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REPORTS

MENTAL HEALTH SERVICES RECIPIENTS: THEIR ROLE IN SHAPING ORGANIZATIONAL POLICY

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One of the most controversial issues in inpatient psychiatry today is the use of restraint and seclusion. The divergence of opinion on the need for these measures varies both between mental health providers and representatives of the consumer/survivor/ex-patient movement who have themselves been restrained or secluded[1] as well as among providers (Blanch & Parrish, 1990, 1992; Chamberlin, 1985; Cotton, 1989; Fitzgerald & Long, 1973; Fisher, 1994; Gair, 1980; Grigson, 1984; Guirguis, 1978; Gutheil, 1978; Irwin, 1987; Outlaw & Lowery, 1992; Pilette, 1978). In addition, there is wide variation in recommendations for indications and contraindications for restraint and seclusion, as well as for related methodology, safety precautions and documentation requirements in policy and regulation (American Psychiatric Association, 1985; Fassler & Cotton, 1992; Fisher, 1994; Guirguis & Durost, 1978; Tardiff & Mattson, 1984).

The reevaluation of policy regarding this divisive subject occurred at the New York State Office of Mental Health (OMH) at a time when the issues of consumer input and innovation were receiving increased attention nationally (Osborne, 1992). Organizational transformation is motivated partly by the recognition of the need for more efficient operations in times of fiscal constraint for public as well as for private, for-profit agencies (Beatty & Ulrich, 1991; Cohen & Brand, 1990; Osborne, 1992). At-

[1]A note on language: people who have first-hand experience with the mental health system use a variety of terms to describe themselves: consumers, psychiatric survivors, ex-patients, recipients. As there is no single accepted term, the terms listed above will be used interchangeably in this paper.

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tempts to streamline large public bureaucracies have included some of the mechanisms employed by organizations in the private sector. Emphasis on the "customer" for whatever product the agency produces has become central to this effort (Beatty & Ulrich, 1991). Yet characteristics of public agencies differ substantially from those of private for profit organizations, requiring a different approach to recipient input (Osborne, 1992).

These trends have affected the public mental health sector in several ways. State mental health agencies across the country have begun to incorporate into their planning and policymaking decisions the views and opinions of people who have experienced the mental health system. A variety of mechanisms have been used, including the establishment of offices of consumer/expatient affairs within the agency. The office is a vehicle for bringing recipient perspectives into the agency's internal decision-making structure, and plays the role of internal change agent. It is headed by a consumer/survivor/ex-patient director who is a member of the management team and a participant in the policy-making process. The office effects change by bringing the outsiders' perspective inside the organization, changing the nature of the discussion by their very presence, and giving systems reform the legitimacy of a place on the organizational chart (National Association of Consumer/Survivor Mental Health Administrators, 1993; Penney & Hilton, 1994).

THE NEW YORK STATE EXPERIENCE

The New York State Office of Mental Health employs approximately 25,000 people and operates 31 inpatient psychiatric hospitals which serve about 9,500 people at one time. In addition, it operates approximately 200 outpatient programs and is responsible for licensing around 2,000 inpatient and outpatient programs state-wide. The organization is headed by a commissioner who is appointed by the governor. Reporting to the commissioner are an executive deputy commissioner, a chief medical officer, and five deputy commissioners. This organizational approach is described in the literature as a "traditional, hierarchical, centralized, command-and-control mode of organizational design and management practice" (Perlmutter & Gummer, 1994). Organizations that fit this profile are increasingly in the process of being transformed into more self-directed and self-managed entities (Osborne, 1992; Penney & Hilton, 1994).

In March 1992, the commissioner instructed the agency's chief medical officer and deputy commissioner for quality assurance to appoint a task force to study the use of restraint and seclusion and to make recommendations to the commissioner on issues related to their use. This decision was prompted by an internal review of policies as well as media coverage of the issue. The task force, of which the first author was chairman and the third author a member, consisted of a broad spectrum of individuals working in the agency (e.g., therapy aides, directors of nursing, clinical directors and executive directors of state psychiatric centers), staff of the agency's quality assurance division and office of counsel, and a representative from a large municipal hospital. There were, however, no recipients of mental health services on the task force.

The task force met bi-monthly over the following year and engaged in a number of activities: reviewing the literature on restraint and seclusion; surveying state mental health authorities on policies regarding restraint and seclusion; visiting state, municipal, voluntary, and a Veterans' Administration hospital to look at their practices; reviewing a one-month statistical snapshot of restraint and seclusion use in the state hospital system in comparison to a similar study in 1984; reviewing deaths in restraint and seclusion; and discussions with a number of invited guests.

In March 1993, the task force issued its report (New York State Office of Mental Health, 1993) which included 27 recommendations that emphasized staff training initiatives in the prevention and management of violence; methodological modifications in the use of restraint and seclusion; and steps intended to maximize patient and staff safety when restraint and seclusion were used. At the end of its work, members of the task force felt that they had created a balanced set of empirically and clinically based recommendations.

The first indication that this view was not shared by all stakeholders came when the agency's senior staff, which included the director of recipient affairs (the second author), reviewed the draft report. The director, who had not been aware of the task force's existence, was critical of the lack of recipient participation, contending that an issue which so powerfully affects service recipients could not be effectively studied without their participation. She also noted what she regarded as an over-emphasis on the mechanics of restraint and seclusion, and a lack of emphasis on finding ways to reduce the use of these interventions. The director felt that the lack of recipient participation so invalidated the work of the task force that it should be reconstituted and begin its work anew. Although members of the task force saw clearly in retrospect that it had been an error not to include recipients, they were shocked and troubled at the idea that a year of careful work, and what they still regarded as sound recommendations, might come to nought.

The draft report was circulated for comment outside the agency, and a number of recipient groups expressed dissatisfaction with the report. The agency's recipient advisory committee (RAC) reviewed the report at its May 1993 meeting and objected to the absence of recipient involvement, to the content of a number of recommendations, and to the lack of consideration of alternative methods for dealing with dangerous behaviors. The RAC communicated these concerns to the deputy commissioner for quality assurance and requested a meeting to discuss their objections and to offer alternative recommendations.

The commissioner asked the deputy commissioner for quality assurance and the director of recipient affairs to convene a group of recipients to meet with members of the original task force; the combined group met twice during the summer of 1993. The recipient delegation included several members of the OMH Recipient Advisory Committee, individuals who had experienced restraint or seclusion, and a recipient who was also a former mental health therapy aide. Initially, the atmosphere of this workgroup was tense; recipients were upset with their exclusion from the process and felt threatened by the tone of some of the recommendations, while task force members were distressed at being criticized for reasons they did not fully comprehend. There was an uneasy but largely unspoken assumption that it would not be possible for the two groups to reach agreement on issues related to restraint and seclusion.

The discussion began with the recipients expressing strong belief that they must participate significantly in developing the policies that affect their lives. The deputy commissioner for quality assurance acknowledged that the process had been flawed, and asked the recipients to raise issues that they felt were overlooked by the task force. The recipients noted that the report did not articulate a statement of principles to govern the use of restraint and seclusion. It was suggested that had the task force begun their work by developing a goal (such as reducing the use of restraint and seclusion), their recommendations might have been more focussed and more recipient-friendly.

The recipients expressed concern that the report did not acknowledge that there is often a culture of violence on inpatient wards, that staff sometimes provoke or abuse patients and then restrain or

seclude them if they become agitated. Recipients asked that there be more accountability for staff behavior. They also observed that some routine practices on psychiatric units actually increase the potential for violence. Requiring unoccupied people to congregate in a closed space like a dayroom, for example, creates unnecessary tension. Not allowing people privacy and quiet time for reflection and healing is also an exacerbating factor. Recipients suggested that these practices be examined with the goal of replacing unhelpful practices with more beneficial ones.

Some critical issues, the recipients believed, had not been addressed by the task force precisely because none of the members had ever experienced restraint or seclusion. It was noted, for example, that the report was narrowly focused on the mechanisms of control and did not take the individual's feelings about their experience into consideration. Recipients pointed out that many psychiatric inpatients have histories of childhood sexual or physical abuse, and that restraint or seclusion can often retraumatize these individuals. It was suggested that patients be asked in advance what works to calm them in a crisis, so that staff might successfully intervene in these circumstances without resorting to restraint or seclusion.

The face-to-face meetings between professionals from the task force and recipients who were dissatisfied with the task force report had an impact on the professionals. Although they expressed some trepidation at facing a group of critical, even angry, recipients, they had the patience to sit through the emotionally difficult parts in order to deal seriously with the content of the criticisms. They found, perhaps more than they anticipated, that the recipients had crucial first-hand information, different perspectives, and a sensitivity based on their experiential knowledge which contributed substantially to policy discussions about restraint and seclusion. The task force members recognized, as a World Health Organization (1988) document put it, "that consumers of mental health services know more than anyone else about certain aspects of service provision and therefore have both a right to be heard and valuable information to contribute."

In addition to meeting with task force members, the recipient workgroup developed its own set of recommendations on the use of restraint and seclusion. These recommendations focussed on confirming that restraint and seclusion are emergency safety interventions, not treatment; that OMH should have a primary goal of reducing the use of these interventions; and that OMH should address conditions which disempower patients and promote violence. The workgroup also suggested that recipients be involved in training staff on using restraint and seclusion and that individuals be debriefed after episodes of restraint and seclusion to help staff determine how future situations might be deescalated. The group further recommended that OMH facilities having the lowest rates of restraint and seclusion be studied as potential models from which best practice guidelines might be developed.

RECOMMENDATIONS

Over the next year, the two sets of recommendations—those of the original task force and those of the recipient workgroup—were crafted into a final set of recommendations regarding the use of restraint and seclusion in New York State psychiatric centers.

In June 1994, the *Final Recommendations on the Use of Restraint and Seclusion* (New York State Office of Mental Health, 1994) were issued. This report included 26 recommendations which emphasized reduction in the use of restraint and seclusion and recipient input both on the wards and during staff training. The document essentially merged and re-ordered the two sets of recommendations, including most

of the recommendations of both groups, into a final document. Two of the task force recommendations and two of the recipient workgroups's recommendations were not included in the final report. These included an original task force recommendation that there be increased emphasis on physical abilities of therapy aides. Recipients felt that emphasizing physical abilities encouraged an atmosphere of violence. Also dropped was the recommendation of the recipient workgroup that wrist-to-belt restraints not be used as treatment interventions, (Van Rybroek, Kuhlman, Maier, & Kaye, 1987). The recipients had opposed this recommendation because they felt that it was inconsistent with agency policy that restraint should only be used as an emergency safety intervention, not as a treatment modality.

After the task force and recipient workgroup recommendations were merged into a final report, a lengthy process of review by OMH senior staff and the commissioner ensued. This process, which entailed several meetings of the top managers and took several months, did not substantially alter the re-drafted document. The value of this review was that it gave the participants the opportunity to develop a sense of shared ownership of the process and helped to shift the frame of reference of the participants from one of skepticism to acceptance. This process has been described as part of a necessary process to change the cognitive structure of the managers in an organization (Isabella, 1990). The final product signalled a shift of focus for the organization, one that includes recipient viewpoints and criticisms of the organization as it now exists. An example from the final report is as follows:

> OMH and its facilities must address conditions in its facilities which disempower patients and promote violence. Such conditions include: (1) the "culture of violence" on some inpatient wards, where staff often provoke patients to violence and use violence or intimidation to control patients. (2) common ward practices which limit choice and increase frustration and tension. (New York State Office of Mental Health, 1994, p. 8)

The final report was reported on widely in the media, and was the source of new policies and regulations which were written in 1994 and will be implemented in 1995. These policies stress recipient involvement and have a primary goal of reducing the use of restraint and seclusion.

ORGANIZATIONAL TRANSFORMATION

The eventual adoption of new, more humane and sensible policies regarding restraint and seclusion is one facet of the transformation of the Office of Mental Health into a more efficient and responsive organization. Some of the elements described in the literature on organizational transformation are evident in the process described above. These include:

Strong leadership. Leaders of organizations in which innovation has occurred are characterized as having personal characteristics including high self-confidence, persistence, energy, and risk taking (Gummer, 1990, 1992). The leadership of OMH demonstrated these characteristics through the creation of a bureau of recipient affairs, headed by a strong and outspoken advocate, within the Office of Mental Health. The insertion of this strong pro-recipient force within the bureaucracy had the potential to interfere with the inertial forces inherent in a large bureaucracy, which maintains vested interests that have taken years to consolidate (Haveman, 1992; Osborne & Graebler, 1992).

Advocacy within the organization. The presence of an advocate within the organization is a crucial variable for the

success of innovation (Delbecq & Mills, 1985; Giordano, 1977; Penney & Hilton, 1994). The development of offices of consumer/ex-patient affairs within state agencies has brought a new focus on the role of internal change agents. The role of the change agent is to question the dominant paradigm, raise disturbing questions, present possible alternatives, and encourage others in the organization to look with fresh vision at old ways of doing things. The internal change agent exerts pressure from within for systems change, which complements the pressure that external advocates exert on the system. These are different roles that require different sets of skills and different approaches to change. Together, these two forces can bring about innovations that neither would be capable of alone (Penney & Hilton, 1994).

Instilling a "customer" perspective. The presence of a bureau of recipient affairs, headed by a vocal advocate for the recipient perspective within the organization, was a key factor in introducing a "customer" perspective into OMH policymaking. This led to culture shock for some who had been insulated from the realities of service recipients, as illustrated by the surprise of task force members when their carefully crafted and well-intentioned report was criticized for lack of recipient input. With the eventual review and recommendations of the recipient workgroup, experiential knowledge from a recipient's perspective had a strong impact on the tone and content of the final recommendations.

The group that reviews innovations must be separate from line management. In this case, both the original group convened by the commissioner, and the group of recipients formed later, were separate from the usual oversight processes. Indeed, the recipient group consisted of persons who are largely independent from the bureaucracy and experience with self-help and client-run activities. These activities are characterized by flexibility and the use of a nonhierarchal structure in which "people reach across to each other rather than up and down" (Zinman, 1986).

Opportunity for dialogue, with time and support for building modifications into the proposal. Over 500 copies of the *Report of the Task Force on Restraint and Seclusion* were sent for review to organizations and in response to individual requests. The widespread dissemination of the document was one factor that led to the review and input of the recipient workgroup.

One of the most important lessons to be taken from this process is that, although the above-described steps crucial to innovation were undertaken, they were not done so in a carefully thoughtout, planned fashion. The flexibility of the organization in response to criticism allowed the participants to find their way amidst conflicting messages and roles, to reach the ultimate goal of a fair and useful document with an excellent change of implementations.

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