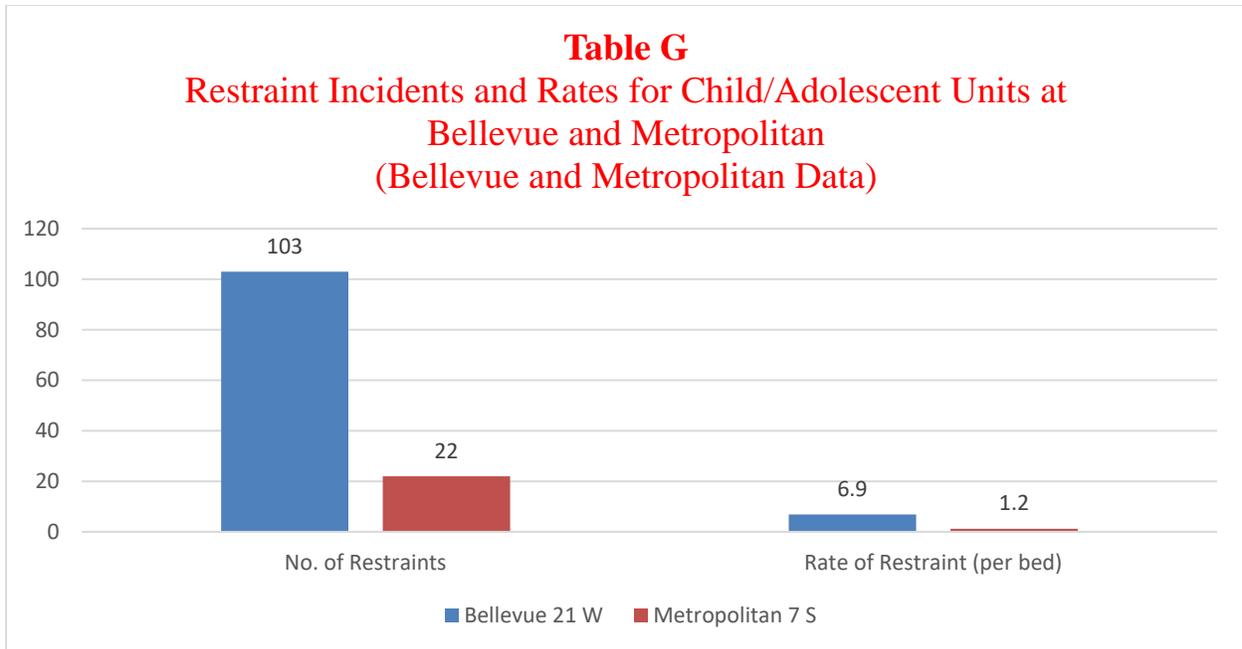
The highest rate of mechanical restraint at Bellevue was found on 21W, an adolescent unit with a total capacity of 15 beds. During the period reviewed, Bellevue reported 103 incidents of mechanical restraint on 21W, bringing its total rate to 6.9 per bed. When compared to 21N, also a 15-bed unit serving adolescent patients, the difference in mechanical restraint use is staggering – it is nearly five times higher on 21W.⁶² Thus, as seen in Table F, a teenager who happens to be hospitalized on the west side of the floor rather than on the north side has a nearly five times greater chance of being placed in mechanical restraints during his or her hospitalization.



Because none of the other HHC hospitals with child/adolescent units provided a breakdown of the number of mechanical versus manual restraints, a direct comparison to another hospital’s acute care unit was not possible. But, as set forth in Table G, Metropolitan’s child and adolescent unit, 7 South, with a capacity of 18 beds, reported only 22 incidents of restraint (manual and mechanical), for a rate of 1.2 restraints per bed, during the period of September 2014 - August 2015, supporting the thesis that the rate of mechanical restraint on Bellevue’s 21W unit is a significant outlier.⁶³

⁶² Bellevue’s children’s unit, 21S, reported no mechanical restraint use. Instead, brief manual holds were used on that unit 63 times during the period reported – a manual restraint rate of 4.2 per bed.

⁶³ Appendix J, Metropolitan Hospital Center Response to Request for Restraint Data (October 5, 2015).



Perhaps most significant to the analysis of data involving the mechanical restraint of children/adolescents is the fact that New York City Children’s Center, a long-term care state facility for children and adolescents, does not use mechanical restraints at all.⁶⁴

The overall use of mechanical restraint on children and adolescents, many of whom are receiving inpatient mental health care for the first time, must be closely scrutinized. A recent study noted that adolescents receiving inpatient care reported feeling “anger, helplessness, sadness and shame from being physically restrained. Perceiving it as a punishment rather than a treatment, they developed behaviors of non-cooperation and doubting the staff’s intentions.”⁶⁵ Although seclusion should be considered before using mechanical restraints on adolescents,⁶⁶ seclusion was ordered for 21W patients only seven times as compared to 103 orders for mechanical restraints.

As on the forensic units, the use of mechanical restraints on 21W is unacceptably high.

7. Finding: Bellevue’s restraint forms do not require the recording of essential details concerning restraint incidents and do not provide guidance for the use of less restrictive interventions before the imposition of mechanical restraints.

The foregoing problems with the use of mechanical restraints at Bellevue may in part be attributable to shortcomings in the structure of its three-page “Restraint/Seclusion Order Form and Flow Sheet” (“Restraint/Seclusion Form”). This is the form Bellevue uses to document the use of

⁶⁴ Appendix I, OMH Response to FOIL Request (December 7, 2015).

⁶⁵ Sergey Vishnivetsky, at. al., *Seclusion Room vs. Physical Restraint in an Adolescent Inpatient Setting: Patients’ Attitudes*, 50 (1) *Isr J Psychiatry Sci* 6 (2013) at 9.

⁶⁶ *Id.* (“This study found that inpatient adolescents preferred the use of a seclusion room over bed restraint as confinement means in situations in which they may have endangered themselves or their surroundings. They considered confinement by physical restraints to be more threatening than seclusion in a seclusion room.”)

mechanical restraints and seclusion. This form, which focuses on the collection of generalized rather than incident-specific information, leads to inaccurate and insufficient reporting as set forth below.

- a. *The Restraint/Seclusion Form fails to include essential details about the patient and the restraint incident.*

The Restraint/Seclusion Form⁶⁷ consists almost solely of check-off boxes that do not provide any room for a discussion of the patient's response to the restraints, the situation requiring restraints, or any other incident-specific details.

Not surprisingly, in light of the generic and limited nature of the Restraint/Seclusion Form, the descriptions provided by staff of the behavior leading to the use of mechanical restraints is often cursory or non-existent. Many forms employ vague descriptions of patients, such as "agitated," "delusional," "hostile," or "aggressive" without indicating specific behavior. One staff member in particular has a pattern of writing only "agitated and potentially assaultive" on all forms for all patients, with no specificity or details to identify individual behaviors or situations that justified the order for restraint. Moreover, the form is often not completed, especially in sections listing "pre-existing medical conditions" and "history of sexual/physical abuse." In these sections, unit staff at times wrote "unknown," although such information should be readily available in the patient's current medical record.

- b. *The Restraint/Seclusion Form should be restructured to require documentation of the use of specific de-escalation and debriefing techniques, which would reinforce that these techniques are mandatory whenever possible.*

The portion of Bellevue's Restraint/Seclusion Form entitled "De-Escalation Process (To be done by the RN)" is merely a series of yes/no questions.⁶⁸ Such questions discourage detailed reporting. Without details about the events surrounding the use of restraints, it is difficult, if not impossible, for Bellevue to create specific future plans for individual patients. Information regarding the underlying causes of behavior which led to mechanical restraints is paramount to avoiding their repeated use.

Similarly, with the exception of therapeutic hold forms currently used on Bellevue's children's unit, the restraint forms utilized at Bellevue do not include any debriefing information.⁶⁹ In order to deter future uses of restraints for an individual patient, it is invaluable to review with the patient, staff, and treatment team what went wrong and what can be done better in the future. For example, the Metropolitan Hospital Procedure Manual notes that "[f]ormal debriefing is a collaborative process among treatment team, patient, and other involved parties, designed to rigorously analyze use of restraint intervention to examine incident that lead to use of restraint and facilitate improved future outcomes by managing event more effectively or preventing occurrence."⁷⁰ Metropolitan's "restraint order and monitoring form" also calls for staff to include

⁶⁷ Bellevue Restraint and Seclusion Order Form and Flow Sheet, Appendix C, Attachment A.

⁶⁸ *Id.*

⁶⁹ Appendix K, Therapeutic Holds Form and Flow Sheet, Bellevue Hospital Center.

⁷⁰ Appendix B, Metropolitan Restraint Policy at 1.

information about the restraint incident from the patient himself: “What precipitated the incident? (From the patient’s perspective) ... How did being placed on restraints make you feel? Could the situation be handled differently? (From the patient’s perspective.)”⁷¹

The Bellevue data revealed numerous incidents of repeated mechanical restraints for individual patients that could have been avoided were more detailed debriefing information required and utilized. For example, one patient was physically restrained for a total of 20 hours over the course of two days; another patient was physically restrained for a total of 14 hours (nine consecutive) between March 9 and March 11, 2015; and a third patient was restrained for a total of 14 hours between May 2 and May 5, 2015. Other patients were likewise repeatedly restrained throughout the course of their hospitalizations. If mechanical restraints are being ordered regularly for an individual patient, that patient’s treatment plan should be closely reviewed and modified with an eye toward avoiding future restraint. Although not a panacea, debriefing information can and should significantly inform this process.

8. Finding: Bellevue’s mechanical restraint practices do not comport with recommendations by the New York State Office of Mental Health for reducing such use.

The goal of OMH regarding restraints, like seclusion, is to significantly reduce, if not eliminate, their use as part of mental health treatment.⁷² OMH has adopted the conclusion of the National Association of State Mental Health Program Directors that restraint is not therapeutic, and thus its use reflects a failure in treatment.⁷³ OMH takes the position that the use of restraint for purposes of managing violent behavior can be significantly reduced through the creation and maintenance of environments that promote hope, recovery, and the empowerment of patients, by implementing strategies to advance positive behavior management, and by emphasizing staff education regarding the risks and safe use of both restraint and seclusion. Thus, it is OMH’s expectation that all facilities authorized to use restraint and seclusion, including New York City hospitals, will develop and actively implement policies and procedures that encourage these results.⁷⁴

As the findings above show, Bellevue’s implementation of such methods diverges significantly from OMH’s policy, as demonstrated by Bellevue’s high rate of use of mechanical restraints. A comparison of OMH’s policy and procedures, as reflected in the OMH Patient

⁷¹ Appendix L, Interdisciplinary Integrated Restraint Order and Monitoring Form for Violent/Self-Destructive Reasons, Metropolitan Hospital Center at 2.

⁷² OMH Official Policy Manual “Patient Care-Patient Management” Directive PC-701, pertaining to “Seclusion and Restraint”, June 10, 2014 at 2; “Setting the Stage: Preventing Violence, Trauma, and the Use of Seclusion and Restraint in Mental Health Settings,” Powerpoint Slides 37-38, available at <http://www.omh.ny.gov/omhweb/dqm/restraint-seclusion/nyspars.html>.

⁷³ “Setting the Stage: Preventing Violence, Trauma, and the Use of Seclusion and Restraint in Mental Health Settings,” Powerpoint Slide 70. In addition, the OMH Directive PC-701 indicates that seclusion and restraint are interventions to be used only as a measure of last resort to avoid imminent injury to the patient or others, and the use of restraint should serve as a prompt for treatment teams to review the effectiveness of treatment approaches in use for the restrained patient. OMH Official Policy Manual “Patient Care-Patient Management” Directive PC-701 at 1.

⁷⁴ OMH “Implementation Guidelines: 14 NYCRR §526.4 Restraint and Seclusion” (July 12, 2016) available at <https://www.omh.ny.gov/omhweb/guidance/implementation-guidelines.pdf> at 1.

Management Directive PC-701, with Bellevue's restraint and seclusion protocol and the implementation of that protocol is instructive.

OMH's protocol limits the time period for all restraint orders to one hour for adults and 30 minutes for patients ages 9 – 17 and it prohibits the use of restraints on children under the age of 9. In contrast, Bellevue's protocol allows restraint orders for adults and children ages 9 to 17 exhibiting violent behavior to be renewed every two hours. Orders for the restraint of children under the age of 9 can be renewed every hour. Bellevue restraint orders for patients with non-violent behavior may be renewed after 24 hours.⁷⁵ These procedures fail to comport with OMH's shorter time limitations and its goal of minimizing the use and extent of restraint and seclusion.

OMH's protocol also discusses strategies for reducing or eliminating restraint. Among the strategies is a requirement that staff employ an individual crisis prevention plan for each patient and develop a mechanism to ensure that all staff, on every shift, are aware of the patients' individual crisis prevention plans.⁷⁶ The protocol requires that, at a minimum, the crisis plans be attached to the patients' treatment plans as well as be compiled into a condensed form readily accessible by all staff.⁷⁷ While Bellevue's protocol does not specifically speak of an individual crisis prevention plan document, it does require documentation in the clinical records of the triggers and behaviors leading to the restraint event and any post-restraint review of the event and changes to the patient's treatment plan.⁷⁸ Beyond documentation of the event, however, the Bellevue protocol does not require that staff on every shift receive information regarding each patients' crisis prevention plan or that such information be readily accessible to staff. Furthermore, as previously discussed, Bellevue does not have a delineated procedure for post-event debriefing with the patient and the treatment team. In the absence of procedures to identify and reduce the use of mechanical restraints for each patient, and based upon Bellevue's considerable use of restraints, including medications, to manage patient behavior, Bellevue's protocol and practice fail to meet OMH's expectation that its licensed facilities will actively implement policies and procedures that encourage the reduction or elimination of mechanical restraints.

Finally, Bellevue's data collection and analysis of incidents of chemical and mechanical restraint, as well as its practices relating to debriefing of staff to improve performance and reduce use of mechanical restraints, fail to comport with OMH goals and standards. The OMH protocol provides for a review of the use of restraint that includes patient evaluation, post-acute event analysis, and an immediate, detailed formal patient debriefing with the goal of reversing or minimizing negative effects and preventing future use of such interventions.⁷⁹ In addition to addressing the needs of the patient, the debriefing serves the additional purpose of addressing staff and organizational issues to improve the process and decrease the use of this intervention. Bellevue's protocol provides for documentation of the restraint event in the medical records, continuous data collection, and monitoring of data for compliance with the Bellevue protocol.⁸⁰ The protocol, however, does not delineate debriefing procedures that include the patient and treatment team, including those necessary to identify opportunities for process improvement.

⁷⁵ Appendix C, Bellevue's Restraint Policy.

⁷⁶ OMH "Implementation Guidelines: 14 NYCRR §526.4 Restraint and Seclusion" at 11.

⁷⁷ *Id.*

⁷⁸ Appendix C, Bellevue Restraint Policy at 7.

⁷⁹ OMH "Implementation Guidelines: 14 NYCRR §526.4 Restraint and Seclusion" 17-18.

⁸⁰ Appendix C, Bellevue Restraint Policy at 9.

Moreover, there is no indication as to which members of the treatment and supervisory staff and/or organizational staff receive and analyze the data.

9. Finding: Bellevue does not adequately document its use of intramuscular psychotropic medications as a form of restraint.

The OMH protocol provides that drugs may be used as a restraint only in rare instances where the degree of harm posed by a patient's behavior necessitates the use of medication to rapidly change the behavior to ensure the safety of the patient and others.⁸¹ The protocol also requires that if the medication is used to manage behavior or restrict a patient's freedom, such use is deemed a restraint and must be identified as such.⁸² Bellevue's protocol identifies chemical restraint as a restriction to manage the patient's behavior or restrict the patient's freedom, and, significantly, prohibits such restraint.⁸³ In contrast to the OMH protocol, however, the Bellevue protocol does not identify instances in which drugs might be used to manage behavior. More importantly, as noted above, despite its prohibition against using medications as restraints, Bellevue staff routinely use medications in the course of physically restraining patients, thus suggesting that the purpose of such use is to manage behavior. Furthermore, both federal and state law require that such use be documented as a restraint, a requirement missing from Bellevue's protocol. Neither the protocol itself, nor Bellevue's practice, comport with federal and state laws or policies and procedures.

SUMMARY OF FINDINGS

Regardless of the context in which Bellevue's use of mechanical restraint is examined, it is clear that this use is alarmingly high. Bellevue employs mechanical restraints more frequently per bed than any other HHC hospital, even when its CPEP, non-CPEP, and forensic units are broken out and compared separately against similarly populated hospitals and units. Yet the use of restraints varies widely among units within Bellevue, with some units showing notably higher rates of mechanical restraint than others. Although Bellevue employs seclusion more frequently than other HHC hospitals, it utilizes mechanical restraints far more frequently than the less-restrictive intervention of seclusion. And, finally, it must be noted that Bellevue is failing to document accurately the use of chemical restraints and adult manual restraints. As a result, it can be assumed that the actual use of restraints at Bellevue during the year reviewed for this report is even higher than the numbers in this report reflect.

RECOMMENDATION

The information reviewed by DRNY and MHLS demonstrates that Bellevue must take immediate steps to decrease its use of mechanical restraint across all units, to ensure that restraints are utilized only as a measure of last resort, to place greater emphasis on alternative de-escalation techniques, and to incorporate formal debriefing into its restraint review process. Bellevue should also actively work to decrease the overall use of seclusion, even as seclusion is properly used as a less-restrictive alternative to mechanical restraints. Additionally, the use of emergency psychotropic medication during incidents of restraint and seclusion is of significant concern. The

⁸¹ OMH "Implementation Guidelines: 14 NYCRR §526.4 Restraint and Seclusion" at 3.

⁸² *Id.*

⁸³ Appendix C, Bellevue's Restraint Policy at 2.

Bellevue administration must take action to improve tracking of the use of emergency psychotropic medication as a form of restraint.

1. Bellevue needs to take immediate, affirmative steps to change how it uses mechanical restraint.

The data reviewed by DRNY and MHLS demonstrates that the use of mechanical restraint is a common practice at Bellevue when a patient becomes difficult to manage. Yet given the availability of less traumatic de-escalation techniques, mechanical restraint should not be so widely utilized. In order to make a clear shift toward creating a more therapeutic environment, the Bellevue administration must prioritize alternative ways to manage patient behavior.

- a. Bellevue should focus on de-escalation and less restrictive interventions, including the use of seclusion as an alternative to mechanical restraint.*

As noted above, mechanical restraint can be a frightening and traumatic experience for patients. Beyond the trauma of being physically strapped to a bed and unable to move one's limbs (often for an extended period of time), patients enduring mechanical restraint may be further traumatized by how they are placed in the restraints. For psychiatric patients who may be acutely paranoid, experiencing auditory or visual hallucinations, or otherwise feeling very ill, this experience can be terrifying. The people on whom these techniques are being used are not only experiencing psychiatric emergencies, but are more likely to be particularly vulnerable persons, such as victims of past physical, sexual, or emotional abuse.⁸⁴

Accordingly, Bellevue should look to the OMH Positive Alternatives to Restraint and Seclusion (PARS) Initiative, which has identified six strategies for reducing the use of restraint and seclusion.⁸⁵ The Substance Abuse and Mental Health Services Administration has also embraced these strategies and posted this information on its National Registry of Evidence-Based Programs and Practices.

Bellevue should also train its staff to consider seclusion as a less restrictive means of addressing dangerous behavior. By definition, if properly executed, seclusion is far less restrictive and traumatizing than preventing nearly all physical movement through mechanical devices. Bellevue's restraint and seclusion forms should be modified to make clear that the use of seclusion is a preferable and less-destructive intervention.

If hospital staff must use mechanical restraint on a patient because other de-escalation techniques have been attempted and failed, it should be recognized that certain patients may find the experience especially traumatic based on their own histories. To that end, Bellevue must build in after-care components to ensure that the trauma of being placed in restraints is acknowledged and addressed by qualified treatment providers. Additionally, Bellevue should continue to work within a model of trauma informed care, and ensure that patients with a known trauma history have

⁸⁴ Sarah L. Desmarais, et.al., *Community Violence Perpetration and Victimization Among Adults with Mental Illness*, 104 American Journal of Public Health 2342 (2014).

⁸⁵ See OMH, "Six Core Strategies for Reducing the Use of Restraint and Seclusion," <https://www.omh.ny.gov/omhweb/dqm/restraint-seclusion/corestrategies.html> (last visited July 28, 2016).

an individualized treatment plan that recognizes, and aims to prevent, traumatization through the use of mechanical restraints.

- b. Bellevue should review its current training on the use of mechanical restraint, and ensure that it also teaches effective methods of reducing the frequency of restraint.*

Bellevue administration should take proactive steps including, but not limited to, following PARS strategies for staff training and reshaping its hiring, training, and job performance practices to promote trauma informed, recovery-oriented, non-coercive care. To that end, Bellevue should review its staff training process with regard to restraint use, with an eye toward developing comprehensive practices that reshape staff perspective on the appropriateness of these techniques. Training content should focus on the importance of trauma-informed, recovery-oriented care, especially given that the frequent use of restraint does not promote that level of care. Training in de-escalation techniques will be particularly important, especially on units where patients regularly exhibit challenging behaviors that may not initially respond to redirection by staff.

In order to inform new training content and strategies, Bellevue should seek input from patients, behavioral specialists, and other psychiatric facilities that have successfully decreased their use of mechanical restraints.

Finally, Bellevue should also design an assessment tool that looks at the adequacy of staff performance when using restraint interventions. This assessment should be regularly tracked and reviewed in order to identify strengths or weaknesses in staff performance and their causes. Future trainings should be oriented to address the identified weaknesses in both individual and team performance.

- c. Bellevue should improve its staff-to-patient ratios to ensure that adequate resources are in place to manage patients in crisis.*

Bellevue administration should also review staff-to-patient ratios to ensure that each unit has the proper number of fully trained staff necessary to ensure and promote trauma-informed, recovery-oriented care. Without these necessary resources, even exceptional staff will encounter difficulty managing patients in crisis.

- d. Bellevue should require debriefing after the use of restraint to help prevent repeated use for individual patients.*

All incidents of restraint use should be followed by debriefing with both patients and treatment providers. Such debriefing should be well documented so that the information generated can be employed to avoid repeatedly placing individual patients in mechanical restraints. Debriefing strategies can include analyzing restraint events to mitigate further trauma and to gain knowledge that informs policy, procedures, and practices. This requires a proactive effort on the part of the Bellevue administration to retrain staff on debriefing practices, as well as making a concerted effort to integrate those practices into the training for newly hired staff.

2. The Restraint/Seclusion Form should be redesigned to include more patient-specific information and to require documentation of alternative de-escalation methods and less-restrictive forms of intervention.

Bellevue should redesign the Restraint/Seclusion Form to require specific and detailed documentation of de-escalation efforts, rather than using a series of check-off boxes. As presently designed, the forms do not make clear the need to consider other interventions that may be effective before mechanical restraints are ordered. The forms should be structured to require documentation of different options available for dealing with difficult patient behaviors.

For example, the current form lists an option to use “wrist & ankle” restraints before “seclusion.” Placing the option for “seclusion” first may remind staff that seclusion is generally a less traumatic intervention for most patients that could be a more effective choice if de-escalation has failed.⁸⁶ Mechanical restraint should be the last option available after all other interventions have been tried, and the form should reflect that less intrusive interventions must be considered first.

3. Bellevue should develop and implement a more effective data collection system that accurately tracks the use of restraint and seclusion and accounts for the concurrent use of chemical restraints.

Data collection provides insights on progress and ensures accountability. Bellevue should improve its data collection system in multiple ways.

First, Bellevue should develop a standardized data collection system for the use of restraint and seclusion. As demonstrated by the wildly different numbers of restraint and seclusion incidents reported by Bellevue and by HHC, the systems in place to document such incidents currently lack standardization. Moreover, the data collection system used should have sufficient specificity to track the type of restraint and the frequency of its use by individual units and staff members. As indicated above, DRNY’s and MHLS’s investigation revealed significant problems with how the Restraint/Seclusion Forms and Flow Sheets are being completed. Current records documenting the use of mechanical restraint are frequently generic and provide insufficient information specific to the patient at issue.

Second, Bellevue must start to track incidents where restraint or seclusion is used in conjunction with emergency psychotropic medication. Under federal regulations, any use of psychotropic medication as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement, and that is not a standard treatment or dosage for the patient’s condition, constitutes a restraint.⁸⁷ Although Bellevue routinely administers IM medications concurrent to placing an individual in mechanical restraints, it does not record these IMs as restraint incidents as required under both federal and state regulations.⁸⁸ Bellevue must therefore revise its policies to

⁸⁶ Again, seclusion may not be used for patients with a sole diagnosis of a developmental disability. *See* n. 56, *supra*.

⁸⁷ 42 C.F.R. § 482.13 (e).

⁸⁸ *See* 42 C.F.R. § 482.13 (e); 14 NYCRR § 526.4 (c)(13).

ensure that co-occurring use of emergency psychotropic medications is properly documented as a separate use of restraint.⁸⁹

Following the adjustment made by New York State-operated psychiatric centers at the behest of the Joint Commission, Bellevue must begin tracking manual restraints, including those used to facilitate mechanical restraints or seclusion. These restraints should likewise be documented on Bellevue's restraint forms.

CONCLUSION

It is clear that Bellevue uses mechanical restraints at a higher rate than other public hospitals. Many units at Bellevue, in particular the forensic units and the CPEP, frequently use mechanical restraints to manage patient behavior. De-escalation is not discussed or adequately documented on forms. In the numerous incidents of back-to-back restraint that were documented in the collected forms, there were no indications that alternative interventions had been attempted before the renewal of subsequent mechanical restraint orders. Meanwhile, there is no separate documentation adequately tracking the concurrent use of chemical and mechanical restraints – occurrences that merit particular scrutiny given that the practice of administering both forms of restraint appears to be standard at Bellevue.

The prevalence of mechanical restraint use lessens the ability of Bellevue to provide patients with trauma-informed care, a critical component of treatment that strengthens treatment outcomes. If the treatment itself, in this case the use of mechanical restraints, is a source of patient trauma, that traumatic experience will undermine the patient/clinician relationship. Additionally, trauma inflicted during a hospitalization may also affect a patient's future treatment compliance, as well as the decision to seek treatment again after leaving the hospital.

The Bellevue administration immediately needs to address its restraint and seclusion policies and practices. Using de-escalation tools that reduce restraint, retraining staff, improving staffing ratios, requiring a more thorough debriefing process, revising its forms for documenting restraint and seclusion, and collecting better data, are critical steps necessary to change the way mechanical restraint is employed at Bellevue. Given that comparable public hospitals in NYC have much lower rates of mechanical restraint use, the foregoing recommendations are reasonable actions that Bellevue should make an immediate priority.

⁸⁹ More generally, although Bellevue utilized IM medication on over 13,000 separate occasions in the year analyzed, not one of these was reported as a restraint. Bellevue should train its staff to document and record any use of medication as a restraint, regardless of whether it occurs concurrent to mechanical restraints or seclusion.