The practice of seclusion: to change or be changed?

A review of the current discourse on its use

Authors

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Abstract

Seclusion is an intervention used as a safety measure to manage violent patients with disturbed behaviour who pose a risk of harm to others (Department of Health, 2008). However, it is perceived as a contentious practice and has received much criticism in the general move to treating psychiatric patients in the least restrictive environment. Subsequently, there has been much debate on its therapeutic value, and a call for this intervention to be phased out. This paper outlines the purpose of seclusion and examine the evidence on the use of seclusion in adult mental health settings, its impact on nurses and patients involved in this practice with emphasis on the interpersonal nature of nursing care for this intervention.

Key findings on the effects of seclusion

In reviewing the literature on the use of seclusion, it is evident that opinions are divided amongst professionals, patients and carers on this contentious practice. There are those who argued that seclusion is a therapeutic intervention where patients have reported positive benefits such as feeling safe and having a therapeutic space for themselves to reflect and to allow for a non-disruptive expression while they restabilise on their medications (Meehan et al, 2004; El-Badri and Mellsop, 2008).

Conversely, others have mixed views about seclusion and have commented on both the benefits and adverse effects of seclusion (Happell and Harrow, 2010; Van Der Schaaf et al, 2013) which impact on patients' human rights with regards to their autonomy, dignity, freedom and privacy and which affected their recovery (Hoesktra et al, 2004; Bowers et al, 2012, Ezeobele et al, 2014; Holmes, Murray and Knack, 2015; Brophy et al, 2016). Both patients and staff involved in the intervention of seclusion reported negative experience of seclusion. Patients expressed feelings of anger, abandonment, being depressed, scared and feeling punished (Bowers et al, 2012, Ezeobele et al, 2014). Patient's mental states were worsened because they felt isolated and anxious and reported increasing feelings of paranoia (Frueh et al, 2005). Some patients reported that their experiences were so bad that they resulted in relived past trauma and felt dehumanized (Bowers et al, 2012). Nursing staff expressed mixed feelings of fear, frustration, power, and relief that the patient was secluded (Van Der Nagel et al, 2009)

These adverse experiences negatively impacted on the nurse-patient relationship where patients lost trust and confidence in nurses' due to the anger they felt towards them leading to a lack of therapeutic rapport and relationship (Ezeobele et al, 2014; Brophy et al, 2016).

The purpose of seclusion

In mental health settings, seclusion is a restrictive practice which involves relocating a patient to the confines of a locked room particularly designed to contain and observe patients until it is deemed safe for them to be allowed to reintegrate with other patients. The Mental Health Act Code of Practice (2015) in England, dictates that the sole purpose of seclusion is for the safe management of a severe and acutely disturbed patient who poses an immediate risk of physical harm to others. Internationally, most countries have legal and administrative frameworks that set out specific guidance and conditions for the use of seclusion but the circumstances and measures under which seclusion are used can vary (see appendix 1).

Under current UK legislations and guidelines, the room used as seclusion needs to be fit for purpose with access to basic facilities (NMC, 2015; CQC 2015). The care planning of the secluded patients in line with their care plans requires that they are continually observed by a nurse who will engage therapeutically with them to monitor their mental state, physical needs and safety with regular medical reviews and base line observations such a blood pressure and pulse monitoring (Department of Health, 2013).

For patients placed in seclusion, their mental and physical state (baseline observations) would be regularly monitored based on local hospital policies on seclusion and rapid tranquilisation because these patients would usually be administered medications that have deeply sedating effects in managing their agitation and aggression. These medications known as rapid tranquilising medications, are given to very agitated patients to quickly calm them down to minimise the risk of harm to others when all other means of managing patients' aggressive behaviour have been unsuccessful (Parker, 2015).

The possible side effects of these medications include respiratory depression/arrest, cardiac problems, loss of consciousness, Neuro malignancy syndrome and seizures (Ranjan and Chandra, 2005; Parker, 2015). Monitoring of baseline observations would include temperature, pulse and oxygen levels (NICE, 2015). In case of an uncooperative secluded patient some baseline observations can still be noted such as mental alertness, respiration rate, mobility, their skin colour and how their breathing is, which is a part of the vital signs national early warning system (RCP, 2015; NHS England, 2015).

Contemporary thinking and legislations

In contemporary mental health nursing, seclusion is used as a last resort option when all other de-escalation strategies have been exhausted (Department of Health, 2008). Its use is justified in emergency situations to prevent harm to others in managing aggressive and violent patients (Mental Health Commission, 2015). This practice is subject to the legislations and restricted to patients under the jurisdictions of the Mental

Health Act (1983, revised 2007). However, as stated by Department of Health (DH, 2008) in cases where an informal patient is secluded, it is an indication for formal detention. Informal patients can also be secluded in an emergency under common law doctrine where there is a need to protect others from the immediate risk of significant harm. In such cases assessment under the Mental Health Act would be considered or help sought from the Police (Department of Health, 2008) depending on the local Trust and the police arrangements in place.

Furthermore, seclusion can be preceded by physical restraint which has led to injuries and even deaths such as the case of David Bennett (NSC Strategic Health Authority, 2003) and more recently Olaseni Lewis while being restrained by police officers (INQUEST, 2017). Following subsequent serious incident reviews a memorandum of understanding has been developed to the appropriateness of using the police as emergency assistance in physically restraining people in healthcare settings (College of Policing, 2017).

Mental health law is about promotion of mental disorders and protection of dignity and autonomy (Moral and Muir-Cochrane, 2002), but when seclusion deprives individuals of their liberty, it has potential for misuse and may lead to legal judgements (Mayers et al, 2010; Knox and Holloman, 2011).

So, it is worth noting that the guidance for the use of seclusion in the Mental Health Act Code of Practice (2015) provides clarification on its use and any unjustified departure from the code can be deemed unlawful such as in the case of patient ‘S’ against Airedale Hospital and Ashworth Special Hospital. The appeal court found that the hospitals were in breach of article 8 of the European Convention on Human Rights: the right to respect for private life (Dyer, 2003).

Current mental health nursing practice involves caring, advocacy and engagement with patients, based on person centred values that promote compassionate care (Department of Health, 2012, Hewitt-Taylor, 2015). Care delivery is underpinned by a recovery approach which aims to give patients’ a voice and which would allow their concerns primacy by embracing their needs, values and preferences (Ashcroft and Anthony, 2002) while respecting their human rights (Geller, 2012). However, the existence of a seclusion room sits uncomfortably with the principles of care and the therapeutic purpose of this intervention. Most studies report a negative patients’ experience which restrict patients’ autonomy and privacy (Happell and Koehn, 2011, Whitecross et al, 2013; Merineau-Core and Morin, 2014) and diminishes patients’ self-responsibility and self-control, limiting their ability to develop coping strategies for their recovery (Brophy et al, 2016).

Hence, the therapeutic nature of seclusion can be perceived as an oxymoron due to the contradictory effect of this practice and is further confounded by what Morrall (2000) described as a “psychiatric paradox”. The concept of the “psychiatric paradox” relates to the conflicting role of clinicians in empowering their patients, and at the same time

exerting some forms of power and control over them. The detention of patients, is a relevant form of power that is bestowed to clinicians in mental health settings and becomes more apparent in restrictive practices such as seclusion which adds another layer of control by physically and socially excluding patients from others as a safety measure (Meehan et al, 2004; Hoekstra et al, 2004; Van Der Nagel et al, 2009).

However, it is worth noting that power is an unavoidable position in mental health nursing and at times are necessary to care for acutely ill vulnerable individuals requiring detention until the time they can assume control over their lives (Coastworth-Puspoky et al, 2006). As treatment progresses there is gradual shift of power and control to patients in restoring their independence (Scanlon, 2006, Coastworth-Puspoky et al, 2006).

So, it is imperative that in the use of seclusion the concept of this imbalanced power is given full consideration and the patient is enabled to regain control of the situation as soon as it is appropriate to do so. The decision to seclude the patient needs to be proportionate to the degree of the threat faced by balancing the therapeutic and safety factors and considering the effectiveness and harmfulness of this intervention (Georgieva et al, 2012) and not a planned intervention influenced by the ward's prevailing culture and staff attitudes and views to using seclusion without considering other alternatives first (Hoekstra et al, 2004).

The therapeutic value of seclusion

The main reason for using seclusion is for safety concern (Oberleitner, 2000; Muir-Cochrane and Holmes, 2001) and both staff and patients felt that without seclusion, acute in-patient units will be unsafe environments (El-Badri and Mellsop (2008). Healthcare staff are at risk of violence and aggression and some groups such as mental health staff working on acute inpatient wards are more at risk than others (Cornaggia et al, 2011, NICE, 2015).

Some studies have reported that when more male and experienced nurses are on duty, the level of seclusion is reduced (Jansen et al, 2007). However, other studies have shown that addressing staffing levels did not reduce the use of seclusion (Meehan et al, 2004) but effective teamwork and policies to guide decision making process and reporting of incidence management have shown to decrease rates of seclusion and restraint (Bonner et al, 2002).

Nevertheless, it has been reported that seclusion protected patients and other individuals from harm and injury, helped patients to change their behaviour and enabled them to reflect on their current situation (El-Badri and Mellsop, 2008). These findings are supported by Holmes et al (2015) who reported that patients self-requested seclusion and felt the intervention was for their own best interests to regain their sense of control and safety. Ezeobele et al (2014) described similar findings where patients found the observing nurse closely monitoring them to be reassuring while they stabilised

on their medications. However, it is unclear from these studies whether seclusion was used in its strictest terms and what preventative measures were used to avoid seclusion. Still, even if it is a self-request, clinicians need to be able to justify the decision for its implementation as patients' capacity to consent to this intervention can be questioned. Informed consent is based on autonomy (Mental Capacity Act, 2005), but the evidence for the use of seclusion shows acutely disturbed patient may not be able to be actively involved in the decision making for implementation of this intervention (Adshead ,2000). With patients with psychotic disorders who are detained, the decision to seclude them is made in their best interests (MCA, 2005), although El-Badri (2008) argued that staff do not communicate seclusion with patients, hence consent is not sought.

Adverse findings on the use of seclusion

Maintaining a therapeutic environment and a trusting relationship is important in all fields of nursing but in mental health nursing it is fundamental to patients' recovery to promote health and growth (McCabe and Priebe, 2005). The emphasis is on developing a trusting relationship with the patient to enable them to feel safe and secure (Scanlon, 2006). Containment with the appropriate support and structure helps patients to deal with their feelings and behavior in a safe environment (Norman and Ryrie, 2013). Therapeutic relationship is at the core of the patient experiences and the main barriers to a positive nurse-patient relationship with regards to the use of seclusion are lack of trust and use of coercion by staff (Gilburt et al, 2008).

The coercive practice of seclusion which restricts the freedom of movement of the patient to a minimally furnished room where the patient is continually observed (Bowers et al, 2012, Van Der Schaaf et al, 2013) can compromise the nurse-patient relationship. Although the supportive observation meant for therapeutic engagement with the secluded patients it can also be perceived as an invasion of their privacy which can subsequently affect the essence of this interpersonal process. This may lead to loss of trust and rapport that had been developed and result in anger and resentment towards the nurse (Ezeobele et al, 2014). Seclusion also limits patient's autonomy and control (Happell and Koehn, 2011; Whitecross et al, 2013) where the nurse may not be able to fully address secluded patients' needs (Moran et al, 2009; Merineau-Cote and Morin, 2014).

Patients also perceived a power differential with the nurse and reported feelings of powerlessness during seclusion where they felt the nurse had control over them and their environment (Ezeobele et al, 2014; Holmes, Murray and Knack, 2015; Brophy et al, 2016). The issue of power and control was exemplified by patients' perception of a lack of compassion as they felt that nurses were not empathetic to their needs through their interaction with them (McInnes et al, 2014).

One main impact of seclusion on the nurse-patient relationship is when seclusion has not been used as a last resort but as a punitive measure for patients' disruptive behaviours where non-restrictive interventions would have been more appropriate (Meehan et al, 2004; Holmes, Murray and Knack, 2015). Voskes et al (2014) posit that the misuse of seclusion does not recognise personhood and is contrary to responsive person centred care. Patients reported to feeling vulnerable, threatened and provoked (Hoekstra et al, 2004; Ezeobele et al, 2014; Holmes, Murray and Knack, 2015) prior to being secluded and felt nurses were either unable or unwilling to use de-escalation skills to defuse the situation when provoked. As identified by Flynn (2012) in the Winterbourne case review, where patients were mistreated, vulnerable patients were not believed when they complained. This can lead to patients feeling a sense of abandonment and injustice and viewed nursing staff as uncaring and limited decision making in the whole process resulting in aggressive feelings towards nurses (Sibitz et al 2011, Holmes, Murray and Knack, 2015).

The consequences of negative experiences of seclusion can lead to a detachment of the nurse-patient relationship where patients are reluctant to be open about their feelings to nurses (Hoekstra et al, 2004; Ezeobele et al, 2014; Holmes, Murray and Knack, 2015; Brophy et al, 2016). It can also have disastrous consequences such as traumatic experiences exacerbating patients 'fear, distress, humiliation, hallucinations and anxiety as well as worsening their condition resulting in concordance issues where patients discontinued their treatment and disengaged from mental health services (Georgieva et al, 2012). The disengagement also extended to relationship outside clinical settings affecting patients' confidence and ability to trust others and feeling insecure (Hoekstra et al, 2004).

Staff involved in the practice of seclusion also reported negative experiences such as stress and initial feelings of aversion and anger towards the violent patients (Hoekstra et al, 2004; Meehan et al, 2004) for the unsafe situation, but also expressed feelings of regret, aversion and feared it would damage the therapeutic relationship with them (Van Der Nagel et al, 2009; Chambers et al, 2015). Nonetheless, they also expressed the general feeling that it was the right thing to do by ensuring the safety of everyone (Holmes, Murray and Knack, 2015).

Ethical challenges

The ethical justification for restrictive practices such as seclusion have been the subject of much debate for decades. The ethical arguments adopt the positions that people have alienable rights and freedom and the use of seclusion is at odds with the recovery and patient focused approaches, aimed at fostering patients' autonomy and choice in empowering patients to make their own decisions (Kontio et al., 2010). However, this standpoint is not unchallengeable as from a pragmatic perspective, staff have a broader duty of care to ensure the safety of everyone in the practice setting (Barton et al ,2009).

Hence, seclusion may be deemed not unreasonable when managing the highly disturbed patient when non-intrusive interventions have failed.

From a deontological point of view, seclusion is perceived as an intervention that violates the rights of the patient and does not respect their dignity and autonomy (Meehan et al, 2004). Critics of seclusion argue that seclusion has been used to control patients and is punitive (Morall 2002, Holmes ,2004). Using seclusion as a punitive measure or as a form of social control contradicts Article 3 of the European Convention of Human Rights (Human Rights Act, 1998), which stipulates that individuals should not be subject to torture, degrading treatment or punishment. Equally, the use of seclusion can be defended from a teleological ethical position where the protection of others justifies the safe containment of an otherwise uncontrollable high risk behaviour (Meehan et al, 2004). Hence, from a utilitarian ethical principle, the best outcomes that provide a safe and therapeutic environment for the greater number may seem a sensible rationale for using seclusion.

Nevertheless, investigations into the use of restrictive interventions have shown that these practices have not always been used as a last resort (DH, 2014), some studies have also reported other reasons such as alcohol misuse and medication refusal (Van Der Merwe et al, 2013; Merineau-Cote and Morin, 2014) for the use of seclusion. Although there are policies and procedures for the use of seclusion there is no clear agreement for an ethical framework guiding staff for this practice (Bloch, 2006).

Seclusion reduction approaches

The drive to reduce restrictive practices has gained prominence in the last decade with a call to ban seclusion entirely such as the move to a ‘force free future’ (RCN, 2016 p 7). The discourse on abolishing seclusion, has received mixed views as a feasible proposition (Bowers et al, 2012). Although there is a consensus among nurses for implementing alternative strategies (Meehan et al, 2004), nurses have also expressed doubts about being able to function without a seclusion room even with increased staff and resources for patients with chaotic backgrounds and complex issues with a propensity for higher violence and aggression. Feasible alternatives such as time out, to modify and regulate patients’ behavior has been proposed as an option that may not compromise staff and patient safety (Bowers et al, 2010). Still, time out also restricts and isolates patients’ and could be construed as another form of seclusion and feeds into criticism of the different guises of psychiatry as a coercive practice where one restrictive practice is replaced by another one as a renewed frame of reference (Szasz, 2007)

The Positive and Proactive Care framework (Department of Health, 2014) advocates the reduction in restrictive practices in mental health settings and puts forward an agenda to reduce restrictive practices. The agenda is aimed at balancing the concepts of safety, harm and freedom of choice by using a human rights’ based approach that

promotes patient involvement and empowerment and staff compliance with legal framework using a non-discriminatory person-centred plan of care. It also focuses on a positive behavioural support approach that enables nursing staff to recognise patterns of behaviour, implementing de-escalation and distraction techniques while helping patients understand the context and meaning of their challenging behaviour to reduce aggression and violence. It recommends the use of the Safewards model (Bowers, 2014) as a preventative measure in identifying factors within the staff, patients and the environment which may lead to conflict and/or containment. The Safewards model presents a range of practical approaches which can positively influence patients' behaviours and staff responses to avoid flashpoints and improves the efficacy of de-escalation techniques.

Furthermore, based on the Engagement model Borckardt et al, (2011, p 478) proposed the AIDET ('Acknowledge' patients, staff 'Introduce' themselves, articulate the anticipated 'Duration' of the clinical contact, 'Explain' the reason for the contact, and 'Thank' patients for their cooperation) in improving communication with patients. Applied to the practice of seclusion this approach involves acknowledging the impact of seclusion on the patient's mental state, considering patient's needs, giving thoughts to the anticipated duration of the seclusion experience, explaining the reason for seclusion, maintaining communicating throughout as well as thanking the patient for their co-operation.

Post incident reviews including debriefing are important discussions in helping to identify less restrictive interventions to reduce seclusion and improving the nurse-patient relationship (Department of Health, 2014). It provides the opportunity for everyone involved in the seclusion to reflect on the incident leading to the seclusion, evaluate emotional impact, the appropriateness of therapeutic skills and consider alternatives (Goulet and Larue, 2016). Such discussions need to involve patients when appropriate so they are informed about the reasons behind the decision to use of seclusion and how it could be possibly avoided in the future (Holmes, Murray and Knack, 2015).

Sustaining the therapeutic relationship

Both patients and staff expressed various emotions during the care experience of seclusion, which can strain the nurse-patient relationship. The purposeful and safe use of seclusion which considers its effect on patients and their vulnerabilities, implemented in an informed and respectful way can go some way in sustaining the nurse patient relationship.

Maintaining the therapeutic relationship can be a challenging endeavour when patients blame nursing staff for secluding them and express anger, resentment and distrust towards them (Holmes, Murray and Knack, 2015). Adopting a positive attitude even when threatened and subjected to aggressive behaviour by patients is important in preserving the therapeutic relationship. This requires staff to be trained in managing

potential aversive feelings using distancing strategies (Ezeobele et al, 2014; Holmes, Murray and Knack, 2015) and displaying professional authenticity to reduce the use of seclusion (Janssen, 2007). In addition to appropriate training as recommended by Skills for Care and Skills for Health (Department of Health, 2014) in areas of therapeutic engagement, de-escalation skills and staff also need support to manage their own personal vulnerabilities to increase their confidence and make them less risk adverse to using seclusion (Department of Health, 2014).

Minimal interaction and lack of meaningful communication with the observing staff has been reported (Brophy et al, 2016). So, every opportunity should be taken by the observing staff to engage therapeutically with the patient, establish their thoughts and feelings as part of the holistic assessment to maintain safety in the aim of keeping seclusion as short as possible (Department of Health, 2013). Increased visibility of patients and more nurse-patient interaction may also require changes in ward layout to minimise the physical separation of nurses from patients (Van Der Schaaf et al, 2013; Kai Ling Wong et al, 2015).

The opportunities to engage with the patient following the cessation of seclusion should not be missed when the patient feels able and agrees to take part in a post seclusion review. This exercise provides a therapeutic space for the patient and the nursing team to discuss the patient's reaction towards the seclusion, their experiences while in seclusion and discussion of alternative strategies. The need for seclusion can also be explained to the patient at this review, with joint planning on avoiding the use of seclusion in the future (Larue et al, 2010). It is also important that patients are provided a safe and supportive environment to reflect on the reasons why they were secluded either by discussing it with a member of staff of their choice (Hoeskestra et al, 2004) including Advocacy Services or writing down their perspectives of the incident leading to seclusion.

Above all a sustained shift in professional attitude to accept seclusion as a last resort thorough education, training and support is required (Bowers et al, 2010). Although educational attainment based on a proactive and safe management of the disturbed and violent patients appears to have reduced the use of seclusion there are limited studies investigating attitudinal dimensions of professionals in mental health practice on this intervention (Mann-Poll et al, 2012). Further studies on the lived experience of patients and their views on the acceptability and effectiveness of the strategies and training aimed at reducing seclusion would also be useful.

Conclusion

It is evident from the literature that the use of seclusion continues to generate strong views with strong support but also ambivalent feelings to discontinue this intervention. The very nature of this intricate intervention raises many concerns which makes a prima

facie case for this practice to be questioned, despite its acceptable use as a last resort intervention.

In an era of mental practice which advocates for patient's choice and empowerment, there is an obvious incongruity of a practice that has the potential to exercise some aspects of control over another individual through social exclusion with the recovery approach and the fundamental principles of mental health nursing care.

The reasonableness for its use will continue to generate further debate until there is a clear consensus on other safe and effective feasible alternative approaches would entail when other non-restrictive strategies in addition to preventative measures have been unsuccessful.

Until then a relational approach with a genuine intent to actively engage with the patient in an empathic manner that make them feel understood and that also help them to understand the need to resort to seclusion when balancing safety and harm is important in improving the care experience and maintaining a quality nurse patient therapeutic relationship.

Current legislation and practice guidance offer some protection to the patients, but the convention in practice may reflect a different picture. Every opportunity should be explored to empower patients subjected to this disempowering intervention by ensuring the right response at the right time while supporting staff who are using this intervention as the absolute last resort.

Appendix 1

Country	Reasons for seclusion use	Legislation	Seclusion room conditions
Canada Holmes, Murray and Knack (2015)	Last resort emergency measure but widespread across all settings. For safety reasons but sometimes seen as punitive.	Patient Restraint Minimisation Act (2001) Health Care Consent Act (1996) Mental Health Act (2001)	Poor lighting Unhygienic at times Poor air circulation Not comfortable Less attention from nurses
The Netherlands Hoekstra et al (2004) Van Der Nagel et al (2009)	Seen as a treatment option to regulate dangerous behaviour and for hazardous situations only	Special Admission Act for Psychiatric Hospitals (1994)	Wearing straitjackets
America Ezeobele et al (2014) Recupero et al (2011)	Therapeutic intervention for staff to exert power and control	National Mental Health Association (2000) The American Psychiatric Nurses Association (APNA, 2007)	Small room with bubble window Very cold Bare mattress Observing nurse not checking up on patients
Australia Brophy et al (2016)	For control or to manage disturbed behaviour. Not used as a last resort.	Mental Health Act (2014)	No air circulation No toileting facilities Excessive force
South Africa Department of Health (DH, 2012)	Emergency last resort measure for immediate threat of harm. Not for self-harm or suicidal patients.	Mental Health Care Act (2002) National Health Act (2003)	Seclusion room near nurses' station Secluded for up to 4 hours Half hourly observations
India Kandelwal et al 2015	For violent and difficult to control patients	Mental Health Care Bill (2011)	Patients are chained and roped
Japan Noda et al 2013	Last resort measure to ensure safety and reduction of disturbed behaviour	Japanese Mental Health Act (1995)	Secluded patients are likely to have a diagnosis of schizophrenia and substance misuse
England	Last resort emergency measure for immediate	Human Rights Act (1998)	Reviews every 2 hours Constant observations

Bowers et al (2012)	harm	Mental Health Act (1983)	Room fit for purpose Post debrief

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