

Seclusion and Restraint as a Last Resort Method: A Brief Report and Student Commentary

Volume 32, No. 1 (2021)

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Abstract

This paper will explore the use of seclusion and restraint and the possible impact it leaves on patients. It will begin by defining and explaining the use of seclusion and restraints, along with the impact of what are often lasting adverse effects. Research shows seclusion and restraints may cause emotional suffering, injury, and a lack of trust between the patient and practitioner. While there may be times seclusion and restraint appear necessary for safety concerns, the negative impact cannot be ignored. For this reason, *The Engagement Model* and the *Violent Safety Program* may be viable alternatives. This topic remains complex, but awareness and the implication of alternative techniques will likely reduce the use of seclusion and restraints and produce a more positive and productive treatment environment.

Key Words:

Seclusion, restraints, coercion, involuntary treatment

Navigating the field of mental health as an ethical practitioner can be challenging. When trying to improve an individual's psychological and emotional well-being, the dignity and humanity of the patient must be preserved, both as a best practice and an outcome. At the same time, other concerns such as safety must be considered. Not all patients will be compliant, and there are times where restraints or seclusion will need to be used to avoid and manage dangerous or harmful situations. While this is not ideal, restrictive safety measures may in some cases be necessary as a last resort.

Seclusion and Restraint Techniques

Seclusion is defined as the confinement of an individual to a room or space where he or she cannot exit freely, whereas restraint is the use of physical restraint, device, or medication used to restrict if not control a person's movement or

behavior (Brophy et al., 2016). Seclusion and restraints have been used in mental health practice for decades, though in recent years have been a source of growing controversy.

The use of seclusion and restraints dates back to the late 1700s. Newton-Howes (2013) describes treatment during this time as *inhumane*, often resulting in patients locked and even chained in unsanitary, poorly lit rooms. It was not until the late 1700s that the environmental conditions for individuals in seclusion began to improve. Newton-Howes (2013) discusses the 'traitement moral' created in 1793, which led to changes in asylums. Newton-Howes (2013) continues to discuss improvements such as The Retreat in northern England founded in 1796, which banned the use of chains and physical punishment. The use of clearly cruel and unusual practices has been better legislated over time, the topic of seclusions and restraints remains complex and controversial.

A study across the United States and Europe found a varying degree of seclusion and restraint use in psychiatric hospitals in different locations, as well as preferred treatment techniques. Al-Maraira & Hayajneh (2019) note physical restraints were favored by the United Kingdom, Iceland, Austria, Germany, Japan, and Norway, while seclusion was preferred in Finland, the Netherlands, New Zealand, and Switzerland. Al-Maraira & Hayajneh (2019) indicated Norway and Wales utilized seclusion on less than 1% of their inpatients, while New Zealand used seclusion on 15.6% of their inpatients. Conversely, the Netherlands reported using restraints on 1.2% of inpatients, while Germany used physical restraints on 8% of inpatients. Additional study information was not provided regarding the period of time these statistics were collected, though the available statistics help illustrate the vast difference between countries regarding their preference and perhaps acceptability of using seclusion and restraint.

The complexity of the techniques is clear, for each mental health facility may utilize seclusion or restraints for varying reasons. This could be due to laws and regulations of the state or country, as well as provider preference. Overall, these techniques continue to be used to promote safety for both patients and providers in situations that may be dangerous or violent.

Vulnerability Factors

Furthermore, there has been research conducted to determine specific characteristics that may attribute to the use or increased use of seclusion and restraint. It has been reported that specific patient characteristics may associate with use or increased use of seclusion and restraint. Patients' cultural background, specific mental disorder, gender, age, and socioeconomic status may be contributing factors to the use of seclusion and restraint. Al-Maraira & Hayajneh (2019) report that immigrants experience seclusion or restraint techniques at a higher rate than native patients. A possible reason for this is due to communication barriers. Language barriers could cause a break in the patient-nurse relationship and the patient may be misunderstood.

Additionally, patients who have complex and prolonged psychotic episodes are often secluded or restrained more often and for longer than patients who have brief psychotic episodes. Al-Maraira & Hayajneh (2019) indicated patients with schizophrenia or bipolar disorder experienced longer durations in seclusion and restraints. Vuckovich & Arminian (2005) suggest how manageable the nurses view a patient and judgement whether or not the episode will escalate likely affects the nurse's decisions regarding safety of staff and patient.

Gender is another characteristic that has produced mixed results. Some studies show that male patients have an increased chance of being secluded or restrained, while other studies have found this not to be true. Additionally, Al-Maraira & Hayajneh (2019) found age was a significant factor, for it was typical for younger patients to experience seclusion and restraints more frequently and for longer periods of time.

Lastly, socioeconomic status often associates with higher likelihood of being secluded or restrained. Al-Maraira & Hayajneh (2019) found that patients of a lower socioeconomic status are more likely to experience seclusion and restraints over a patient who has a high socioeconomic status. These are all characteristics that practitioners may want to be aware of. Particularly, because it is important to be aware of biases that may ultimately worsen the damaging effects of seclusion and restraint.

Seclusion and Restraint Impact

While mental health facilities generally deem these techniques necessary to avoid physical harm, seclusion and restraints can also cause unnecessary suffering, injuries, and possibly even death to both staff and the patient (Ross et al., 2014). Investigations have found the use of seclusion and restraints to result in deprivation of liberty, loss of personal integrity and dignity, and violation of human rights (Brophy et al., 2016). Therefore, these techniques should only be used as a last resort effort to prevent imminent danger, with other, less traumatic techniques being tried first.

Research conducted by Ross et al. (2014) uncovered that in the late 1990’s approximately 142 deaths occurred due to the use of these measures. Deaths are sometimes attributed to the increased risk of psychological and emotional injury the patient experiences while in seclusion or restraints (Ross et al., 2014).

Patients generally deem coercive practices, such as seclusion and restraint, as non-therapeutic and even traumatizing. It has been estimated that approximately 90% of individuals who receive mental health services have a pre-existing trauma history (Ross et al., 2014). In effect, putting a patient in seclusion or restraints may trigger a past traumatic event and thereby interrupt the patient’s recovery. An example from Ross et al. (2014, p. 39):

Thomas spent 6 1/2 hours in seclusion. Thomas was stripped of his clothing and woke up in seclusion clothed only in his underpants. No consideration was given to Thomas’s past history of political imprisonment and torture, or his religious beliefs regarding the removal of clothing. Thomas was not

provided with an explanation of his change of patient’s status (voluntary to involuntary) nor why he was being placed in seclusion. He did not receive a debriefing session after his seclusion experience... As a result of his involuntary seclusion, Thomas now experiences insomnia, nightmares, stress, tension, pain and a lack of trust in the public mental health care service. He continues to have flashbacks of torture, flashbacks of hospitalization and now has chronic depression.

Seclusion and Restraint Research

In focus group research conducted by Brophy et al. (2016), individuals shared their thoughts about seclusion and restraint techniques, including why they should be used less frequently. The focus groups were broken into supportive others (parents, siblings, partners, and advocates) and patients (individuals who experienced or witnessed seclusions and restraints, as well as advocates). Each group had around 30 individuals. From the focus groups emerged six themes, including: Human rights, trauma, control, isolation, dehumanization and ‘other’, and anti-recovery

Table 1: Emergent Themes

Category	Example
Human Rights	“We’ve had people who have come in and said this happened and I don’t know why. I don’t know why they dealt with me this way and why was I thrown on the floor and injected when all I said was please don’t give me any more of that medication it makes me really, really unwell.” - (Supporter).
Trauma	“And I can say that my son is so traumatized by these events, that he lives in fear of being picked up at any stage. He’s marked.” - (Supporter). “...put you in a cell that has no toilet and no air and leave you there for 10 hours and then you’ll be cured, and it’s not...you go in there seeking help and surviving the traumas in your life, but you end up having to cope with even more trauma. It’s pointless.” - (Patient).

Control	<p>“Control for me became a sort of key feature ... because I guess the feeling of the medical staff was that it was out of control...so isolation was obviously a way, the other way was sort of punishment.... The other thing that I thought was interesting, and the feedback I get and being on a unit, is that the idea of medical routine, so if people are not behaving accordingly to the routine...that they need to have their obs taken, they need to have their medication done, and that’s just routine, doesn’t matter what the individual’s state of mind is, so then they have to be kind of contained within that routine.” - (Supporter).</p>
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Isolation	<p>“Deny people their freedom, for example if it’s restraint of freedom of movement, or the freedom to ask questions, the freedom to be able to interact with other people, I mean isolation basically is almost another form of punishment, you’ve been bad, you’ve done something wrong. I mean that’s how I see somebody being isolated. And takes that confidence away, because you must be bad so you are in isolation.” - (Patient).</p>
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Dehumanization and “other”	<p>“You literally just get dehumanized and it’s sort of that once you have become part of that system you do become almost, well not completely, but treated in a sub-human way...” - (Patient).</p>
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Anti-recovery	<p>Seclusion and restraint, the very practices themselves, are sort of very anti-recovery...[Recovery is] all about self-responsibility, self-direction, and then seclusion and restraint is all about someone else’s control, so it doesn’t actually sit with recovery at all.’ - (Patient).</p> <p>‘It’s pretty hard because you can’t even use like some of your strategies you’d use at home because you’re just in these four walls.’ - (Patient).</p>

The views of supporters and patients are important because they are the individuals directly affected by the use of seclusion and restraints. Their concerns should be heard, because they can help improve the techniques that are used in the mental health field and thereby improve the overall quality of care. While the use of seclusion and restraints is unlikely to be fully eliminated due to safety concerns, it is important to understand why and how professionals choose to use seclusion or restraint.

Justifying Seclusion and Restraints

Several qualitative studies have reported both patient and practitioner reactions and feelings

regarding seclusion and restraints. In these studies, the practitioners were primarily registered nurses working in psychiatric settings. Nurses generally acknowledged the benefits of reducing the use of seclusion and restraint, albeit with concerns about safety-related issues. Green et al. (2018) reports that some psychiatric nurses stated their role was to take at least some extent of control of difficult situations and make sure that the staff and patient were safe. This includes utilizing seclusion and restraint when a patient appears at-risk for behavior escalation, which in turn puts risk on staff and the patient themselves. However, Goulet & Larue (2018) report that the nurses often find it difficult to apply

seclusion and restraint protocol, often feeling sadness, guilt, and anguish.

Vuckovich & Arminian (2005) interviewed 17 California nurses to better understand the justification of coercion. Nurses found justifying coercion extremely difficult, and it took a strong pre-existing relationship with the patient to confidently utilize involuntary measures. In order for the nurses to feel confident in justifying seclusion and restraint, there must be an established patient-nurse relationship. Nurses developed relationships with patients by getting to know them, encouraging productive behavior such as taking their medication, and showing the patient that they had their best interest in mind. For example, when put in a situation where they may have to justify coercion, nurses considered many factors including the severity of the illness, danger to the patient, danger to others, and patients' rights. Nurses interviewed in the study by Vuckovich & Arminian (2005) reported finding it difficult to admit when a patient was unable to make a decision for themselves, sharing the feeling that forcible injection was the worst humiliation a patient could experience.

Researchers Vuckovich & Arminian (2005) explain that the nurses all used a similar process before coercion: They would assess the need of the patient, negotiate, and proceed with coercion if deemed necessary. One of the preventative steps involves the nurse negotiating with the patient. Vuckovich & Arminian (2005) explain that when the patient believes that a decision is 'just' even when undesirable, there is a reduction in the stress associated with the outcome and lesser likelihood of a violent response. When negotiation techniques are used, the patient often feels their voice was respected in the decision-making process, even if the decision was against their wishes at the time. Additionally, the nurses used persuasion as a preventative step. This involved the nurses explaining to the patient what would happen if they did not cooperate, such as the use of seclusion or restraint.

In all, Vuckovich & Arminian (2005) concluded their study by finding that nurses generally only

used coercion as a last resort and in cases where there appeared to be an immediate safety issue. While seclusions and restraints are not commonly seen as a positive treatment method, they may be a necessity at times. However, many of the preventative steps mentioned above (relationship building, negotiating with the patient, and explaining to the patient what will happen if they do not follow treatment procedures) may be alternative techniques to seclusion or restraint. Additional alternative techniques include the *Engagement Model* and the *Violent Safety Program*.

Alternative Techniques and Models

There are times when professionals deem it necessary to use force such as seclusion or restraints, but ideally as a last resort option. Due to this, several different models have been developed to treat mentally ill patients in a more humane way that may in turn ease the use of seclusion and restraints. These models attempt to reduce the use of seclusion and restraint by working with patients to learn about aspects of their histories, which may be relevant to their treatment. For example, this may include their past traumatic histories, as well as implementing new tools such as the *Violent Assessment Tool*.

These models provide an opportunity to document what seems to work best for each patient in a crisis or stressful situation. These models are important because they allow the staff to learn more about each individual. This is helpful because not every patient will respond to a crisis or high stress situation the same way. Therefore, these models are put in place to help individualize treatment. Hopefully, by trying out alternative techniques, crisis situations can be de-escalated without the need for the use of seclusion and restraints.

One model that has been adopted by several mental health care systems is *The Engagement Model*. As described by Borckardt (2011), this model is based on four components: trauma seminars to educate the staff, changes in programmatic rules and language, patient involvement in treatment planning, and changes to the physical characteristics of the therapeutic environment. It is hoped that by using

this model, staff would better learn how to effectively and less coercively respond to a situation where a patient may be experiencing distress or significant symptoms. *The Engagement Model* encourages staff to develop the skills to effectively de-escalate crisis situations; hopefully without resorting to the use of seclusions and restraints.

Via *The Engagement Model*, necessary skills are taught to the staff through four separate seminars, one for each component of the model. The trauma seminar informs the staff of the effects that trauma can have on patients. The rules and language seminar focuses on policy and removing or modifying rules that may be too restrictive and perhaps counter therapeutic. Additionally, the therapeutic environment seminar demonstrates how small changes such as the paint color on the walls and decorating techniques can drastically change the treatment environment.

While *The Engagement Model* focuses mainly on generalized factors, *The Violent Safety Program* described by Sullivan (2005) intends to reduce the use of seclusion and restraints while providing a safe and therapeutic environment. Per Sullivan (2005), *The Violent Assessment Tool* uses three steps that involve both the mentally ill individual and staff together. The parts include gathering a detailed history and precipitants to violence, a detailed discussion on how the patient expresses his or her anger/aggression and identifying different strategies for intervention that the patient might find helpful when faced with potential loss of control. Depending on the individual, some of the interventions could include walking away, focusing on breathing, watching television, reading, talking about the situation to staff, alone time and relaxation, meditation, and other calming and recreational activities.

Use of *The Violent Safety Program* and *The Violent Assessment Tool* can help staff to better understand the individual and the techniques that work best for them. Collaborative approaches may help the individual build up a level of trust with inpatient staff, which may in turn improve the effectiveness of interventions and reduce the need for seclusions and restraints.

Research on these models appears limited. It is unclear whether they have been successful in reducing seclusion and restraint when implemented in mental health facilities. Accordingly, there is a need for additional research to determine the effectiveness.

However, mental health facilities report alternatives that they have implemented have been effective, which have similar concepts as mentioned in the *Engagement Model* and *Violent Safety Program*. A study conducted by Newton-Howes (2013) reports that one mental health facility found it important to look into the behavior and cause of the disturbance before resorting to seclusion and restraint. This includes looking at the family history that is on file for the patient, any medical or physical concerns, and measuring the patients' vital signs. Newton-Howes (2013) states that if there are any concerns regarding medical causes for the patient's agitation, then there should be an assessment of the patient before seclusion or restraints. If this is not a viable or safe option, vital signs should be checked immediately after. Additionally, Newton-Howes (2013) explains that combined care is an important finding in the study, in which case as-needed oral medications for agitation may be necessary if de-escalation is not effective. In other words, providing as-needed oral medications may help to prevent the need for seclusions and restraints.

As explained by Newton-Howes (2013) environmental manipulation includes improving patients' comfort. This may include a relaxing atmosphere or room, training staff about emergency psychiatric care and crisis management, and providing respect and sufficient time to patients. A study conducted by Goulet & Larue (2018) quotes a patient saying he would have calmed down if the environment of the seclusion room had been similar to the comfort room, which other patients have generally agreed with. It is possible that implementing more environmental changes into facilities may help de-escalate patients and thereby reduce the use of seclusion and restraint.

Finally, proper therapeutic interactions and check-ins with the patients while in seclusion or restraints is often well-received. Al-Maraira & Hayajneh (2019) explain that, during seclusion and

restraint, there should be regular check-ups to assess the patient's basic needs. This may help to prevent malpractice claims and hopefully prevent further harm to the patient. There are several limitations to consider. For example, escalations may happen quickly, and inpatient staff may need to react quickly for safety reasons. Therefore, if in an escalating and potentially violent situation, nurses may choose seclusion or restraint. This also depends on the alternative techniques available in their facility, education staff have received regarding crisis management, and knowledge and familiarity with the patient. Additional limitations include staff not having enough time to spend with the patients to form a therapeutic alliance or determine what the patient deems effective or de-escalating. Without having a solid relationship and additional knowledge, the currently proposed techniques may be less likely to be effective in terms of preventing coercive measures. Finally, advanced and ongoing training would be an additional and considerable expense to under-resourced mental health facilities. These are all important limitations to consider when viewing alternative techniques.

Conclusion

The techniques mentioned in this paper will hopefully improve patients' emotional and psychological well-being, preserve their dignity as much as possible, and reduce the use of seclusion and restraint. This would promote recovery in the manner envisioned by Deegan (2007). If *The Engagement Model* and *The Violent Assessment Tool* are utilized more readily, seclusion and restraints may be used less often. By doing so, the patient may be less re-traumatized by the process of hospitalization, and therapeutic experiences will occur more frequently. However, it should also be noted that these alternative techniques will likely work best for less seriously or imminently violent patients. It may be too risky to use therapeutic techniques when there is imminent risk of harm to other patients or inpatient staff. While patients' well-being is a primary concern, it should not surpass the safety of the staff. This is why seclusion and restraint should be kept as a policy as a last resort technique.

In such cases, there should be a focus on how to improve the patient experience *when* seclusion and restraints are deemed necessary. When reviewing research on patient experience with seclusion and restraint, a common theme in their reactions is that of punishment, traumatization, and confusion. It is possible that traumatic effects can be lessened via intermixing therapeutic approaches before, during, and after coercive processes.

Importantly, patients described seclusion and restraints as punishment for acting out behavior (Brophy et al., 2016). It was also stated many times that patients felt confused as to why they were being punished or put into seclusion and restraints (Brophy et al., 2016). Such experiences are clearly damaging to the psychological and emotional well-being of patients, and in opposition to a productive treatment plan.

To help improve the coerced patient experience, Vuckovich & Arminian (2005) advise de-briefing sessions should follow the use of seclusion or restraints. The debriefing sessions could help the patient to further understand why the use of seclusion or restraints was necessary, review the approaches used before the last resort procedure, and explore how to avoid the use of seclusions and restraints in the future (Vuckovich & Arminian (2005)). Finally, individual therapy sessions could be offered to the patient after the use of seclusion and restraints to help address damaging aftereffects.

Implications for Practice

While reducing the use of seclusion and restraints may be controversial, and not without safety risks, there would be benefits as follows. Reduced coercion would likely associate with improved patient-provider relationships, which could occur through implementing *The Violent Assessment Tool* and *The Engagement Model*. These tools can help to promote a more therapeutic environment and improve treatment. While crises and safety issues requiring at least some extent of coercion are inevitable, de-briefing sessions may help to manage patient after-effects. Debriefing sessions are common in inpatient settings, though offering of

individual therapy thereafter could be something of a growing edge.

Individuals that have experienced or witnessed mental health care have spoken on the issues in previously discussed research. It has been demonstrated how coercive measures such as seclusion and restraint can be extremely damaging to the patients' well-being and have lasting effects on their receptivity to mental health care. While safety is a constant concern in dangerous inpatient hospitals, the voices of those who have experienced or witnessed this treatment should be heard. Their feedback has allowed for coercion-alternative techniques to be created. If better implemented, alternative techniques may help mental health professionals to better serve patients and, in many cases, stay safe themselves.

Acknowledgments

I would like to acknowledge Dr. Graham Danzer for his input and guidance. While working on this paper Dr. Danzer has provided an invaluable amount of insight and support. His comments, edits, and willingness to assist has greatly improved this research paper.

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