Restraint and Seclusion: 
The Model for Eliminating Their Use in Healthcare
Tim Murphy, MS and Maggie Bennington-Davis, MD

The results speak for themselves. This model works!

By implementing the authors’ methodology, our feature hospital has gone from: Over 365 seclusions in a year to one seclusion in the past two years. Hundreds of episodes of leather or mechanical restraint use to zero in the past two years.

Straightforward, thorough, and motivating
Restraint and Seclusion: The Model for Eliminating Their Use in Healthcare, is both encouraging and motivating, and drives home the mission-critical message: the use of restraint and seclusion is not treatment.

Successful strategies to institute change
This book takes you through a journey of one hospital’s efforts to reduce the use of restraint and seclusion. From how to start and build support to what you can expect along the way, this book offers a complete restraint and seclusion reduction methodology that you can implement in your own facility to improve treatment outcomes.

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Foreword by Sandra L. Bloom, MD

Tim Murphy, MS
Maggie Bennington-Davis, MD
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Developing the vision

CHAPTER 1
Healing is always possible, even when curing is not.
–Brigit of Ireland

Something has gone awry in the system we use to treat severe mental illness. An article in the *New England Journal of Medicine* read, “The pharmacologic treatment of mental illness has become so successful that psychiatry no longer needs to focus on the psyche.” In its zeal to cure people of their symptoms, the delivery system we use has been distorted to the point that it alienates the very people we seek to serve. We must do better.

Successful efforts exist to decrease and even eliminate use of restraint and seclusion in hospitals. But why *should* restraint and seclusion be eliminated?

**The call for reform**

The simplest reason for reform is that physical and mechanical restraint is dangerous to patients and staff and has caused significant injuries and deaths to those restrained. Reform has been demanded by the Centers for Medicare & Medicaid Services, the Joint Commission on Accreditation of Healthcare Organizations, the National Association of State Mental Health Program Directors, and the National Alliance for the Mentally Ill, as well as numerous consumers groups and the American Psychiatric Association.

In addition to the dangers associated with them, restraint and seclusion are problematic because they frequently are used as punishment and coercion. They are applied inconsistently and subjectively in many facilities. They are not therapeutic interventions; in fact, they traumatize both those who experience them and those who administer them. The experience of restraint and seclusion causes alienation from the mental health system, from treatment staff, and from physicians. It disrupts potentially therapeutic relationships and interferes with engagement in treatment. The use of these interventions perpetuates the cycles of violence and trauma that many of the people we serve already have experienced.
Chapter 1

Transforming the system

In addition to the aforementioned healthcare agencies calling for reform, the Institute of Medicine outlined the following improvement in 2001 (National Executive Training Institute):

- Continuous, healing relationships
- Customization of treatment to individual needs and values
- Consumer/patient control of treatment
- Risk reduction to ensure safety
- Transparent information about healthcare practices and systems

In 2003, President Bush’s New Freedom Commission called for system transformation in which

- recovery is a goal for everyone
- services are consumer-centered
- focus of care increases consumers’ ability to self-manage illness and to build resiliency
- consumers and families are full partners in patient recovery

Those that have already successfully decreased and eliminated use of restraint and seclusion have demonstrated that sustained improvement requires a fundamental shift in thinking about the people they serve, their illnesses and symptoms, and the staff who serve them. Indeed, the practices of restraint and seclusion are significantly tied to other coercive practices, and cultural change is required in order to intercede (National Executive Training Institute).

In order to change basic beliefs and assumptions about people with symptoms of mental illness and about the illnesses themselves, mental health systems and the care they deliver must become trauma-informed. Staff must change their fundamental approach to the treatment environment from one of power and control to one of customer service. Both staff and the people they serve must experience their relationships in new ways—with respect, hope, dignity, and involvement.

This magnitude of organizational change and the organizational dynamics that are involved in it requires leadership. The first task of such leadership is to imagine a new version of the future: a future in which healers create an environment of engagement and healing and where miracles can happen.
Obstacles to the vision

The main obstacle to cultural change is old paradigms: “We’ve always done it that way before.” “It has worked for 20 years.” “This is what I was taught in school.”

Organizations that have undergone successful transformational change share two key features: leadership and vision. Leaders establish direction through a vision, and a compelling vision is the first step to shifting the paradigm. The vision guides decisions, performance, culture, and attitude. It motivates all members of the organization to work toward something better. Vision gives meaning to our work. It fixes a standard of excellence. It insists that all employees give their best. It energizes people and inspires them to a future to which they are eager to commit. A vision is not only helpful in the change that is required for this particular transformation in healthcare; it is essential.

A vision summarizes the ideal state of an organization. It can come from either influential and powerful leaders or from the collective voices of the organization. Where it comes from is less important than ensuring that it is driven by specific values that staff share, that they understand, and to which they commit.

To begin, imagine five years from now. Imagine the most desirable situation you can conceive, for you, for the people you serve, and for your staff. Describe what you imagine, as if it were a painting or a picture. Use words and drawings; use metaphors and images. Draw on beliefs and values. Weave in current realities and the environment of your work.

A new vision is fragile. Tradition, hierarchy, stereotypes, stigma, bigotry, complacency, and fear of ridicule are all enemies of vision. Change is overwhelming for many people and organizations, especially if people don’t know where they are headed or why. Therefore, once conceived, communicate, share, and translate the vision so that everyone in the organization understands and connects to it. Adopting it will provide energy and direction to the mission.

Examples of vision

- To create an environment where the healed and the healers work together to find paths to recovery

- To eliminate the weapons of power, control, and coercion—including restraint and seclusion—so that the environment is optimized for partnership in healing

- To create a place of absolute safety and respect for the staff and the people we serve
• To work together with those we serve in a trauma-informed, intelligent, and safe environment in which person-centered treatment is facilitated

• To work in an environment where restraint and seclusion are unnecessary and where the alternatives of respect, kindness, safety, and education replace them

Being the visionary

The purpose of this book is to lay out a pathway for those who serve the mentally ill, whether in a hospital, in a residential program, in an outpatient setting, or in a school. We must learn new ways to engage in the process of healing. These ways must depend on cooperation, collaboration, hope, and trust, which are the very things missing from today's treatment strategies for those suffering from mental illness.

New ideas and new strategies always emerge from the visionaries. Someone has to develop the vision that drives the plan that creates the change that improves the service.

In the Engagement Model, we call on a full-scale culture change where the treater and the treated forge a new alliance, with recovery as the goal and partnership and respect as the pathway. The vision does not have to strive for the elimination of restraint and seclusion (ours did not); instead it may call for an environment free from coercion. Or it may call for a new partnership between patients and treatment care staff in which the patients are involved in all decisions involving their care, such as meal times, visitors, lengths of stay, and how their specific treatment is to be delivered. With visions like these, the need for controlling mechanisms like seclusion, restraint, and time-outs—and the injuries associated with them—become relics of the past.

Once the vision is set, a leadership team must be identified. That leadership community will develop the plan to create the culture where the vision can be realized.

In Chapter 4, we look at how you build your leadership team using your current management structure and what you may need to do in order to augment the leadership skills that already exist.

Key points in this chapter

1. Significant change must be leadership-driven
2. Leaders need to establish a clear vision for change
3. Engagement between the treated and those providing treatment is the goal of the change for reducing restraint and seclusion
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