

Using Seclusion/Restraint in Behavioral Healthcare

Using seclusion and restraint to manage patients having behavioral health crises can lead to severe physical and psychological harm, including death. Research shows these patients also remain in care longer.¹ Thus, the federal government and professional healthcare associations assert that these interventions should be used only when less-restrictive measures have failed.²

In some cases, the use of seclusion and restraint may be necessary to prevent imminent harm to the patient or others, disruptions to the patient's treatment (when the patient has consented to treatment), damage to the physical environment, and elopement

from the unit or facility.³ In violent patients, seclusion or restraint may allow time to assess and evaluate the cause of the patient's behavior.

Any use of these interventions may expose healthcare organizations and behavioral healthcare providers and staff members to liability. Therefore, having an effective risk management approach and thorough policies and procedures related to seclusion and restraint are imperative.

Following are recommendations for using seclusion and restraint safely and for reducing their use when delivering behavioral healthcare to patients.⁴

1

Review your organization's policies for restraint and seclusion. Ensure that they comply with state and federal regulations and accreditation standards and that the organization's actual practices align with its policies. Policies should specifically indicate who has the authority to order seclusion and restraint.

2

Assess behavioral health patients to identify the risk for violence (including previous restraint and seclusion history), medical risk factors for death and injury, and psychological risk factors that suggest the need for a trauma assessment.

3

Provide behavioral healthcare staff with (a) guidelines indicating what staff responses are appropriate in relation to types of patient behavior, and (b) standards for assessing whether patient behavior meets the criteria of imminent danger.

4

Ensure that only behavioral healthcare staff members who have adequate training in correct techniques and protecting patient rights and safety are involved in seclusion and restraint procedures.

5

Ensure that qualified and appropriately trained staff members assess and monitor the physical and psychological needs of secluded or restrained patients. Monitoring may involve constant observation by a trained sitter.

6

Ensure that a physician or other licensed practitioner performs a face-to-face evaluation within 1 hour of the initiation of restraint or seclusion to assess the patient's physical and psychological well-being.

7

[Assess the environment of care](#) for behavioral health patients and correct any deficiencies that may lead to patient violence or potential harm for patients, staff members, and visitors.

8

Document all cases of seclusion and restraint. Specify in the health record why seclusion or restraint was necessary and by what means it was administered, any alternative options that were used or considered, periodic patient assessments, and any negative health outcomes resulting from seclusion or restraint.

9

Debrief after every occurrence of seclusion and restraint to identify ways to avoid future use of them and to mitigate any adverse effects of the event for staff members and bystanders. Consider a two-fold approach: (1) an immediate postevent debriefing to confirm everyone's safety, gather details, and review documentation; and (2) a subsequent, more formal debriefing to analyze the event and to identify areas for improvement.

10

Train behavioral healthcare providers and staff members on de-escalation, conflict negotiation skills, [trauma-informed care](#), cultural competence, etc. Be sure training is ongoing, competency-based, and adapted to the behavioral healthcare staff members' knowledge and responsibilities.

11

Collect data on the use of seclusion and restraint in your healthcare organization to identify trends and compare it to other organizations. Data may serve as an established performance measure for your organization. Ensure senior management is kept aware of data reports.

12

Establish an organizational priority to consistently reduce the use and duration of seclusion and restraint. Use data to assess progress toward this goal.

Resources

- [American Psychiatric Association: Seclusion and Restraint](#)
- [American Psychiatric Nurses Association: APNA Position: The Use of Seclusion and Restraint](#)
- [Crisis Prevention Institute: Are You Using These 6 Core Strategies for Reducing Restraint and Seclusion?](#)
- [Mental Health America: Rights of People With Mental Health and Substance Use Conditions](#)
- [National Association of State Mental Health Program Directors: Position Statement on Seclusion and Restraint](#)

Endnotes

¹ McLaughlin, P., Giacco, D., & Priebe, S. (2016). Use of coercive measures during involuntary psychiatric admission and treatment outcomes: Data from a prospective study across 10 European countries. *PloS one*, 11(12), e0168720. doi: <https://doi.org/10.1371/journal.pone.0168720>

² 42 U.S.C. § 482.13 Condition of participation: Patient's rights. Retrieved from www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-B/section-482.13; American Psychiatric Association. (2022). *Seclusion or restraint*. Retrieved from www.psychiatry.org/getattachment/e9b21b26-c933-4794-a3c4-01ad427eed91/Resource-Documents-SeclusionRestraint.pdf; American Psychiatric Nurses Association. (2022 [last revised]). *APNA position: The use of seclusion and restraint*. Retrieved from www.apna.org/apna-position-the-use-of-seclusion-and-restraint/

³ First, M. B. (2022). Behavioral emergencies. In *Merck Manual for the Professional*. Retrieved from www.merckmanuals.com/professional/psychiatric-disorders/approach-to-the-patient-with-mental-symptoms/behavioral-emergencies

⁴ The risk tips in this publication are based on the following sources: Haimowitz, J. D., Urff, J., & Huckshorn, K. A. (2006, September). *Restraint and seclusion – A risk management guide*. The National Association of State Mental Health Program Directors. Retrieved from <https://power2u.org/wp-content/uploads/2017/09/R-S-Risk-Manag-Guide-Oct-06.pdf>; First, Behavioral emergencies; Crisis Prevention Institute. (2019, August 5). *Are You Using These 6 Core Strategies for Reducing Restraint and Seclusion?* Retrieved from www.crisisprevention.com/blog/behavioral-health/are-you-using-these-6-core-strategies-for-reducing-restraint-and-seclusion/

This document does not constitute legal or medical advice and should not be construed as rules or establishing a standard of care. Because the facts applicable to your situation may vary, or the laws applicable in your jurisdiction may differ, please contact your attorney or other professional advisors if you have any questions related to your legal or medical obligations or rights, state or federal laws, contract interpretation, or other legal questions.

MedPro Group is the marketing name used to refer to the insurance operations of The Medical Protective Company, Princeton Insurance Company, PLICO, Inc., and MedPro RRG Risk Retention Group. All insurance products are administered by MedPro Group and underwritten by these and other Berkshire Hathaway affiliates, including Wellfleet Insurance Company, Wellfleet New York Insurance Company, and National Fire & Marine Insurance Company. Product availability is based upon business and/or regulatory approval and may differ among companies.

© 2026 MedPro Group Inc. All rights reserved.