

## EDITORIAL

# Restrictive interventions and seclusion: time for another look

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During the late summer of 1984, I began my career as a Health Care Assistant in Mental Health. By 1986, I was often involved with taking patients to seclusion rooms and locking them alone inside. The large red brick Victorian asylum within which I worked, had at least one seclusion room attached to every admission ward in the 700-bed hospital. Over the years, I became very familiar with the seemingly endless cycle of going from ward to ward assisting with getting people into seclusion rooms and thereafter taking part in the ‘seclusion reviews’. Looking back, it’s hard for me now to easily recall the reference points of the era that had me so utterly convinced that seclusion was an essential part of working in a safe hospital. Nevertheless, for many years, utterly convinced I remained.

Locking a patient alone in a room, ‘traditional seclusion’, remained an important part of most institutions’ ability to respond to a variety of behaviours, in particular aggression. In addition, seclusion also very often represented the response to various and sometimes dubious perceptions of the risk a patient posed. I spent the first ten years of my career working with seclusion and considering it to be an important and necessary method of dealing with disturbance. Even in the early 1990s, I remained convinced that such methods were essential. More importantly, I also was convinced that without traditional seclusion, serious consequences for the safety of inpatient wards would ensue.

During 1994, I found myself in the role of Ward Manager of our brand new PICU service. With a new, highly staffed and motivated service it was only right (or so we thought) that there should be new expectations for practice development. Caught up in the excitement and optimism of a new service, we set ourselves the challenge of trying to avoid the use of locked door seclusion for as long as



possible. We were determined to at least try to significantly reduce dependence on seclusion for managing disturbed behaviour. Back then, despite our best efforts, our expectation was that we would probably succeed in avoiding the use of seclusion for no longer than a week or two. Eventually or even inevitably, we would have to resort to the tried, tested and familiar practice of locking a patient alone in a room. Deep down we somehow knew, no matter how hard we tried, that the time would come when the seclusion room provided the only safe answer to the risk presented.

Within the young and enthusiastic team that had been assembled to operate the first PICU in the County, a sense almost of competition emerged amongst the team members. There was an infectious desire to demonstrate to the patients, to each other and to ourselves, that de-escalation and creative engagement for management of aggression could successfully avoid the need to lock a person alone in

a room. In this atmosphere, we wondered who would be the first within the team to concede that the key to the seclusion room was all that was left so that the unit could return to safety?

The first week went by with the absence of high drama. By the third week, while there had been episodes of disturbance that had been managed with a variety of different approaches, none of those approaches involved locking a person alone in a room. The use of activity programmes, escorted leave and positive engagement had seemingly brought enough calm that there was not even the need for a patient to be separated from the rest of the unit for ‘special observation’. Unfortunately, by week four, things had changed.

A serious assault occurred within the Unit which marked a turning point from which there would be no return. The assault left the Deputy Ward Manager with a very bloody and fractured nose. Difficult physical intervention was required for the initial management of the situation. There was need for the patient to be removed to a quieter area of the unit, away from others, although never separated from staff. Following a period of de-escalation, things seemed to settle down. With the incident as good as over, almost without realising it, we found that we were not the other side of a seclusion room door looking through a toughened glass panel at the patient within. We became aware that we were instead still with the patient in a quiet area, the situation calming without clear need to find the seclusion room. What, if anything could this mean?

When we were able to catch ourselves thinking, it seemed that we had somehow come to feel that the resort of locking a patient alone in a room was unavailable. The previous weeks had unexpectedly created a strange new culture. Within the atmosphere of the unit, the ethos had taken hold that there were other, better, ways of dealing with aggression than locking the patient away. It seemed inescapable that the decision had been taken that it was not necessary to lock away in a room, the person who had seriously assaulted the staff member.

This proved to be a point of no return. There was consensus and confidence within the PICU team that the Unit could operate without the provision of a locked door seclusion room. To solidify this new reality, there was ceremonial removal of all the locks from the seclusion room door. From that day to this, nearly a quarter of a century has passed. For all of this time the local PICU has never needed to lock a patient alone in a room.

Since the revision of the Mental Health Act Code of Practice (MHA COP) was published in 2015, there has been consistent focus on the use of ‘restrictive interventions’ in UK mental health inpatient services (DH 2015). Reports of patients spending hundreds of days and even years in seclusion and long-term segregation has caught the attention of both the clinical community and policy

makers. A Care Quality Commission Mental Health (CQC) Act monitoring visit report in 2015 noted that in a medium secure unit ‘One of the seclusion rooms was occupied by a patient who had been secluded for the past 23 months’ (CQC 2015)

During the last five years, the UK has been preoccupied with reducing restrictive interventions and promoting practice which is considered ‘positive and safe’. Over the next two years, there will be another close look at where we are with these issues in general and with close scrutiny of the use of seclusion in particular.

Since 2015, methods of managing disturbance involving separating a patient from their peers and engaging them intensely with allocated staff members now meets the definition for seclusion within the MHA COP. This also requires regulation and review as set out in Chapter 26 of the MHA COP (DH 2015). Over the past four years, there have been attempts to produce guidance to assist services to recognise when there is a need for detailed review and regulation as described by the Code of Practice.

Difficult questions remain however with the understanding and regulation of seclusion. These include: Do we need to lock patients alone in a room at all? If we do not lock patients alone in a room and instead prefer to stay in company with patients believing this method superior, then at what specific point should review and regulation commence? How have circumstances emerged which allow patients to be subject to long-term segregation, in some cases for many months and even years in duration?

In a previous *JPI* editorial ‘Seclusion: what’s in a name?’ (Dix 2017) we considered the difference between traditional seclusion involving a patient being locked alone in a room and patients kept away from their peers although in the company of the staff. The recent addition of the need for the latter to be regulated identically to traditional seclusion has also motivated important debate.

Other restrictive interventions including the use of restraint, restriction of items (in some units even extending to toilet tissue) has also again added to the level of concern regarding restrictive interventions. Another *JPI* editorial ‘Searching for contraband and finding answers in a PICU’ (Dix 2018), covered the thorny issue of searching patients within a mental health unit and the extent to which this also could be seen as a blunt instrument for control, the value of which remains inconsistently understood.

Within the UK, the Care Quality Commission (CQC) are the regulators for mental health services. Possibly re-energised after the events of Winterbourne View scandal (CQC 2012) there are continuing determined efforts for identifying and managing the use of restrictive interventions. Once again, the CQC is leading it’s commendable ‘Positive and Safe Champions Network’ offering close scrutiny of the use of restrictive interventions and inviting members of the clinical community to contribute

to analysis leading to reduction of the need for the more coercive methods of managing disturbed behaviour.

During 2016, NAPICU produced a national position statement on the use of seclusion and long-term segregation in the context of the then new 2015 Mental Health Act Code of Practice (NAPICU 2016). Despite this publication, a variety of guidance videos and nearly four years of implementation, confusion remains regarding the nature of seclusion and expectations for its regulation.

We at the *JPI* invite more commentary, analysis and debate in respect of the use of restrictive interventions in general and continuing issues regarding the use of seclusion in particular.

We urge you to seek out the positive and safe practice development events and make your experience count for improving practice towards least restriction. Most importantly, ensure that you share your wisdom with the readers of *JPI*.

## References

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national association of psychiatric intensive care & low secure units

NAPICU, the UK's National Association of Psychiatric Intensive Care and Low Secure Units, was formally established in 1996. A not-for-profit multidisciplinary organisation, it is committed to developing and promoting the specialty of psychiatric intensive care and low secure services. It is dedicated to the continuous improvement of patient experience and outcome, and to the promotion of staff support and development.

NAPICU undertakes research, education and practice development using quarterly meetings and annual conferences, this journal, training initiatives, and its website and social media. Its members work in specific wards or units which have joined the Association, or as individual mental health professionals in any discipline. Membership is international and is open to both practitioners and academics.

NAPICU's core aims are:

- to improve patient experience and outcomes;
- to promote staff support and development;
- to improve the delivery of care;
- to audit the effectiveness of care;
- to promote research, education and practice development; and
- to provide best practice guidance in association with national bodies.

Its Executive Committee works with key stakeholders to shape policy and practice in the area of acute in-patient psychiatry, including psychiatric intensive care and low secure services.

**NAPICU website:** <http://napicu.org.uk>

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