The Engagement Model for Reducing Seclusion and Restraint 13 Years Later

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ABSTRACT
In 2001, an inpatient psychiatric unit sought to greatly reduce, or even eliminate, the use of seclusion and restraint by initiating the Engagement Model. Despite many changes in management and staff, the model has remained largely intact and effective during the past 13 years. The current article reflects on key clinical interventions and leadership approaches that have helped sustain the culture change undertaken to better serve patients on this unit. [Journal of Psychosocial Nursing and Mental Health Services, 53(3), 39-45.]
During the past several years, greater attention has been given to efforts to reduce and eliminate the use of seclusion and restraint (S/R) and other coercive methods that have historically been used in psychiatric facilities. In 2001, based on the Sanctuary approach of Sandra Bloom (1997), the authors’ hospital took on this challenge and initiated the Engagement Model (Murphy & Bennington-Davis, 2005)

The goal of this model was to implement an acute care, inpatient psychiatric recovery model that provided a safe and healing environment founded on trauma-informed care. Positive therapeutic alliances based on respect, hope, dignity, and recovery would be built with patients and efforts were directed toward individualization of treatment, with maximization of patient involvement. Management and staff desired to shift power and control from staff to patients as much as possible and reduce or totally eliminate the need for S/R.

Despite multiple management changes at medical director and nurse manager levels, significant reduction in overall staff hours, and no change in admission criteria for the population served, the Engagement Model remains largely intact and is still embraced and protected by staff. The introduction of the model rapidly resulted in a significant reduction in the use of S/R, with many years of low levels or no S/R episodes (Murphy & Bennington-Davis, 2005). As the 13-year mark of the model passes, it is important and instructive to reflect on aspects of the model believed to have helped sustain this significant reduction in S/R, and also to ask what may have contributed to some recent spikes in those numbers (Table). The goal of the current article is to highlight key clinical interventions and leadership approaches and offer practical suggestions and observations to others who strive for more humane patient care.

KEY CLINICAL INTERVENTIONS

Admission Process

Patient engagement, for better or worse, begins long before the patient is admitted for care. Most patients are admitted for services through emergency departments (EDs). Negative experiences in EDs are unfortunately too frequent, and may include long wait times, treatment by staff with limited understanding of mental illness, and routine seclusions in sterile and uncomfortable rooms. To further efforts toward positive patient engagement, staff at the authors’ institution expanded their efforts to improve patient experience in the ED. A group of mental health examiners (MHEs) who are skilled at screening and interacting with patients who exhibit acute symptoms was developed, and older policies related to automatic seclusion of all psychotic patients during waits in the ED were changed. The MHE supervisor acts as liaison between the ED and inpatient staff to help reduce admission wait times for patients. Because trauma history can be an unseen precursor to aggressive behaviors, admission screening tools provide information about individual patient trauma history, triggers, history of assault or aggression, and strategies the patient finds helpful for self-calming and regaining self-control. This latter strategy has been a part of other recent successful programs aimed at reducing or eliminating S/R (Lewis, Taylor, & Parks, 2009; Stewart, Van der Merwe, Bowers, Simpson, & Jones, 2010). This individual patient information is regularly referred to and updated, as patients are helped to move toward increased ability to cope with agitation, anger, or symptoms that might lead to aggressive behavior.

Minimizing the Power Differential: A Culture Shift

The medical model is traditionally hierarchical. It often becomes even more so in acute settings, where management of escalating behaviors can be a daily challenge. A safe and intentional reduction of this hierarchy is a key factor in therapeutic milieu (Norton & Bloom, 2004). Several strategies can prove useful in creating and sustaining an environment in which power is shared more equally, yet remains safe for both patients and staff. Attention to non-coercive communication, verbal and nonverbal, is foundational (Murphy & Bennington-Davis, 2005). This communication includes attention to signage, words, body posture, phrasing, and tone of voice. Such principles apply to interactions with patients as well as between staff members. Hierarchy can also be reduced through timely response to patient requests and staff finding commonality with patients.

Since 2001, staff at the authors’ institution have been offered the opportunity to eat family-style meals with patients. These meals are free to staff, who then receive traditional 30-minute lunch breaks at a different time. Breaking bread with others builds relationships and breaks barriers, thus potentially reducing the likelihood of interpersonal violence. Staff members intentionally seat themselves at tables with patients and engage in casual conversation (e.g., sports, hobbies, music) or recovery-related topics. A previous recreation therapist was known to be skilled at this interaction. Her table was often the most animated, with people laughing and enjoying themselves. These were patients who had depression, schizophrenia, and bipolar disorder, but the atmosphere of a shared meal and friendly conversation created an environment in which they were able to relax and experience a sense of “normal.” Another facility recently used this as an aspect of their program to reduce S/R. They anecdotaly reported enhanced staff/patient relations and noted the additional benefit of an increase in customer satisfaction with food scores, despite the fact that no changes were made to the food that was served (Lewis et al., 2009).

Another strategy found to be useful is to have staff spend less time in the nursing station or offices. An increased staff presence in the milieu has numerous benefits (Lewis et al., 2009). Such
presence can take the form of simply sitting and chatting with patients over a cup of coffee, playing a game of cards with patients, or reading a newspaper or magazine in the day area during a downtime. In the days of paper charting, staff often made a concerted effort to do all of their charting in the patient day area. Charting in this way involved a multitude of interruptions, but patients typically took note of the fact that staff were charting on their observations and interactions with them throughout the day. It was not uncommon for patients to sit down with staff, sometimes simply to chat, and other times to ask what staff were writing about them. One staff member regularly asks his patients, “What should I chart about your progress today?” Such interactions provide a therapeutic opportunity to give the patient feedback, reinforce treatment goals, and strategize with them for continued progress. An added benefit is that relationships become more partnership based.

Other strategies to minimize the hierarchy have also been used. Gaillard, Shattell, and Thomas (2009) examined patient experiences of being misunderstood in mental health settings. One theme that emerged from their study was that patients felt misunderstood when they were “not viewed as autonomous adults who could collaborate in planning treatment of their illness” (Gaillard et al., 2009, p. 196). At times, the current authors have focused on inviting patients to participate in weekly treatment team meetings. For the past 2 years, therapy staff have met twice per week with each patient to discuss patient-identified strengths, goals, progress, and treatment team recommendations. Although it requires extra time and planning, such practices promote a collaborative approach. In the long term, it may add to the patient’s sense of autonomy and worth, which are factors believed to contribute to overall patient engagement and recovery.

Patient participation in treatment planning can have the added benefit of decreasing power struggles, particularly with patients who have borderline, antisocial, or narcissistic personality disorders. Although patient requests may be unusual at times, an understanding of the dilemma of traumatized individuals expands staff’s ability to recognize the need beneath the request or behavior. Staff may have the power to say no to a patient request, but is the fallout worth it? When requests are reasonable and not dangerous, it has been found helpful to include those items in the choice options offered to an individual patient. Some examples might include allowance for pet visits, use of music/headphones at times that are outside of the normal unit guidelines, a judicious loosening of American Dietary Association restrictions, authorized use of computers, supervised use of guitar or karaoke equipment, or monitored knitting. Curran (2007) and Meehan, McIntosh, and Bergen (2006) suggest that inflexibility in rules or interventions is a barrier to restraint reduction efforts and may even precipitate aggression. The current authors’ experience has shown this to be true, and they and other staff strive to offer patients creative options whenever possible. At a recent morning community meeting, patients enthusiastically praised the night shift staff who had flexed the usual guidelines and facilitated patient use of the day area long into the evening. Staff supplied extra snacks and hot beverages and supported a healthy, patient-initiated opportunity to de-stress and socialize. Spontaneous, individual interventions are also welcomed and recognized, and staff are encouraged to think “outside the box” when exploring alternatives.

**TABLE**

<table>
<thead>
<tr>
<th>Year</th>
<th>Mechanical Restraint Events (n)</th>
<th>Seclusion Events (n)</th>
<th>Manual Restraint-Only Events(^a,^b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>38</td>
<td>101</td>
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<tr>
<td>2001</td>
<td>7</td>
<td>53</td>
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<td>2002</td>
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<td>2003</td>
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<td>2009</td>
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<td>19</td>
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<td>2010</td>
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<td>3</td>
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<tr>
<td>2011</td>
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<td>7</td>
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<tr>
<td>2012</td>
<td>0</td>
<td>30</td>
<td>13</td>
</tr>
<tr>
<td>2013</td>
<td>0</td>
<td>13</td>
<td>40</td>
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</tbody>
</table>

\(^a\) Brief hands on by staff.  
\(^b\) Prior to 2012, manual restraint-only events were not reported, thus no data are available.
One male staff member competed in a push-up competition with an angry, escalating patient as a way to help the patient regain control. Such interventions can then be added to the patient’s treatment plan.

Physical Environment
A physical environment that invites and supports interpersonal interactions (e.g., staff/patient/visitor) is another element to consider. In a recent randomized controlled study, a significant reduction in the use of S/R was associated with inexpensive changes made to the physical characteristics of the therapeutic environment (Borckardt et al., 2011). Warm colors, small seating areas that invite conversation, pleasant wall decor, and the use of plants and lighting to create inviting spaces can help patients and staff feel more valued and comfortable. In the current authors’ facility, two small side rooms are used as patient television viewing areas, so that the main day area promotes conversation and personal or small group interactions.

One critical component of the Engagement Model was the implementation of twice daily community meetings. These meetings, led by patients with staff guidance and assistance, provide structure as well as a regular forum for discussion of community expectations, issues, and concerns. At each meeting, non-threatening, recovery-focused discussion questions are asked (e.g., What treatment goal will you work on today? What skill will you use today to help you cope with intrusive people?). The community guidelines and nonviolence policy for the unit are also read at each meeting, with time allowed for questions about policy and discussion of any current safety concerns. Patients are informed of pertinent daily announcements and are asked to present any concerns or observations. Each concern is not always able to be addressed in the context of a particular meeting, and firm but respectful verbal redirection is sometimes repeatedly needed. For the meeting to remain therapeutic for all patients, a staff member will sometimes invite a particular patient to join him or her in a side room so that his or her individual concern can be listened to at length and addressed in a more appropriate setting. Nonetheless, the atmosphere of the daily reinforcement of community structure provides stability, emphasizes safety (both real and perceived), invites openness, tends to enhance cohesiveness, informs staff of brewing concerns or complaints, and enables patients to be heard and informed of responses to their concerns. Similar meetings have been used in other settings with good results (Lewis et al., 2009; Norton & Bloom, 2004).

Although it is counterintuitive, patient engagement can also be enhanced during particularly challenging situations on the unit. For example, it is not uncommon for some patients to behave in disruptive, intrusive, and/or aggressive ways, while the remainder of the patient population, who shares the same space, is not engaging in these types of behaviors. In this instance, it can be difficult to balance the needs of the many with the needs of the few. When such behaviors are first becoming apparent, staff may respond with added attention to the more troubled patient(s), with heightened attempts to minimize power struggles, and application of multiple interventions as alternatives to restraint. From the perspective of both patients and staff, these few patients may appear to be “running the unit.”

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help the patient(s) whose behaviors are impacting others, while still attending to the varied needs of the rest of the patient population. Less disruptive patients may report fear, anger, and/or retraumatization or they may perceive that they are not receiving the treatment they deserve, due to diversion of resources to peer(s) who are behaving in disruptive or aggressive ways. Such complaints are not always unfounded, as energy and attention naturally flow toward disruptive patients. Staff may respond quickly (and sometimes impatiently) to these increased needs and requests, while overlooking the fact that such challenges inherently present an opportunity for patients themselves to further engage in the community process and contribute to the solutions. In other words, the fact that part of the solution lies within the problem may be overlooked.

These circumstances can be viewed as opportunities to listen to and dialogue with all patients. A special community meeting can be held, either to address brewing problems or debrief an incident that has already occurred. These meetings can be requested by staff or patients, and patients themselves are encouraged to request a community meeting if they feel the need. Community-wide meetings become an opportunity for patients to verbalize their own anxiety/stress responses and to choose and practice coping strategies. Patient experience is normalized when staff also relate their feelings of discomfort or anxiety.

Such meetings provide an opportunity to educate patients about the trauma-informed model of care. Frequently, the majority of patients verbalize that the more troubled patients should be “locked up.” In the context of a community meeting, these patients are asked whether they themselves have experienced seclusion. Many have and indicate that it is not an experience that they would like to repeat. More often than not, empathy begins to grow, spontaneously generating genuine, caring feedback to the previously targeted peer. Constructive outcomes have been the usual result, with patients themselves brainstorming ways in which they can support their peers, while maintaining their own sense of safety and well-being. Rooms may be made available where patients can go for a quieter atmosphere, additional staff may monitor the milieu areas, and special groups focused on active practice of relaxation or distraction techniques may be held in side rooms. Another tactic has been to use one staff member who remains with the more challenging patient, engaging with him or her on a consistent basis until he or she begins to stabilize. Although one-on-one interventions have a financial impact, S/R has its own costs, including potential injury, psychological impact on staff and those served, as well as monetary implications.

**LEADERSHIP APPROACHES**

**Shared Decision Making: Empowering Staff to Own Their Practice**

According to Huckshorn (2004), a core strategy for the reduction of S/R requires vision and commitment at the leadership level. The current authors also believe it is important for organizational leadership to effectively increase ownership to staff when implementing such changes. Creating opportunities for and welcoming staff input and discussion are crucial. Leaders must also be able to intervene and empower in such a way that they do not override judgment by staff, but rather creatively support and promote sound problem solving and innovative ideas (Chandler, 2012; Delaney & Lynch, 2008). As a result of effective leadership at the management level, staff have developed a more defined low stimulus protocol for intrusive or disruptive patients, increased the use of spontaneous staff “huddles” for problem solving, and promoted greater individual initiative in creating early self-management plans for challenging cases. When managers offer themselves as resources rather than as the ultimate decision makers, it has been found that staff are more likely to take ownership for the success of program changes.

The authors have also discovered that it is crucial for staff to feel empowered in terms of decision making when acute situations occur on the unit. With intentionality, creativity, and hard work, zero S/R events have been maintained for prolonged periods. But sometimes the scale tips. There may come a point at which other tools have failed and S/R seems
to be the last option, not only in terms of physical safety, but also for the psychological safety of all patients and staff. In such cases, it is crucial that staff be given the freedom to make this determination. In the authors’ experience, when the expectation of zero S/R was communicated to staff, their own best clinical judgment was sometimes overruled. Recent evidence may support the authors’ experience, as at least one study suggested that when staff do not feel that unit safety measures are adequate, S/R use may actually increase (De Benedictis et al., 2011). The current authors have found that when staff are continuously immersed in the theory and practice of the trauma-informed model of care, they themselves take the initiative to evaluate all possible alternative interventions before resorting to the use of S/R.

**Staff Education and Quality Review**

Many authors have highlighted the need for up-to-date staff education (Curran, 2007; Huckshorn, 2004; Johnson, 2010). New staff members may come from work environments that were not based in trauma-informed care. As a result, interventions/attitudes that have become second nature to them can clash with, or dilute, the effectiveness of the Engagement Model. In addition, “drift happens.” No matter how well trained or experienced staff are, routine and repetition tend to decrease overall awareness and attention to tasks. If, over time, staff are not reminded of the rationale for the philosophy of treatment, the edge provided by such awareness can be lost. One experienced staff member presented an in-service on the history and development of the treatment model. Both new employees, and those who experienced the 2001 paradigm shift in treatment at the authors’ facility, expressed that this freshening of philosophical perspective was beneficial to them.

Annual Professional Assault Crisis Training (Fox, Johnson, & Nihart, 2014) is now required for all psychiatric, ED, float pool, and Security Services staff members at the authors’ institution. The hospital Security Services works closely with the ED and psychiatric unit, responding quickly to assist when notified of escalating situations and participating in debriefings of unit events in which they are involved. In the early years, security staff often wanted to jump in and “take care of” the situation. They are now masterful in the use of deescalation techniques and are often gratefully acknowledged by patients as those who first helped them regain control while in the ED. Such positive experiences in the ED build a foundation for patient engagement following admission to the unit.

A thorough review of S/R events is crucial to maintain overarching goals and help pinpoint potential problem areas. The intent of such reviews should be to ensure safety and promote problem solving for avoidance of future S/R events, and a non-punitive environment is key to these goals (Huckshorn, 2004). When staff who made the critical decisions resulting in S/R are supported, they feel safer and are more likely to promote enhanced patient treatment and care. In addition, timely reviews of incidents with the patients themselves can lead to prevention in the future and incorporation of self-control strategies in treatment plans.

Over several years, the current authors’ management team performed a root cause analysis (The Joint Commission, 2013) on all incidents of S/R, with subsequent all-staff review in a nonjudgmental forum. This review helped identify missed opportunities or untapped resources, which guided subsequent interventions and reinforced awareness of goals and strategies related to S/R. The authors’ facility’s own incident review process has become less deliberate and consistent over the years, which may contribute to intermittent increases in the use of S/R. A special practice team has been asked to review this matter and make recommendations.

**Rewards and Recognition**

Ongoing recognition of unit successes and individual staff initiatives related to improved patient care is encouraged. Such steps reinforce positive movement toward a therapeutic culture of care and improve overall morale and cohesiveness. Whether it is the recognition of individuals at staff meetings or via department e-mail, unit-wide get-togethers to celebrate specific milestones, or any number of other ways to acknowledge success, such celebrations serve as a continuing reminder of the goals to be reached.

**CONCLUSION**

Although the authors agree with those who underscore the need for sound methodology to evaluate the impact of specific program changes (Borckardt et al., 2011; Stewart et al., 2010), there is also much to be said for experience. In the past 13 years, the authors’ commitment to use S/R as little as possible has remained strong. However, when practice becomes lax about foundational elements of the model, the S/R statistics seem to reflect this leniency. Some
areas have been tightened, new interventions have been added, and more self-direction to staff in other regards has been given. Although the authors believe that the Engagement Model continues to be effective and beneficial to their patient population, there is always the need for continued evaluation and improvement. Other facilities are encouraged to seek greater reduction in the use of S/R.

REFERENCES


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