A practical guide to the use of seclusion in mental health settings

Dr Hamid Alhaj, MD, PhD, MRCPsych
Consultant Psychiatrist
Hon Senior Clinical Lecturer
Director of Medical Education
NAPICU Director of Research
Objectives

- To understand what seclusion is and how it is viewed compared to other restrictive interventions.
- To develop your knowledge of what the cautions of seclusion are and when it is considered appropriate to use.
- To recognise the standard requirement for seclusion environments/facilities.
Background

- **Definition**
  
  (the Code of Practice to the MHA 1983 in England)

  “the supervised confinement of a (person) alone in a room, which may be locked, for the protection of others from significant harm.

  Its sole aim is to contain severely disturbed behaviour, which is likely to cause harm to others”.
Restrictive interventions

- RIs include
  - Mechanical
  - Physical restraint
  - Chemical
  - Seclusion
- Controversies around
  - Legal
  - Ethical
  - Practical
  - Risks
Seclusion

Use of seclusion 2016/17 (1 outlier removed)

• The national mean average shown is 203 incidences per 100,000 bed days (excluding leave).
• SHSC reports 3rd highest in the country, with a figure of 614 incidences per 100,000 occupied bed days.
• Over the 3 year period incident numbers have reduced slightly (5%) to 299 for 2016-17.
• Compared against bed days Sheffield incident rates for seclusion are 35% higher over the 3 year period.
• Rates in Sheffield have been between 2 to 3 times higher than the NHS average over the 3 yrs.

Data: 12 mths worth.

### Table: Number of incidences of use of seclusion in 2016/17 per 100,000 occupied bed days excluding leave

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
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<tbody>
<tr>
<td>No of seclusion incidents</td>
<td>315</td>
<td>296</td>
<td>299</td>
</tr>
<tr>
<td>Sheffield per 100,000 bed days</td>
<td>453</td>
<td>507</td>
<td>614</td>
</tr>
<tr>
<td>UK per 100,000 bed days</td>
<td>156</td>
<td>219</td>
<td>203</td>
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Update Apr-Dec17
221 same as 2016-17
Cautions with seclusion?

- The use of seclusion can have a detrimental psychological, emotional and physical effects on patients (Bonner et al 2002; Holmes et al 2004).

- RIs have been implicated in being: ‘a major contribution to delaying recovery, and have been linked with causing serious trauma, both physical and psychological’ (Department of Health, 2014).
  - However, a study found that the presence of seclusion did not appear to affect the rate of recovery as measured by HoNOS (Griffiths et al 2018).

- A US study (Frueh et al 2005) found traumatic and harmful experiences within psychiatric settings, with seclusion being used at 59 % and restraint 34 % of inpatients.

- Seclusion should only be used for detained patients (CoP).
Does seclusion work?

- Systematic reviews have found no randomised control trials to assess its effectiveness and safety (Nelstrop et al 2006; Sailas & Fenton 2000; Van Der Merwe, Bowers, et al 2009).
  - an RCT involving restraint or seclusion may be unethical.
- Sailas and Fenton (2000) suggested that RIs are of no therapeutic benefit.
Does seclusion have therapeutic benefits?

- There are particular situations, where all other options have been considered, seclusion may be *the option* that presents the *lowest risk* and is likely to be of *most benefit* to the individual concerned, i.e. ‘least restrictive’ option (CoP).
- Seclusion room can provide a unique low stimulus environment.
- Some patients prefer it to other RIs.
- Rate of improvement (using HoNOS) was higher in the secluded group with borderline PD (Griffiths et al 2018).
Factors associated with seclusion

- Generally inconsistent findings among different studies.
- **Demographic:** younger age, being male, longer hospital stay and involuntary admission.
- **Diagnosis:** schizophrenia, bipolar, personality disorders, organic and substance use related disorders.
- **Clinical settings:** The Royal College of Psychiatrists (2007) reported that seclusion is more frequent in forensic units (53%) compared to acute and rehabilitation wards (33 and 25%, respectively).
Seclusion rooms

- Privacy and dignity.
- Physical comfort.
- Access to food and drink.
- Communication with staff.
Seclusion rooms (MHA CoP)

- specifically designed and designated for the purpose of seclusion.
- allow for communication with the patient (e.g. via an intercom).
- include limited furnishings (a bed, pillow, mattress and safe blanket or covering).
- have no safety hazards.
- have robust, reinforced window(s) that provide natural light.
- have externally controlled lighting.
Seclusion rooms (MHA CoP)

- have robust door(s) which open outwards.
- have externally controlled heating and/or air conditioning, which enable those observing the patient to monitor the room temperature.
- have no blind spots, and alternate viewing panels or CCTV should be available when required.
- have a clock that is always visible to the patient from the room.
- have access to toilet and washing facilities.
New Seclusion Design – Media wall

- [https://www.youtube.com/watch?v=bUrnTNJ9uME](https://www.youtube.com/watch?v=bUrnTNJ9uME)
Conclusions

- Seclusion is of questionable therapeutic benefit and should not be used unless the risks cannot be managed by any less restrictive approach.

- Seclusion must only be used in the context of a comprehensive policy on the management and prevention of aggressive behaviour.

- Proactive behavioural support plans can mitigate against the need for such restrictive measures.

- It is necessary to acknowledge the use of seclusion and ensure that it is properly monitored with the aim of reducing the known risks associated with its use.
Thank You