Replacing Seclusion and Restraint Practices in Psychiatry With Sensory Rooms

EMMA COSTAIN

EMMA COSTAIN

Emma Costain is a 2025 graduate of the Columbia School of Social Work, specializing in policy practice and mental health. As a social worker, she is passionate about research and policy advising in the mental health field, with a particular focus on acute psychiatric inpatient care. Having grown up in a military family, she embraces the idea that home is wherever the heart is.

INSPIRATION

My inspiration for this paper stems from both personal and professional experiences. The idea to replace seclusion and restraint (S/R) practices first took shape during my generalist year practicum at a behavioral health hospital. Drawing on my background working with individuals with Autism Spectrum Disorder and my expertise in behavioral health, I developed the concept of implementing Sensory Rooms as a humane and therapeutic alternative to S/R.

I firmly believe that patients should have agency in their treatment and leave the hospital with transferable coping skills rather than traumatic memories. My work is grounded in advocating for patient rights and ensuring that individuals in acute psychiatric care are active participants in their own recovery. Through this paper, I hope to highlight the urgent need for non-coercive interventions in mental health treatment and contribute to a shift toward more compassionate, patient-centered care.

ABSTRACT

The use of seclusion and restraint (S/R) in acute psychiatric inpatient settings persists as a controversial practice, causing significant harm to patients and stress to staff. This policy brief examines the ethical, financial, and systemic implications of S/R and advocates for replacing S/R with sensory rooms—an evidence-based approach fostering emotion regulation, patient autonomy, and trauma-informed care. Recognizing that eliminating S/R may not be immediately feasible, this brief proposes an incremental approach through a hypothetical pilot program at Jackson Behavioral Health Hospital: converting an isolation room, or a room where a patient receives intervention separately from other patients, on each psychiatric inpatient unit into a sensory room, alongside incentives to reduce overall S/R usage. Sensory rooms can then be evaluated as a humane and cost-effective alternative to S/R practices. This policy brief aims to advance knowledge on patient-centered interventions in mental health care and underscores the ethical imperatives and financial incentives for legislative and organizational policy reform in psychiatric care.

Keywords: seclusion, restraint, sensory rooms, psychiatric inpatient care, policy reform, trauma-informed care, social justice

REPLACING SECLUSION AND RESTRAINT PRACTICES IN PSYCHIATRY WITH SENSORY ROOMS

The field of mental health has progressed in many regards. However, the archaic practice of seclusion and restraint (S/R) still dominates acute psychiatric inpatient care, causing unnecessary trauma and distress for both patients and providers. The Code of Federal Regulations (CFR) define seclusion and restraint as follows:

- Seclusion is "the involuntary confinement of a person alone in a room or area from which the person is physically prevented from leaving" (Condition of participation: Patient's rights, 42 CFR 482.13(e)(1)(ii)).
- Restraint is "any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a person to move his or her arms, legs, body, or head freely" (Condition of participation: Patient's rights, 42 CFR 482.13(e)(1)(i)(A)).

This policy brief will not only exhibit the ethical and financial costs of S/R in psychiatric settings, but will also shed light on potential policy interventions that can significantly reduce the prevalence of S/R. By applying the concept of *emotion regulation*, often used for individuals with autism spectrum disorder, and integrating it with the principles of patient autonomy, acute psychiatric inpatient hospitals can replace seclusion rooms with designated *sensory rooms* (Recovery Ways, 2022). As discussed later in this brief, sensory rooms are spaces that provide patients with efficient, transferrable, and relevant distress tolerance skills that can be used both within the hospital and in their daily lives.

BACKGROUND AND HISTORICAL CONTEXT

The use of S/R in Western psychiatric medicine has a long and troubling history, with its inhumane and traumatizing use dating back to the 1700s. While historically rooted in the control and segregation of those

deemed "unmanageable," these practices persist today, often justified as necessary for safety despite growing evidence of their harm and the availability of alternative interventions (Weiss, 1998).

EUGENICS

In the late 19th and early 20th centuries, psychiatric practices were significantly influenced by the rise of eugenics theory—a discredited form of scientific racism that posited human beings could be perfected and social ills eliminated through genetics (e.g., National Human Genome Research Institute, n.d.). Psychiatrists, frustrated by the lack of effective treatment for mental illness, turned to experimental interventions aimed at controlling and segregating individuals deemed "unfit" by societal standards (Turda, 2022).

One such intervention was the lobotomy, introduced in the 1930s as a means to manage patients with severe mental disorders. This procedure involved severing connections in the brain's frontal lobe and was often performed without patient consent (Mashour et al., 2005). Electroconvulsive therapy (ECT; also known as "shock therapy") also emerged during this period, initially administered under coercive circumstances and without adequate evidence of its effects, further exemplifying the era's inhumane treatment approaches (Scull, 2022).

Similarly, S/R also originated as a means of controlling and isolating those deemed undesirable. Though lobotomies were eventually discredited and abandoned due to their devastating consequences, ECT and S/R persisted and were frequently misused as a means of social control rather than medical necessity, reflecting the broader pattern of psychiatric interventions being wielded as tools of oppression (Larson, 2018).

Marginalized populations—including immigrant populations, people of color, impoverished people, and those who were mentally or physically disabled—disproportionately became the victims of eugenics experimentation by psychiatrists, often under the guise of medical

advancement (e.g., Larson, 2018; Mashour et al., 2005). This targeting extended to the widespread and unchecked use of S/R, which was implemented as a means of control rather than care (Larson, 2018).

PSYCHIATRIC CARE TODAY

Decades later, S/R remains deeply entrenched in psychiatric treatment, disproportionately impacting the same marginalized communities that were historically subjected to these practices. Studies have found that Black patients are significantly more likely to be subjected to S/R than their white counterparts, in both emergency departments and inpatient psychiatric settings (Eswaran et al., 2023; Hawkins et al., 2022). This pattern is not incidental; it reflects the persistent biases and systemic inequities that continue to shape psychiatric care. The case of Orville Blackwood in 1991 serves as a tragic example: Blackwood, a Black psychiatric patient, died after being subjected to excessive restraint and medication. The case led to a national inquiry that revealed Black patients were more likely to be misdiagnosed, overmedicated, and subjected to coercive psychiatric interventions (Prins et al., 1993). These findings reinforce what many mental health professionals and advocates have long argued: S/R is not only a failure of psychiatric care but a practice that also reflects deeper patterns of racism, ableism, and classism embedded in the mental health system.

According to international standards (UN General Assembly, 1992), the use of seclusion rooms and restraints are permitted exclusively in instances where the patient is in imminent danger of harming or killing themselves, another patient, or a staff member. However, research has shown that seclusion rooms are more often used as a form of punishment in response to a patient being loud, disruptive, or noncompliant with medications (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010, p. 1). This misuse is not random: It reflects the same systemic biases and discriminatory patterns described earlier in this section, where marginalized patients are disproportionately subjected to control and punishment under the guise of care. The

widespread practice of S/R demonstrates persistent systemic biases within psychiatric care, and is in direct violation of encouraging patient autonomy, providing trauma-informed care, and respecting the human dignity of every patient (e.g., National Association of Social Workers, 2021). Research also shows that patients subjected to S/R face increased risk of extended lengths of stay in psychiatric facilities and reduced likelihood of returning home upon discharge.

Despite its persistence, S/R is neither therapeutic nor necessary—rather, it is a remnant of outdated and oppressive psychiatric models that have disproportionately harmed vulnerable populations for centuries.

WHAT THE RESEARCH ON SECLUSION AND RESTRAINT SHOWS

In addition to the well-documented evidence of bias in its application, S/R has ethical and financial consequences as well. This section highlights not only the devastating impact of S/R on patient well-being but also the significant costs it imposes on hospitals. These consequences further reinforce the urgent need to adopt more humane, evidence-based alternatives that prioritize patient dignity, safety, and autonomy.

Research illustrates how S/R practices, shaped by the systemic biases and inequities outlined in the previous section, can result in devastating consequences for patients and the healthcare system as a whole. These harms are reflected in ethical failures, clinical outcomes, patient mortality rates, and financial costs, as explored in the rest of this section (Recovery Ways, 2022).

S/R: PATIENT TREATMENT AND CONSEQUENCES

S/R can be applied to a wide range of psychiatric conditions, placing nearly any patient admitted for inpatient psychiatric care at risk regardless of their specific diagnosis. The diagnoses most commonly associated with the use of S/R include schizophrenia, schizoaffective disorder, and bipolar disorder; however, the application is not limited to those conditions (Georgieva et al., 2020). Research indicates that patients subjected to S/R face significantly worse clinical and systemic outcomes compared to those who are not restrained.

The use of S/R in psychiatric settings is not only harmful but can also have fatal consequences. The Substance Abuse and Mental Health Services Administration (SAMHSA) (2010) has reported that "an estimated 50 to 150 individuals die each year as a result of seclusion and restraint practices in facilities, and countless others are injured or traumatized" (p. 1). Other patients die from cardiac arrest triggered by the severe physiological stress of being forcibly restrained—a risk heightened for individuals with underlying medical conditions (LeBel & Goldstein, 2005). Some patients have also died due to neglect, when they were placed in seclusion rooms without proper monitoring and experienced life-threatening medical issues or engaged in self-harm.

ETHICAL ARGUMENT

The use of S/R provides "no therapeutic value, [causes] human suffering, and frequently [results] in severe emotional and physical harm, and even death" (Mental Health America [MHA], n.d., p. 1). The use of S/R exacerbates the suffering of patients who are already dealing with difficult mental health conditions. Psychiatric hospitals should not further patient suffering by placing unconsenting patients in seclusion or restraints.

Many psychiatrists argue that S/R is a necessary tool within acute psychiatric inpatient settings because it allows for the management of behavioral issues related to a patient's mental condition, but "there is little evidence that seclusion provides long-term benefits in terms of treating symptoms or reducing aggression" (Newton-Howes, 2013, p. 422). From an ethical perspective, S/R practices disregard a patient's autonomy and directly contradict patient-focused and trauma-informed care. Evidence of therapeutic benefits to seclusion rooms and restraints is lacking, so it is hard to ethically justify using either practice on a

patient against their will. Finally, the antiquated and cruel practices of S/R are not only violations of human dignity but also direct contributors to preventable deaths, serving as glaring symptoms of the poor quality of care, inadequate staff training, and misinformed public policy that continue to enable these abuses (Grasso et al., 2007).

FINANCIAL ARGUMENT

Significant organizational and healthcare costs also contribute to the argument against S/R. A single episode of either seclusion or restraint can cost the hospital "between $302 and $354" (SAMHSA, 2010, p. 2). Beyond the economic costs, hospitals may have to consider legal costs as a consequence of using seclusion rooms and restraints, as patients or family members may take legal action against the hospital due to the harm, trauma, and in some cases preventable deaths that result from these interventions.

Hospitals must consider both patient safety and regulatory compliance when evaluating the use of S/R. Under federal regulations, "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" (Condition of participation: Patient's rights, 42 CFR 482.13(e), 2008/2025). While S/R may be used to ensure "the immediate physical safety of the patient, a staff member, or others," it must be discontinued at the earliest possible time (Condition of participation: Patient's rights, 42 CFR 482.13(e)(2), 2008/2025). In addition to these protections, hospitals that receive Medicare and Medicaid are required to report deaths associated with S/R to the Centers for Medicare and Medicaid Services (CMS), including "each death that occurs while a patient is in restraint or seclusion," deaths occurring within 24 hours of removal, and cases where it is "reasonable to assume" that S/R contributed to a patient's death (Condition of participation: Patient's rights, 42 CFR 482.13(g)(1)(iii), 2008/2025).

CMS has emphasized the importance of preventing such adverse events,

commonly referred to as never events, which are defined as "preventable medical errors that result in serious consequences for the patient" (CMS, 2008, p.1). In response, CMS has implemented payment policies that discourage preventable harm, stating that "never events cause serious injury or death to beneficiaries and result in unnecessary costs to Medicare and Medicaid due to the need to treat the consequences of the errors" (CMS, 2008, p. 1). These regulations and policies reflect both the ethical obligation to protect patients from harm and the financial consequences hospitals may face when safety standards are not upheld.

S/R can also significantly lengthen a patient's hospital stay, placing additional financial burdens on both the hospital and the patient (LeBel & Goldstein, 2005). Patients subjected to S/R experience prolonged hospitalization due to increased psychological distress, physical injuries, and disruption in their treatment process (Newton-Howes, 2013). Instead of de-escalating crises, S/R has been found to increase agitation, aggression, and trauma symptoms in patients, leading to prolonged care requirements and, in some cases, readmissions (MHA, n.d.). These extended hospitalizations not only delay recovery but also exacerbate healthcare costs, further burdening patients, hospitals, and insurance providers. These findings underscore that S/R is not a neutral intervention but a practice that actively contributes to deteriorating patient health, prolonged institutionalization, and increased systemic costs—all of which highlight the urgency for policy change.

The use of S/R also contributes to workforce burnout and staff turnover, creating additional hidden costs for hospitals. The emotional toll on staff and the physical risks associated with managing aggressive incidents contribute to turnover rates as high as 62% in psychiatric facilities (MHA, n.d.). The costs of recruiting, training, and retaining new staff further strain hospital budgets, making the reduction of S/R a financially sound decision.

From a systemic perspective, it is clear that S/R is not only unethical but economically unsustainable. Research consistently shows that reducing the use of S/R leads to better patient outcomes, lower healthcare costs,

and fewer legal and liability expenses (LeBel & Goldstein, 2005). Policy reformers must recognize that in a capitalist-driven society where financial arguments hold significant weight, demonstrating the economic inefficiency of S/R is a crucial strategy for policy change. The data overwhelmingly supports a transition toward alternative interventions, such as sensory rooms, which improve patient care, reduce hospital costs, and align with trauma-informed care principles (Björkdahl et al., 2016).

POLICY ALTERNATIVES TO SECLUSION AND RESTRAINT

Given the well-documented harm and inefficiency of S/R, psychiatric facilities must adopt alternative interventions that prioritize patient autonomy, emotion regulation, and trauma-informed care. One such evidence-based alternative is the use of sensory rooms, which provide *sensory modulation interventions* (SMIs) to help individuals regulate their emotions in a safe and controlled environment. A sensory room offers patients a safe space where they can learn to regulate their emotions and gain skills they can use outside the hospital. Sensory rooms have long been used to support individuals with autism spectrum disorder (ASD) and other behavioral conditions by helping them regulate their bodies and better adapt to their environment. These rooms are commonly found in schools and educational settings, where they not only support emotion regulation but also improve how individuals with ASD interact with teachers and peers. They foster the person's independence and help them advocate for themselves when they are feeling overstimulated or overwhelmed (National Autism Resources, n.d.).

If a hospital replaced its seclusion rooms with sensory rooms, patients could learn methods for emotion regulation that they could then easily transfer into the world outside the hospital. Patients who are being discharged would have a set of skills that allow them to regulate their emotions rather than resorting to self-harm, aggression, or withdrawal. Sensory stimulation methods empower patients by giving them the control and the autonomy to decide for themselves how they want to self-regulate, rather than confining them within prison-like isolation rooms at hospitals (Haig & Hallett, 2023).

Sensory rooms can also be used as a proactive intervention that helps prevent violent outbursts from escalating into crisis situations requiring S/R (Haig & Hallett, 2023). Eliminating the practice of S/R would improve patient outcomes, lower the financial burden on psychiatric hospitals by reducing the average length of inpatient stays, and increase the likelihood of patients' successful reintegration into their communities (Ma et al., 2021).

SENSORY MODULATION AS A RESPONSE TO COMMON S/R TRIGGERS

As mentioned earlier, S/R is applied broadly to patients exhibiting certain behaviors, regardless of diagnosis (Georgieva et al., 2020). Individuals experiencing severe agitation, self-harming behaviors, physical aggression, or extreme emotional distress are the most likely to be restrained or secluded, even when alternative interventions could have prevented escalation (Ma et al., 2021). Sensory rooms are a proactive alternative that could help patients manage these behaviors before they reach a crisis point.

The use of S/R remains prevalent across the globe, yet these practices are traumatizing for both patients and hospital staff. Sensory rooms provide a viable alternative that allows psychiatric facilities to implement *sensory modulation strategies* in place of coercive interventions. Haig and Hallett (2023) explain that "sensory modulation refers to the personalisation of sensory input by controlling the environment, and use of equipment and/or activities designed to support an individual to self-regulate by achieving their optimum level of calm or alertness" (p. 55). Patients who practice self-regulation inside a sensory room can carry those techniques into life outside the hospital and apply them in daily life to enhance healthy behavior.

Sensory modulation techniques (SMTs) can be used to help prevent

behaviors that trigger S/R interventions. These techniques include:

- Tactile: Weighted blankets, fidget tools, or textured surfaces to reduce distress and ground patients.
- Auditory: Sound machines, white noise, or calming music to lower arousal levels.
- Visual: Soft lighting, visual projection tools, or soothing imagery to decrease anxiety.
- Olfactory: Aromatherapy using calming scents like lavender to help regulate mood.
- Proprioceptive: Deep pressure input through body movement, such as via rocking chairs, yoga balls, or stretching, to improve emotional control (Recovery Ways, 2022).

By offering self-directed and patient-centered regulation strategies, sensory rooms reduce the need for coercive interventions that strip patients of their agency and dignity (Haig & Hallett, 2023). These strategies are not only less harmful but are also therapeutic, as they equip patients with new coping skills that promote long-term emotion regulation and autonomy beyond the hospital setting.

SENSORY ROOMS AS A PROVEN INTERVENTION

Ongoing research within acute psychiatric care is developing the best possible interventions for reducing S/R in inpatient facilities. One intervention suggests treating "patients as active participants in seclusion reduction interventions" (Gaskin et al., 2007, p. 298). One of the many benefits of implementing sensory rooms as an intervention against S/R is that it allows the patient to remain in full control of how they choose to regulate their emotions and manage their distress, thereby making them "active participants" in their own treatment. Psychiatric staff must shift their perspective from treatment happening *to* a patient to treatment happening *with* a patient, thereby reinforcing collaborative care models rather than coercion-based interventions.

Table 1 and 2 show some of the benefits of using sensory rooms instead of S/R in psychiatric care, along with considerations when switching to this model.

While there are currently no sensory rooms in inpatient psychiatric settings in the United States, psychiatric hospitals in Sweden have begun exploring this solution. Although staff in such hospitals were initially ambivalent about implementing sensory rooms, over time they observed meaningful improvements, including patients becoming more independent in managing their emotions, building greater confidence in their ability to care for themselves, and experiencing enhanced overall well-being (Björkdahl et. al., 2016). Sensory rooms supported "the important principles of person-centered nursing and recovery-oriented mental health and the ability of staff to implement these principles" (Björkdahl et. al., 2016, p. 472). Implementing sensory rooms in psychiatric inpatient settings aims to help patients regain their individual autonomy within the treatment they receive, as they learn ways to self-soothe and choose which sensory stimulation methods and tools to use.

IMPLEMENTATION OF SENSORY ROOMS

Before implementing sensory rooms as a matter of state or federal policy in the U.S., this brief recommends identifying one acute psychiatric inpatient hospital to implement sensory rooms as a replacement for S/R. Over the course of one year, research would be conducted within the identified hospital to track the results of the sensory rooms. At the conclusion of the year-long research project, the evidence collected could be brought to governmental bodies to propose policy changes regarding seclusion and restraint practices within acute psychiatric inpatient hospital settings.

Jackson Behavioral Health Hospital (JBHH), located in Miami, Florida, could be used to implement the recommended intervention due to its existing inpatient psychiatric infrastructure. Each of the psychiatric inpatient units at JBHH has two rooms designated as observation

rooms, or rooms used exclusively for S/R. For the duration of the year-long research project, one of the adult behavioral health units at JBHH could transform one of their two observation rooms into a designated sensory room. All staff within the unit would be educated on how to use the sensory room when a patient is overstimulated. The patient would be instructed to use the coping tools in the sensory room before staff considered using seclusion and restraint.

To successfully create a sensory room, the room needs to be filled with a variety of objects that appeal to the different senses. There should be multiple options for each of the five senses so that the patient can choose what works best for them as they learn emotion regulation and distress tolerance. Table 3 offers examples of different objects and tools within the sensory room that will provide a sensory experience for each of the five senses.

Given the nature of behavioral health hospitals, the objects in the sensory room cannot put the patient at risk of suicide or self-harm. For example, headphones must be wireless, and there cannot be any sharp objects. In addition to providing tools that appeal to the five senses, the sensory room can contain resources such as books, journals, and handouts that allow the patient to occupy their mind while simultaneously doing something therapeutic. The sensory room should shift away from the traditionally all-white walls of a psychiatric hospital and include decor such as soft carpets and light paint colors, which have been shown to create a calming atmosphere and support patient well-being (Eminovic et al., 2022).

Sensory rooms are not just a theoretical alternative—they represent a research-based intervention that can replace outdated and harmful S/R practices. The transition from coercive interventions to sensory modulation techniques is a necessary step toward ethical, patient-centered psychiatric care.

CONCLUSION AND POLICY RECOMMENDATIONS

The goal of acute psychiatric inpatient treatment is to ensure that the patient is stable enough to return to their community without being at risk for self-neglect or self-harm. As such, acute psychiatric care seeks to help patients reintegrate with their communities upon discharge. Giving patients access to sensory rooms while still admitted to inpatient psychiatric care will show patients the variety of ways in which they can self-soothe and self-regulate, through a variety of sensory modalities that they will be able to carry over into the world outside the hospital after being discharged. Sensory rooms can eliminate the use of seclusion and restraint in psychiatry by making the patients active participants in their treatment and equipping them with necessary distress tolerance and emotion regulation skills. Learning such skills will give patients transferable, relevant, and effective methods of coping, both inside the hospital and in their communities after discharge.

However, achieving systemic change requires collective action at all levels of psychiatric care, not just from policymakers. Social workers play a crucial role in advocating for and implementing alternative interventions within their own workplaces and communities. Even social workers who do not hold policy making roles can educate hospital administrators, clinical teams, and leadership about the proven benefits of sensory rooms. By advocating for pilot programs within psychiatric facilities, conducting data-driven evaluations of sensory room effectiveness, and documenting reductions in S/R use, social workers can generate the evidence needed to push for larger-scale policy reforms. If multiple hospitals implement sensory room interventions and gather compelling research on their impact, this evidence could influence national mental health policies and establish sensory rooms as the standard of care in inpatient psychiatry.

Sensory rooms are not just an abstract recommendation—they are a practical, evidence-based solution that can replace outdated and harmful

psychiatric interventions. Through advocacy, education, and research, social workers at all levels of practice can contribute to a fundamental shift in psychiatric care, ensuring that patients receive compassionate, trauma-informed, and effective treatment.

REFERENCES

Björkdahl, A., Perseius, K., Samuelsson, M., & Lindberg, M. H. (2016). Sensory rooms in psychiatric inpatient care: Staff experiences. *International Journal of Mental Health Nursing*, 25(5), 472–479. https://doi-org.ezproxy.cul.columbia.edu/10.1111/inm.12205

Centers for Medicare and Medicaid Services (CMS). (2008, July 31). *Medicare and Medicaid move aggressively to encourage greater patient safety in hospitals and reduce never events* [Press release]. https://www.cms.gov/newsroom/press-releases/medicare-and-medicaid-move-aggressively-encourage-greater-patient-safety-hospitals-and-reduce-never

Condition of participation: Patient's rights, 42 CFR 482.13 (2008/2025). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-B/section-482.13

Eminovic, S., Vincze, G., Fink, A., Fischerauer, S. F., Sadoghi, P., Leithner, A., Kamolz, L. P., Tscheliessnigg, K., & Bernhardt, G. A. (2022). Positive effect of colors and art in patient rooms on patient recovery after total hip or knee arthroplasty: A randomized controlled trial. *Wiener klinische Wochenschrift*, 134(5–6), 221–226. https://doi.org/10.1007/s00508-021-01936-6

Eswaran, V., Molina, M. F., Hwong, A. R., Dillon, D. G., Alvarez, L., Allen, I. E., & Wang, R. C. (2023). Racial disparities in emergency department physical restraint use: A systematic review and meta-analysis. *JAMA Internal Medicine*, 183(11), 1229–1237. https://doi.org/10.1001/jamainternmed.2023.4832

Gaskin, C., Elsom, S., & Happell, B. (2007). Interventions for reducing the use of seclusion in psychiatric facilities: Review of the literature. *The British Journal of Psychiatry*, 191(4), 298–303. https://doi.org/10.1192/bjp.bp.106.034538

Georgieva, I., Mulder, C. L., & Whittington, R. (2020). Effects of seclusion and restraint in adult psychiatry: A systematic review. *Frontiers in Psychiatry*, 11, 119. https://doi.org/10.3389/fpsyt.2020.00119

Grasso, B. C., Shore, M. F., Clary, C. M., Eng, B., Huckshorn, K. A., & Parks, J. J. (2007). *Medication errors and patient safety in mental health*. Medscape CME. https://www.medscape.org/viewarticle/563039

Haig, S., & Hallett, N. (2023). Use of sensory rooms in adult psychiatric inpatient settings: A systematic review and narrative synthesis. *International Journal of Mental Health Nursing*, 32(1), 54–75. https://doi.org/10.1111/inm.13065

Hawkins, M. A., Sinha, S., & Carter, P. M. (2022). Association of Black race with physical and chemical restraint use among patients undergoing psychiatric evaluation. *Psychiatric Services*, 73(2), 123–129. https://pubmed.ncbi.nlm.nih.gov/34932385/

Larson, Z. (2018). America's long-suffering mental health system. *Origins: Current Events in Historical Perspectives*. https://origins.osu.edu/article/americas-long-suffering-mental-health-system

LeBel, J., & Goldstein, R. (2005). The economic cost of using restraint and the value added by restraint reduction or elimination. *Psychiatric Services*, 56(9), 1109–1114. https://doi.org/10.1176/appi.ps.56.9.1109

Ma, D., Su, J., Wang, H., Zhao, Y., Li, H., Li, Y., Zhang, X., Qi, Y., & Sun, J. (2021). Sensory-based approaches in psychiatric care: A systematic mixed-methods review. *Journal of Advanced Nursing*, 77(10), 3991–4004. https://doi.org/10.1111/jan.14884

Mashour, G. A., Walker, E. E., & Martuza, R. L. (2005). Psychosurgery: Past, present, and future. *Brain Research Reviews*, 48(3), 409–419. https://doi.org/10.1016/j.brainresrev.2004.09.002

Mental Health America (MHA). (n.d.). *Position statement 24: Seclusion and restraints*. https://mhanational.org/issues/seclusion-and-restraints

National Association of Social Workers. (2021). *Code of ethics of the National Association of Social Workers*. https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English

National Autism Resources. (n.d.). *School sensory rooms*. https://nationalautismresources.com/school-sensory-rooms/

National Human Genome Research Institute. (n.d.). *Eugenics and scientific racism*. https://www.genome.gov/about-genomics/fact-sheets/Eugenics-and-Scientific-Racism

Newton-Howes, G. (2013). Use of seclusion for managing behavioural disturbance in patients. *Advances in Psychiatric Treatment*, 19(6), 422–428. https://doi.org/10.1192/apt.bp.112.011114

Prins, H., Backer-Holst, T., Francis, E., & Keitch, I. (1993). *Report of the inquiry into the death of Orville Blackwood*. Midlands Centre for Criminology and Criminal Justice, Department of Health, Afro-Caribbean Mental Health Association, & Institute of Criminology at Cambridge University. https://www.mentalhealthlaw.co.uk/media/1993_SHSA_Blackwood_Inquiry_report.pdf

Recovery Ways. (2022, August 26). *Sensory-based strategies for self-regulation*. https://www.recoveryways.com/rehab-blog/sensory-based-strategies-for-self-regulation

Scull, A. (2022). *Desperate remedies: Psychiatry's turbulent quest to cure mental illness*. Harvard University Press. https://doi.org/10.4159/9780674276475

Substance Abuse and Mental Health Services Administration. (2010, March). *Promoting alternatives to the use of seclusion and restraint issue brief #4: Making the business case*. https://www.samhsa.gov/sites/default/files/topics/trauma_and_violence/seclusion-restraints-4.pdf

Turda, M. (2022, October 24). Exploring the legacies of eugenics in psychiatry—Part I. *History, Archives and Library Blog*. Royal College of Psychiatrists. https://www.rcpsych.ac.uk/news-and-features/blogs/detail/history-archives-and-library-blog/2022/10/24/eugenics-in-psychiatry-part-one

United Nations General Assembly. (1992, February 18). *The protection of persons with mental illness and the improvement of mental health care: resolution / adopted by the General Assembly.* United Nations Digital Library. https://digitallibrary.un.org/record/135851

Weiss, E. M., Altimari, D., Blint, D. F., & Megan, K. (1998, October 15). Deadly restraint: A nationwide pattern of death. *The Hartford Courant*. https://www.charlydmiller.com/LIB05/1998hartfordcourant11.html

TABLE 1
BENEFITS RELATED TO SENSORY ROOMS

Benefits of Sensory Rooms	
Empowers patients	Sensory rooms encourage self-regulation and autonomy by allowing patients to choose their own coping mechanisms, reducing trauma from coercion-based interventions (Haig & Hallett, 2023).
Reduces aggression and violence	Sensory rooms provide a proactive, nonrestrictive intervention that can de-escalate situations before they reach a crisis leading to the use of S/R (Björkdahl et al., 2016).
Improves patient outcomes	Sensory rooms reduce the need for S/R, decrease inpatient stays, and enhance emotional well-being, leading to greater patient stability post-discharge (Georgieva et al., 2020).
Space requirements	Hospitals can use existing rooms designated for S/R to create sensory rooms.
Cost-effective for hospitals	Lower reliance on S/R reduces hospital costs associated with longer inpatient stays, lawsuits, staff injuries, and insurance penalties.

TABLE 2
CONSIDERATIONS RELATED TO SENSORY ROOMS

Considerations for Sensory Rooms	
Initial resistance from staff	Some staff members may struggle with relinquishing control and adapting to a less authoritative model of care (Björkdahl et al., 2016).
Not a one-size-fits-all solution	Sensory interventions must be tailored to individual needs, and not every patient will respond equally well to the same sensory modulation techniques (Georgieva et al., 2020).
Need for staff training	Effective implementation relies on well-trained staff who understand how to guide patients in using sensory tools effectively rather than reverting to traditional control-based interventions (Haig & Hallett, 2023).

TABLE 3
SENSORY ROOMS AND THE FIVE SENSES

Sensory Rooms and the Five Senses	
Taste	• Sour candies • Cold ice cubes • Calming tea (available upon request)
Touch	• Cold washcloths • Kinetic sand • Weighted blankets • Calm Strips • Fidget toys
Smell	• Essential oils • Scented markers • Scented Play-Doh
Sight	• TV screen with calming visuals such as nature walks, relaxing ocean waves, and gentle rain • Posters with breathing techniques
Hearing	• Ambient music • Wireless noise-canceling headphones