**APA RESOURCE DOCUMENT**

Approved by the Joint Reference Committee
February 2022

# Seclusion or Restraint

AMERICAN PSYCHIATRIC ASSOCIATION

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# RESOURCE DOCUMENT ON SECLUSION OR RESTRAINT

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This resource document is intended to support psychiatrists and other healthcare clinicians who may utilize seclusion or restraint. This document is not intended to be comprehensive or completely systematic in nature, nor is it a practice guideline. It is highly recommended that all providers consult with their facility/practice administrator, risk manager, and legal counsel as well as local, state, and federal regulations as it pertains to the use of seclusion or restraint, especially in special populations**.**

**Prepared by the Patient Safety Work Group of the Council on Quality Care**
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Seclusion or restraint (S/R) is used as an intervention of last resort in the management of severe agitation in patients. These interventions carry considerable risks including, but not limited to, psychological distress, physical injury to the patient or staff, and/or death. Legally, S/R can only be used in emergency safety situations and only when all lesser restrictive interventions have been attempted, in order to prevent immediate harm to a patient or others. An extensive literature exists regarding the fundamental goal of providing psychiatric care that helps to avoid the use of S/R [1, 2]. Clinicians often have a limited understanding of the potential risks of each intervention. A framework for determining when to use either modality is a critical clinical concern. The American Psychiatric Association (APA) issued a resource document on the use of S/R in correctional mental health care settings in 2006 [3, 4]. Prior to this, an APA task force had issued a report and guidelines on the psychiatric uses of S/R, but this report and a subsequent addendum are now 40 and 30 years old, respectively, and as the report pointed out, the evidence at the time was limited [5, 6]. In November 2020, the APA Assembly approved Action Paper 2020A2_12.A entitled, “Selection of Seclusion, Restraint, and How to Choose Between These Modalities” [7]. The APA delegated to the Patient Safety Work Group (PSWG) the task of developing a resource document to help guide the use of S/R based on patient experience/preference and clinical considerations.

In this resource document, the PSWG of the APA Council on Quality Care outlines a set of practical considerations for using S/R (See Table 1) and provides resources to increase awareness and highlight areas of importance for psychiatrists and other mental health care clinicians, who are providing psychiatric care for adults in emergency and hospital settings. Many of the same principles apply to other special populations (e.g., children), and some references and resources are provided where relevant, but are not the main focus. This resource document aims to promote patient-centered care and discuss practical matters, including aspects of S/R choice, when these interventions are deemed to be warranted. Topics

discussed include: patient's perspective, risks, trauma-informed and cultural competency (impacts of social determinants of health in general, and racial/ethnic disparities in particular), evidence-based practices, prevention of injury and death, overall quality and safety, the role of psychiatrists, and facility design.

It is recommended clinicians review the literature periodically for new evidence on S/R use in psychiatric care, best practices, and regulatory changes. A suggested background reading list is provided in Table A1 in the APPENDIX. The following set of considerations were developed by the PSWG and approved by the APA Council on Quality Care. These are intended to assist the development of policies for use of S/R. The goal is to encourage appropriate use of these interventions with special attention to the needs of both staff and patients and should not be construed as guidelines or mandates.

| **Table 1: Considerations in the Use of Seclusion or Restraint** | |
|---|---|
| **1.** | Decision-support algorithms help guide the use of seclusion or restraint. |
| **2.** | Understanding the clinician's role in seclusion or restraint can lead to more appropriate use of these interventions. |
| **3.** | Understanding the risks can reduce harm when using seclusion or restraint. |
| **4.** | Advocating for availability of environmental interventions including seclusion rooms can minimize the need for restraint. |
| **5.** | The patient experience of seclusion or restraint is important when considering use of these interventions. |
| **6.** | A culturally competent, trauma-informed, and patient-centered approach is necessary when making decisions about whether to use seclusion or restraint. |
| **7.** | Patient preferences and psychiatric advance directives are critical when considering the use of seclusion or restraint. |

**Consideration #1: Decision-support algorithms help guide the use of seclusion or restraint.** Agitation is defined as a hyper-aroused state (ranging in severity from anxious and cooperative to violent and combative) in which the individual exhibits excessive, repeated, and purposeless motor or verbal behaviors (e.g., pacing, fidgeting, clenching fists or teeth, prolonged staring, picking at clothing or skin, responding to internal stimuli such as hallucinations, threatening or carrying out violent acts). It is important, and in some jurisdictions mandated, to develop protocols and decision-support algorithms for staff to safely manage agitated patients in acute care facilities such as emergency departments and inpatient psychiatric hospitals. The following are principles or key points for consideration in developing such protocols, some of which may be legally required depending on the jurisdiction:

1. The overarching goal in the management of agitation is to help the patient regain control over their behaviors so that they can participate safely in their evaluation and treatment [11].

2. Clinicians should aim to maintain the patient's dignity and opportunities to express a choice or preference to the extent possible, including use of the least restrictive method of intervention (e.g., techniques in verbal de-escalation) to facilitate clinical patient assessment, medically indicated treatment, and to ensure the safety of the patient and others [11-14]. S/R are primarily indicated to protect a patient, the staff, and others from injury [15]. S/R should be used as interventions of last resort to prevent harm to patients or others, when less restrictive means have failed (e.g., verbal de-escalation, environmental interventions, oral medications, described in greater detail below), and for the least amount of time necessary [12, 15]. These details ("last resort", "less restrictive means" and minimum time requirement) are codified in many state and federal laws. It is important to note that the concept of using "less restrictive means" prior to implementing S/R does not mean that a patient or staff harm, or destruction of property, must have already occurred prior to use of S/R. In other words, S/R should be used after less restrictive means have failed, and before harm occurs.

3. Verbal de-escalation techniques are the first-line treatment for patients who are agitated and can be effective for a majority of patients in a behavioral health crisis within 5 minutes [12]. All staff should be trained, capable, and competent in the use of verbal de-escalation, including security and other staff assigned to patient observation roles (for example using the "ERASER" mnemonic, see APPENDIX). The use of appropriate de-escalation techniques should take precedence and be attempted prior to use of S/R, whenever possible and clinically appropriate [12, 14].

4. Environmental interventions should be provided, to decrease stimulation, promote calming, and decrease access to means to harm self or others. These may include moving the patient to a lower stimulation area, use of a quiet room or a sensory room, listening to music, taking a warm shower, using a weighted blanket or vest, aromatherapy, engaging in an activity such as exercise, group therapy, art therapy, occupational therapy or other programming, meditative activities, and close observation or one-to-one observation with a person trained in de-escalation. In certain environments that are not specifically designed for S/R (for example in many medical emergency departments or inpatient medical units), environmental interventions to promote safety may include removal of unnecessary medical equipment or other objects that could be used to harm self or others [12,14].

5. Patients should be initially assessed (ideally upon admission to a facility) to obtain information, including collateral, that could help minimize the use of S/R, including whether there is a Psychiatric Advance Directive (PAD) in place (see Consideration #7). Clinicians should attempt to perform an appropriate patient assessment to identify and manage clinical conditions that may be contributing to a patient's agitated, combative, or violent behavior [16-18].
    a. Agitation has varying presentations on a spectrum, ranging in severity from anxious and cooperative to violent and combative.

b. The patient may not have the ability to understand the situation or the dangers of their behavior or follow directions because they lack insight and/or self-awareness. Staff should be particularly mindful to avoid threatening or aggressive language with such patients.
c. The potential causes of agitation are numerous and varied and can include medical and/or psychiatric and/or substance use conditions. Agitation can also be unrelated to a medical/psychiatric condition; for example, some individuals may act violently as a means of achieving a goal (e.g., antisocial behaviors). It is important for clinicians to develop skill in assessing the etiologies of agitation.

6. The decision to utilize medication to treat agitation is a critical healthcare decision. Pharmacologic intervention may be required for the safety of the patient, clinician, and/or others when verbal de-escalation techniques alone are ineffective [19, 20]. The goal of medication treatment is to calm patients so that they can safely and effectively participate in assessment and treatment, and regain control over their own behaviors. While medications may induce sleepiness or sedation, it is important to recognize that this is not the primary objective, and clinicians should monitor patients carefully to avoid overuse of medications [19]. Medications should never be used as a "chemical restraint", a term that is poorly defined and not well understood. Rather a preferred description of medication interventions is "pharmacological treatment of agitation" [19]. The choice of medication should be informed by the cause of the agitation (another medical, neurological, psychiatric, or substance use condition), as well as patient history and preferences.
    a. Voluntary administration of oral medications (including options for rapid dissolving medications or oral concentrates) should be offered as first line.
    b. Involuntary administration of medications [typically intramuscular (IM) route of administration] should be used as a last resort for situations that present as acutely dangerous. In most cases, patients who require IM medication administration simultaneously require S/R, though in some scenarios a patient may de-escalate with the use of an IM, and S/R can be avoided.

7. Facilities should establish clear protocols to assist clinicians with decision-making among use of "quiet room", locked seclusion, physical hold, or physical restraint [15]. For example:
    a. Quiet room (aka "time out"): Generally applicable for a cooperative patient who would not be a danger to self or others in an unlocked quiet room setting.
    b. Locked Seclusion: Generally applicable for a patient who will not voluntarily de-escalate in an unlocked "quiet room", and who would not be a danger to self in seclusion.
    c. Physical Hold (aka physical restraint): Generally, a staff-to-patient physical contact in which the patient unwillingly participates, such as physically holding a patient in order to administer a medication against a patient's wishes.
    d. Restraints (aka mechanical restraint): Generally applicable for an uncooperative patient who would be a danger to self in seclusion, or for a patient who is an imminent danger to others.

**An example of a diagrammatic representation of interventions for agitation (adapted from [14]) is provided in the APPENDIX.**

8. S/R should never be used as a form of punishment or deliberate/intentional coercion, intimidation, for staff convenience, or as retaliation [11, 15] and such use is also prohibited by law in many jurisdictions.

9. Facilities should maintain clear policies, procedure, and training protocols regarding the management of agitation, including guidance on the use of seclusion vs. restraint.

| **Table 2: Select definitions and excerpts from CMS (adapted from [13]):** |
|---|
| Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior. |
| A restraint is 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. |
| Seclusion and restraint must be discontinued at the earliest possible time. |
| Within 1 hour of the seclusion or restraint, a patient must be evaluated face-to-face by a physician or other licensed independent practitioner or by a registered nurse or physician assistant who has met specified training requirements. |
| Seclusion or restraint may be used only when less restrictive interventions have seen determined to be ineffective to protect the patient, a staff member, or others from harm. |
| All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. |

**Consideration #2: Understanding the clinician's role in seclusion or restraint can lead to more appropriate use of these interventions.** It is important for psychiatrists to know their roles and responsibilities in S/R. The APA has provided an interactive presentation on this topic (https://smiadviser.org/events/seclusion-and-restraint-the-role-of-the-psychiatrist), and it is highly recommended to review this at the SMI Adviser website (a free account can be set up for viewing). This module also provides a list of references related to S/R. An article on this same topic can be found in *Psychiatric Services* [21].

Some important take-aways from the above resources are 1) the history of S/R in psychiatry can be instructive in understanding current use or efforts to reduce their use, 2) S/R are medical interventions with significant physical and psychological risks, and they restrict the liberty of the patient; therefore a psychiatrist should provide oversight, leadership, and staff training/support, and not abdicate total responsibility to other clinicians and staff, 3) seclusion deaths are no longer tracked in The Joint Commission (TJC) sentinel events reports, but restraint deaths are monitored because they were shown to be the most common when data for both S/R were collected by TJC, and 4) psychiatrists, whether inpatient or outpatient, should be aware of and discuss patient S/R events (or witnessing thereof) with the patient and develop safety/crisis prevention plans for potential future events. The interactive presentation above covers some aspects of both adult and child and adolescent S/R, including their use in public schools. Nurses can refer to the American Psychiatric Nurses Association (APNA) Seclusion & Restraint Standards of Practice [22].

All clinicians and staff who utilize S/R should be aware of the potential effects on their morale in making decisions about the use of S/R. In a VA study, higher reported physician and nurse burnout was associated with higher physical restraint use while those with lower burnout were more likely to choose a less restrictive modality like seclusion [23]. There is evidence that patient aggression can provoke anger in nurses and affect decisions regarding S/R use [24]. Use of restraints can potentially affect stress levels for mental health workers, particularly when there is less perceived social support [25].

**Consideration #3: Understanding the risks can reduce harm when using seclusion or restraint.** It is important to understand the differential risks of physical restraints compared to seclusion. While some studies have not found a significant variation in adverse effects between the two procedures [26], others have described notably heightened risks with physical restraint, such as deep vein thrombosis (DVT) and aspiration pneumonia [27]. Compared to non-physically restrained patients, more total days of physical restraint has been associated with an increased risk for pulmonary embolism [28]. Even when preventive measures such as compression stockings and subcutaneous heparin are implemented, a substantial degree of risk for DVT may remain [29]. While both approaches have been associated with psychological distress, individuals undergoing physical restraint in particular report higher rates of perceived coercion and post-traumatic stress [30, 31]. One systematic review found that the incidence rate of PTSD was 25-47% after a restraint event [10]. Those who have been physically restrained have reported feelings of helplessness, tension, fear and rage. Clinicians need to be aware of the significant potential negative effects of physical restraints compared to seclusion when making treatment decisions.

Adverse effects associated with physical restraint have been described by Mohr et al. [32]. The table in this reference shows several items from the data of a survey of 142 patients, using a questionnaire designed to identify the frequency of potentially harmful events and the associated psychological distress experienced by the patient. This clearly shows that commonly used interventions are traumatic to patients [33]. Frueh et al. also studied reports of traumatic or harmful experiences within the psychiatric setting [34].

The use of various types of restraints has been associated with injury and death. Due to a lack of systematic reporting, the exact incidence of these adverse events is unknown. Case reports have described asphyxiation due to strangulation, cardiac arrest, and death from pulmonary embolism in mechanically restrained individuals [35]. Despite a relative lack of formal epidemiological studies of adverse events with restraints in psychiatrically hospitalized patients, mechanical restraints (including trunk belts, vests, wrist restraints, and bed rails) have nonetheless been associated in several studies with fractures and falls [36, 37]. A survey study in the UK found mechanical restraints were associated with a 1.05% risk of physical injury to patients and a 3% risk for injury to staff [33]. Windfuhr et al. [38] reported that among 283 cases of sudden unexplained death (SUD) during acute psychiatric hospitalization, seven deaths occurred within 24 hours of physical restraint and/or seclusion; the study could not definitively attribute SUD to S/R. In contrast, “intravenous sedation" of patients for threat of violence has been associated with dystonia, hypotension and confusion [39]. Finally, the adverse effects of seclusion have been understudied. One report, however, found that seclusion was associated with self-injury [40], which the authors noted could have been prevented by 1:1 supervision. Moreover, all patients, no matter the form of intervention, should be carefully and appropriately monitored throughout the intervention [5, 6].

**Consideration #4: Advocating for availability of environmental interventions, including seclusion rooms, can minimize the need for restraint.** Because restraints are associated with the highest level of morbidity and mortality, every effort should be made to avoid their use. Plans for new psychiatric facilities or renovations to existing facilities should include calming, sensory, and seclusion room(s) to minimize the need for restraint. The choice of seclusion vs. restraint should be based on any federal or state requirements, the clinical presentation and/or patient preference, and should not be unit- or resource-dependent. The APA has a stance on the importance of involving psychiatrists in facility design (“Position Statement on Psychiatrist Input into the Design and Construction of Psychiatric Evaluation and Treatment Facilities”--see APA Policy Finder [41]). Psychiatrist involvement in the design of other hospital or facility units where patients with psychiatric and other behavioral health conditions are treated should also be considered. This resource document will hopefully serve as a support and educational tool to those psychiatrists and other clinicians advocating for appropriate options in their facilities.

**Consideration #5: The patient’s experience of seclusion or restraint is important.** Most psychiatrists have not likely experienced their own personal S/R in a psychiatric facility or other clinical setting (e.g., ED). One way to develop empathy is to consider how they may have felt in other situations in their lives when their freedom, physical or otherwise, was limited or suppressed. For example, they may recall a time as a child when they were not allowed to run free in a crowd (despite desperately wanting to) and were held tightly by the hand or carried by a parent. They can also develop empathy by considering patients’ recounting of such experiences (see Fisher [42] for review and some actual written accounts). Wadeson and Carpenter [43] found that patients described their seclusion room experiences negatively including feelings of fear, estrangement, hostility, retaliation, guilt, paranoia, and bitterness. Other studies have noted that many patients found seclusion at least somewhat necessary and calming [44, 45], reducing overstimulation [5, 6].

Elyn Saks, attorney, author of *The Center Cannot Hold [46]*, and a person who lives with schizophrenia, has described her personal account of the feeling and experience of being restrained in her TED talk [47]. Additionally, she discusses some of the adverse effects of restraint (also See Consideration #3). This valuable resource is recommended for psychiatrists and other clinicians to review, to enhance or renew empathy for patients who experience S/R such that clinical decisions are not taken lightly.

A video resource from the Social Care Institute for Excellence (SCIE; UK), entitled *Restraint: A Human Rights Issue* talks about restraint not being wrong in all situations, emphasizing that its use should be one of last resort, and that there should always be a focus on patient-centered care [48]. Further resources from the SCIE, such as courses and webinars, are also available [49].

An additional video resource, *Restraint,* by CanDo Films, depicts dramatizations based on real patient stories demonstrating both positive and negative experiences of being restrained [50]. The negative experiences reminded patients of past traumas. However, staff are able to counterbalance the difficult experience for the patient when calmly explaining what was happening throughout the restraint. Important points gleaned from these stories are of engaging the patient as part of the team, respecting patient choices (e.g., for seclusion v. restraint) as much as possible (See Consideration #7), providing patient-centered care, and using the least restrictive means possible.

**Consideration #6: A culturally competent, trauma-informed, and patient-centered approach is necessary when making decisions about whether to use seclusion or restraint.** The prevalence of a history of trauma among psychiatric inpatients ranges from 50 to 80% [51, 52]. As such, mental health clinicians should recognize the impact and signs of trauma when considering seclusion or restraint, keeping in mind that these interventions can legally only be used as a last resort. In this context, trauma-informed care has emerged as an approach to allow patients to engage in their healthcare, develop a trusting relationship with their provider, and improve health outcomes [53].

Trauma-informed care is based on the following principles: 1) Healthcare clinicians recognize the prevalence of trauma, 2) Healthcare clinicians recognize how trauma affects all individuals involved including patients and the healthcare workforce, 3) Healthcare clinicians assess and treat trauma-related symptoms to prevent re-traumatization [53].

This approach strongly relies on language and environmental factors. Clinicians should use a patient-centered, objective, neutral and collaborative approach. It is important to maintain a non-threatening or non-aggressive tone, cadence, and volume of voice, as well as body language, when interacting with a patient with a behavioral crisis. The environment and interaction between clinicians and patients should also give the individual space to minimize the risk for further behavioral escalation [53, 54].

Mental health clinicians should also acknowledge the feeling of vulnerability that patients experience with S/R. As such, a culturally competent approach is a key aspect when considering these interventions. Clinicians should strive to be able to understand, appreciate, and interact with people from cultures or beliefs different from their own [55].

Mental health clinicians should also be cognizant of how serious interventions such as S/R can perpetuate disparities, particularly for individuals from racial-ethnic minorities who simultaneously must struggle with the intersectionality of mental health stigma as part of their daily life. Psychiatrists should critically reflect on their pharmacological and non-pharmacological therapeutic interventions (including S/R) in the context of health inequalities seen in the health care system [8, 56].

Physical restraint has been associated with demographic variables, particularly Black or African American race, male sex, non-Hispanic ethnicity, lack of private insurance, and homelessness, during emergency department visits, which may reflect potential implicit and systemic biases regarding decisions in the implementation of S/R. Clinicians should be aware that systemic biases and social determinants of health may influence the likelihood of use of these interventions in certain populations [57, 58]. See Table A2 in the APPENDIX.

S/R can be traumatic experiences that can have lasting consequences for an adult's well-being. Further work is needed to continue to identify structural factors contributing to disparities in interventions for patients with a behavioral crisis to avoid marginalization of disadvantaged populations [57, 59]. Healthcare facilities should aim to develop systems for monitoring institutional data about events leading to S/R. Post-incident reviews (PIR) have been proposed as a tool that can contribute to more ethical and professional practice of S/R to ultimately prevent racial and ethnic disparities [60].

**Consideration #7: Patient preferences and psychiatric advance directives are critical when considering the use of seclusion or restraint.** Patients who have experienced seclusion and/or restraint likely have strong opinions about their use. Most patients would choose seclusion over restraint, but there may be exceptions, depending on previous experience, including psychological traumas. In this context, psychiatric advance directives (PAD) have emerged as a tool to allow people with mental health conditions to state their preferences in advance for treatments in case a mental health crisis impacts their ability to make decisions at the time [61].

PAD can include: 1) preference of medications that are known to have been effective for agitation in the past, 2) a list of people who can participate in the patient's care while in an acute mental health crisis (e.g., male v. female staff), 3) preference of seclusion or restraints, etc. While mental health clinicians should always prioritize the safety of the patient and staff, preservation of the patient's autonomy should always be a primary goal as much as possible [61, 62].

Policies that encourage and emphasize the use of PAD in routine care can empower and help people with mental health conditions protect their autonomy in a behavioral crisis to ultimately support a path to recovery [61]. Apart from exercising autonomy and empowerment, PAD can increase patients' motivation to continue with planned treatment, thus improving treatment adherence [63]. Furthermore, mental health clinicians should consider compassionate use of S/R as standard of care when these interventions are necessary, since it should be done with the aim not only of minimizing harm but also improving patient engagement and recovery [64].

While it is important to recognize the utility of this approach in non-acute situations, challenges might arise when trying to implement it for patients with a behavioral crisis. Lack of knowledge and training, fear that PAD will interfere with clinical aspects of care, and concerns about patient's decisional capacity have been reported as some of the perceived barriers for PAD implementation. Multifaceted strategies would need further exploration to address these barriers with the ultimate goal to facilitate a successful and effective implementation of PAD in clinical practice, particularly in an acute setting [65]. Emergency department, inpatient and other clinicians working with patients in a crisis setting may not be aware of a PAD the patient developed in an outpatient setting. Collateral information from family or other supports may uncover the presence of a PAD. It is important that clinicians ask specifically about PADs. Health information-sharing systems that allow for ready access to PADs in a crisis offer the promise of ensuring PADs are available at point of service when they are needed most [66].

## Gaps in Knowledge and Future Directions

There is still much to be learned about S/R, and training for medical students and residents is lacking or non-standardized. More rigorous research is needed, particularly in the areas of comparisons between S/R and when or how to choose between them, racial/ethnic and other biases in their use, and S/R use in special populations (e.g. children and adolescents [67, 59, 68], geriatric [69], and individuals with developmental disorders [5, 6]). Reducing stigma and disparities in the use of S/R for all patients should be an ultimate goal.

## Conclusions

Seclusion or restraint (S/R) may only be used as interventions of last resort in the management of severe agitation in patients. Both carry risks to patients and staff that must be considered in deciding which one or whether to use them at all in a given clinical situation. Restraint should be used rarely. Seclusion should be minimized. Both S/R episodes should be as short as possible, dignified, and as safe as possible for all involved. Patient preference should always be considered when feasible.

## APPENDIX

| Table A1: Seclusion v. Restraint Background/Historical Reading Suggestions | | |
|---|---|---|
| **Title** | **Author(s)** | **Citation** |
| Seclusion and Restraint: The Psychiatric Uses | | Report of the American Psychiatric Association Task Force on the Psychiatric Uses of Seclusion and Restraint. 1984. [5] |
| Restraint and Seclusion: A Review of the Literature | Fisher WA. | Am J Psychiatry. 1994 Nov;151(11):1584-91. doi: 10.1176/ajp.151.11.1584. PMID: 7943445 [42] |
| A Randomized Controlled Comparison of Seclusion and Mechanical Restraint in Inpatient Settings | Bergk J, Einsiedler B, Flammer E, Steinert T. | Psychiatr Serv. 2011 Nov;62(11):1310-7. doi:10.1176/ps.62.11. pss6211_1310. PMID: 22211210 [26] |
| Restraint and Seclusion in Psychiatric Treatment Settings: Regulation, Case Law, and Risk Management | Recupero PR, Price M, Garvey KA, Daly B, Xavier SL. | J Am Acad Psychiatry Law. 2011;39(4):465-76. PMID: 22159974 [70] |
| Use and Avoidance of Seclusion and Restraint: Consensus Statement of the American Association for Emergency Psychiatry Project Beta Seclusion and Restraint Workgroup | Knox DK, Holloman GH Jr. | West J Emerg Med. 2012 Feb;13(1):35-40. doi: 10.5811/westjem.2011.9.6867. PMID: 22461919 [15] |
| Practicing Patient Safety in Psychiatry | Jayaram G. | Oxford, UK: Oxford University Press. Retrieved 15 Jan. 2022, from https://oxfordmedicine.com/view/10.1093/med/9780199971763.001.0001/med-9780199971763. [71] |
| Ask the Expert: Seclusion and Restraint | Master KJ. | Focus (Am Psychiatr Publ). 2015 Winter; 13(1):47-49 [72] |
| Aggression and Prevention of Use of Seclusion and Restraint in Inpatient Psychiatry | Jayaram G | Focus (Am Psychiatr Publ). 2016 Jul;14(3):354-357. doi: 10.1176/appi.focus.20160016. Epub 2016 Jul 8. PMID: 31975818 [73] |
| Physical Harm and Death in the Context of Coercive Measures in Psychiatric Patients: A Systematic Review | Kersting XAK, Hirsch S, Steinert T. | Front Psychiatry. 2019 Jun 11; 10:400. doi: 10.3389/fpsyt.2019.00400. eCollection 2019. PMID: 31244695 [35] |
| The Role of the Psychiatrist in Seclusion and Restraint | Masters KJ, Huckshorn KA. | Psychiatr Serv. 2020 May 1;71(5):511-513. doi: 10.1176/appi.ps.201900321. Epub 2020 Feb 5. PMID: 32019431 [21] |

| *Table A2: S/R Bias Background Reading Suggestions* | | |
|---|---|---|
| **Title** | **Author(s)** | **Citation** |
| Restraint and Seclusion: A Review of the Literature. | Flaherty JA, Meagher R. | Am J Psychiatry. 1980 Jun;137(6):679-82. doi: 10.1176/ajp.137.6.679. PMID: 7377387 |
| Restraint and Seclusion: A Review of the Literature. | Fisher WA. | Am J Psychiatry. 1994 Nov;151(11):1584-91. doi: 10.1176/ajp.151.11.1584. PMID: 7943445 [41] |
| Demilitarizing Hospital Restraints: Recognizing the Stones in Our Glass Houses. | Dotson S, Ogbu-Nwobodo L, Shtasel D. | Psychiatr Serv. 2021 Jun 2: appips202000730. doi: 10.1176/appi.ps.202000730. Online ahead of print. PMID: 34074142 [4] |
| Racial and Ethnic Disparities in Physical Restraint: Use for Pediatric Patients in the Emergency Department | Nash KA, Tolliver DG, Taylor RA, Calhoun AJ, Auerbach MA, Venkatesh AK, Wong AH | JAMA Pediatr. 2021 Dec 1;175(12):1283-1285. doi: 10.1001/jamapediatrics.2021.3348. PMID: 34515764 |

## EXAMPLE OF VERBAL DE-ESCALATION TRAINING AND EDUCATION

**(ERASER Mnemonic)** Modified and adapted based on the following [74, 12]

### E: Eyeball the patient

Evaluate the patient from a safe distance. Survey the scene and determine if there are features that make the scene unsafe (ex. patient is wielding an object as a weapon). Decide if additional resources are necessary such as security or hospital emergency response (if in doubt err on the side of caution). Are there signs that the patient will not respond to verbal de-escalation?

### R: Respect the Patient's Space

Patients may escalate when there is intrusion into their personal space. Maintain a respectful distance while being aware of your own escape routes should the patient become violent.

### A: A single provider does the talking and builds rapport

Establishing rapport is critical. With multiple providers potentially responding, a single individual should be charged with talking to the patient. If charged with this task, remain neutral, and do not become "emotionally involved" in the patient (such as becoming angry, irritated, or frightened of the patient). State your name and position, offer your help. Be genuine and honest. Use a calm, reassuring, and helpful voice, and a neutral expression. Be concise in your questions, statements, or instructions. Give the patient time to respond.

### S: Sensible Learning

Often patients want to be heard. People who are upset or confused generally want a way to resolve the issue. Help them find a "way out" if it is reasonable. Try to understand what the patient wants. Show a willingness to calmly listen to the patient, without necessarily reacting to demands. This step is likely when iatrogenic escalation may occur (especially if a provider becomes emotionally reactive, angry, frightened, or frustrated). Another provider may need to step in and continue if this happens.

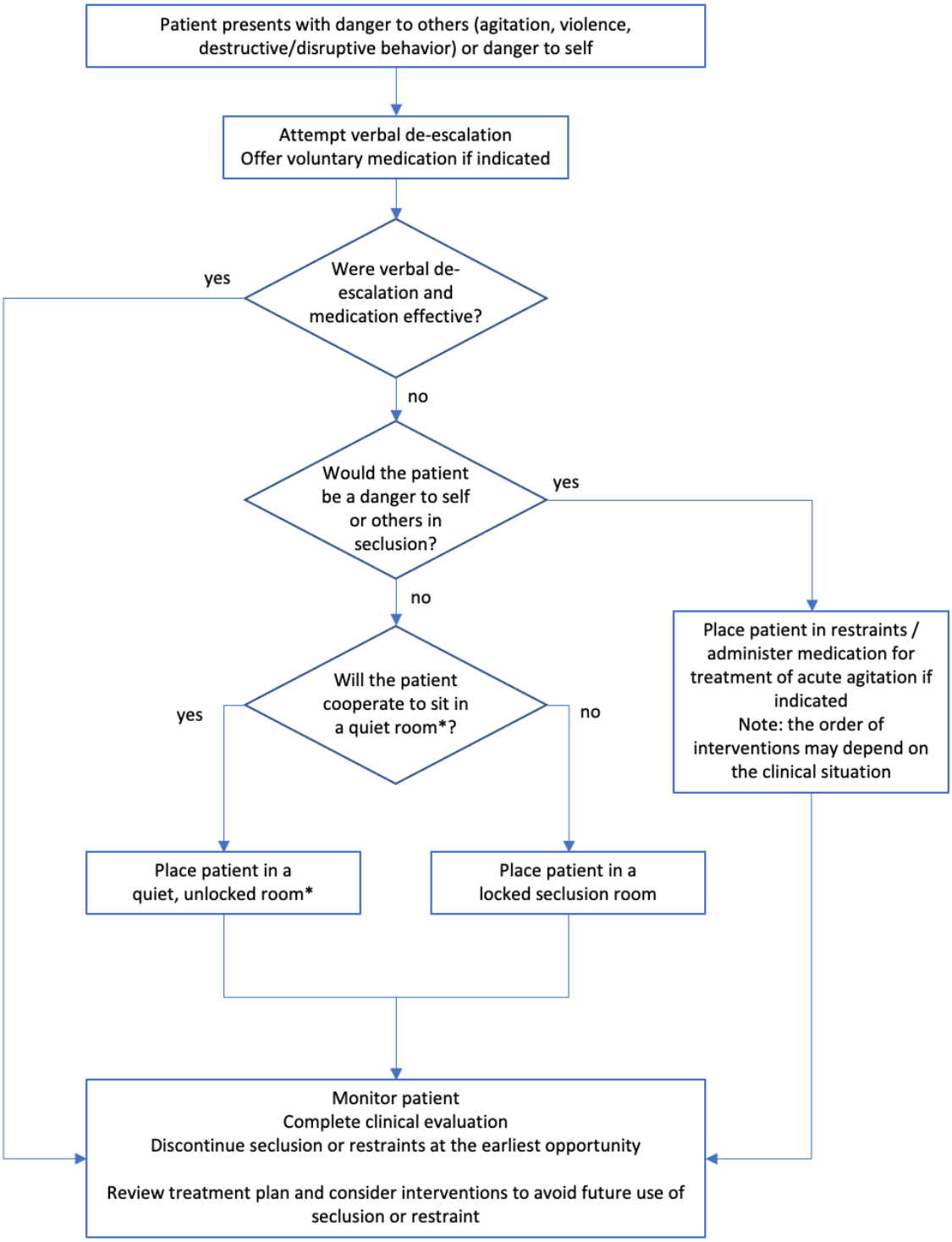
### E: Establish Expectations and Set Boundaries

Boundaries should be set with the patient about behavior that will not be tolerated, consequences of actions, and what the patient is likely to expect. It is important to be clear and avoid using language that can sound intimidating or threatening.
For example, "You may not threaten people, it is our job to make sure that everyone stays safe."
Give specific instructions such as "can you please sit down so we can talk?" Avoid generic directives like "calm down" or "relax". Provide a clear warning to the patient about the need to ensure the safety of both the patient, staff, and others, for example: "We will only use restraint, seclusion, or injectable medication as a last resort if it is necessary to keep you or others safe. We'd like to find a way to address your concerns without having to do that".

### R: Reasonable Choices are Given to the Patient

By retaining some degree of control, many patients will comply with direction if given reasonable choices. For example, a provider could offer, "would you like to have something to eat or drink?" "Is there a member of your team who you would like to talk to?" "Can we offer you an oral medication that can help with _____" "Can you give us some ideas of what would help you?"

Appendix: Sample decision support algorithm for use of seclusion or restraints




* AKA sensory room, quiet room, or time out

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