

GOOD PRACTICE GUIDE

The use of seclusion

2014 VERSION

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Our aim

We aim to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions. We do this by empowering individuals and their carers and influencing and challenging service providers and policy makers.

Why we do this

Individuals may be vulnerable because they are less able at times to safeguard their own interests. They can have restrictions placed on them in order to receive care and treatment. When this happens, we make sure it is legal and ethical.

Who we are

We are an independent organisation set up by Parliament with a range of duties under mental health and incapacity law. We draw on our experience as health and social care staff, service users and carers.

Our values

We believe individuals with mental illness, learning disability and related conditions should be treated with the same respect for their equality and human rights as all other citizens. They have the right to:

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- recovery from mental illness
- lead as fulfilling a life as possible

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice
- We challenge service providers to deliver best practice in mental health and learning disability care
- We follow up on individual cases where we have concerns and may investigate further
- We provide information, advice and guidance to individuals, carers and service providers
- We have a strong and influential voice in service policy and development
- We promote best practice in applying mental health and incapacity law to individuals' care and treatment

Introduction

The Mental Welfare Commission first published guidance on the use of seclusion in 2007. The focus at that time was on restrictions being placed on people in a hospital setting and the authorisation, regulation and monitoring required to safeguard the rights of the individual.

Since then, we have become aware of similar restrictions being applied in a variety of community settings and, in light of changes to current practice, the time seems right to review our guidance.

Locking someone in a room alone, because of their behaviour, is usually referred to as seclusion. The use of seclusion can cause distress and psychological harm and can increase the potential risk of self-harm. It should not be regarded as a therapeutic intervention but it may be necessary as an alternative for managing extremely difficult situations.

We do not advocate the use of seclusion as a first line response to aggressive behaviour. Our view is that it must only be used in the context of a comprehensive policy on the management and prevention of aggressive behaviour. We would expect that proactive behavioural support plans would largely negate the need for such restrictive measures.

However, we recognise that there are particular situations, where an individual is aggressive and deemed to be at risk of causing harm to others. 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. We believe 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.

There is no definition of seclusion in the Mental Health (Care and Treatment) (Scotland) Act 2003.¹ The Northern Ireland Human Rights Working Group on Restraint and Seclusion defines seclusion as "... the supervised confinement of a (person) alone in a room ...the door of which cannot be opened from the inside and from which there is no other means of exit available." It is "an emergency procedure, only to be resorted to when there is an immediate risk of physical harm".² The Code of Practice to the Mental Health Act 1983 in England defines seclusion as "... 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".³ The Court of Appeal in England further described seclusion as "...keeping a person under regular frequent observation, while he is prevented from having contact with the world outside the room where he is confined...".⁴

The Commission's view of seclusion is that it is "the restriction of a person's freedom of association, without his or her consent, by locking him or her in a room. Seclusion can only be justified on the basis of a clearly identified and significant risk of serious harm to others that cannot be managed with greater safety by any other means."

1 Scottish Executive (2003) *Mental Health (Care and Treatment) (Scotland) Act*, The Stationery Office, Edinburgh

2 *Human Rights Working Group on Restraint and Seclusion – Guidance on Restraint and Seclusion in Health and Personal Social Services*, August 2005

3 *Mental Health Act 1983, Code of Practice* (March 1999), The Stationery Office, London

4 *R (on the application of Colonel Munjaz) v Mersey Care NHS Trust and (i) Secretary of State for Health and (ii) MIND; S v Airdale NHS Trust and (i) Secretary of State for Health and (ii) MIND* [2003] EWCA Civ 1036

Although this definition of seclusion does not include situations where someone prevents a person from leaving a room, for example, by physically blocking the exit, the same principles should still apply in such a situation.

Where someone goes to their room by agreement to access a low stimulus environment, this does not amount to seclusion unless they are prevented from leaving.

Why is guidance needed?

The following is an example of the kind of difficulties we heard about. Some details of the case have been changed to reduce the risk of identifying the individual. Further examples of the use of seclusion can be found in Appendix 1.

John

John has moderate learning disabilities, autistic spectrum disorder and epilepsy. He has a history of unpredictable aggressive behaviour towards others including kicking, biting, hitting and hair pulling. A number of staff received serious injuries due to the level of his agitation and aggression. He also self-harms by banging his head off walls, corners and other sharp objects. Over the years it has been noted that he becomes calm if he is in a room on his own, but observed by staff, with a few of his favourite 'comfort' items to hand. Physical restraint seems to make him worse.

John's care and support includes the following areas of good practice:

1. Full Multi Disciplinary Team (MDT) assessment to look at the function of behaviour, sensory assessment, communication assessment, links to physical health issues, control of his anxiety etc.
2. Risk assessment with a number of proactive and reactive strategies.
3. Regular MDT involvement (psychiatrist, psychologist, Speech and Language Therapy, Occupational Therapy, Community Learning Disability Nursing) and involvement of his family in discussions and review. There are regular Care Programme Approach meetings.
4. Positive intervention support plan, including communication strategies, structure and predictability to reduce anxiety.
5. Staff training to ensure routines, consistency of approach and maintenance of a low arousal environment.
6. The psychologist has been closely involved in drawing up and reviewing the behaviour management plan for managing early signs of distress and warnings/triggers, looking at strategies for minimising the likelihood of situations developing, identifying the point at which containment may be required for a short period in his room, how he will be guided to the room, time in environmental restraint (seclusion) (maximum usually about 30 minutes), recovery times before interaction with staff etc.
7. Observation window in his room that can be opened and shut and risk assessment of room.
8. Clear running records of environmental restraint, behaviour during this time, staff response, duration etc and regular audit of these.

9. Legal basis for environmental restraint. Private guardianship varied to include specific powers:
- to grant permission for any adult or adults involved in his care to undertake two person touch support (restraint) in order to safely escort adult to his room when all other strategies have been ineffective and
 - to grant permission to any adult or adults involved in his care to support him in his room by means of environmental restraint (seclusion) which would include locking his door and observing him through a window in his door.

Enquiries from practitioners to the our advice and information service and consultation with others indicated that updating our guidance on the use of seclusion would be helpful. We have previously published principles and good practice guidance on the use of restraint in care settings (*Rights, risks and limits to freedom*⁵) and are often asked our views on the use of seclusion in health and social care settings.

Some observers believe that no one receiving care for any form of mental illness, learning disability or related conditions should ever be locked in a room on their own. However, it is evident that seclusion is used in a number of hospitals, and also increasingly in other settings, in Scotland. In some situations, especially when there is a risk to others, it may be the safest option available to both the individual and those providing care. For instance, where the alternative may involve a long period of restraint with an increased risk of injury, seclusion may be a better option. Similarly, where a person may have a respiratory problem or bone density issues, the risk of injury if restrained would be considerable.

However, locking someone alone in a room is a serious intervention and must be carefully regulated and monitored, both internally and externally. We believe that this is best done by applying a set of principles to its use and ensuring that there is a clear local monitoring framework. As well as being the least restrictive measure, the use of seclusion must always have the benefit of the individual at its heart. Therefore, evaluation of the intended benefit should be carried out after each episode of seclusion.

We believe that seclusion is a form of restraint that requires careful control by agreed decision-making processes and monitoring by mental health and learning disability professionals and support staff who are fully trained in the prevention and management of violence and aggression. Furthermore, staff should have access to regular reflective supervision with regard to their practice. Seclusion itself can carry risks to the individual. It is often used in association with physical restraint and rapid tranquillisation, sometimes in confined spaces. Inappropriate seclusion in substandard environments has the potential to increase the level of stress experienced by a disturbed and distressed person and to increase the risk of, and opportunity to, self-harm. In certain situations there needs to be careful consideration of the balance between the risk of self-harm and the risk of assault on others.

The purpose of this document is to provide clear guidelines for the consideration and use of seclusion and other restrictive practices and to ensure that, where this takes place, the safety, rights and welfare of the individual are safeguarded.

5 Rights, risks and limits to freedom:

http://www.mwscot.org.uk/media/125247/rights_risks_2013_edition_web_version.pdf

Why the increase in restrictions in community settings?

*The Same as You?*⁶ report published in 2000 recommended that Health Boards should aim to reduce their assessment and treatment hospital placements specifically for people with learning disabilities to four for every 100,000 population across the country as a whole. The report proposed that Boards should plan for appropriate community services to reduce the need for in-patient assessments and treatment. Since 1980, there has been a reduction in adult in-patient beds from over 7,000 to the May 2012 census figure of 318. This figure falls within *The Same as You?* estimate of a requirement of between 300-400 places across Scotland.

The Keys to Life (2013) makes recommendations for joint protocols and planning for those with complex care needs for whom no suitable community placement exists, some of whom are in out of area placements some distance from their family.⁷ It goes on to state that placement of people with learning disabilities out of local services into independent, private or other specialist services can also place a considerable, unplanned for, and immediate support demand on 'receiving' health and social care services.

For some people with learning disabilities experiencing stressed and distressed behaviour in a community setting, behavioural support plans should be in place to minimise restrictive interventions. Nevertheless, practices such as physical restraint and environmental restraint/seclusion may still be required to support some people in the community. There is, however, a lack of clear guidance on the subject at present, particularly for community-based care services.

Legal provisions

The Mental Health (Care and Treatment) (Scotland) Act 2003 (The 2003 Act)

The 2003 Act authorises the use of compulsory measures, including situations where a person's mental illness, learning disability or related condition poses a risk to others and the person's ability to take treatment decisions is significantly impaired. There is very little in the 2003 Act and the Code of Practice that deals with the use of force, but the law states that the statutory powers in an Act of Parliament include any related powers necessary to operate the powers in the statute.⁸

Our view is that seclusion without a person's consent amounts to detention. Anyone subject to seclusion in hospital must be detained under the 2003 Act, or the relevant provisions of the Criminal Procedure (Scotland) Act 1995. Due regard must be given to the Principles of the 2003 Act, in particular those of least restriction, benefit and participation. Medical examination must be carried out as soon as possible in order to determine whether the person meets the criteria for detention. If there is any unavoidable delay in the attendance of a medical practitioner, it may be appropriate to use the nurse's power to detain pending medical examination (2003 Act, Section 299).

6 Scottish Executive (2000) *The same as you? A Review of Services for People with Learning Disabilities*, Edinburgh: Scottish Executive

7 Scottish Government (2013) *The keys to life - Improving Quality of Life for People with Learning Disabilities*

8 Bennion F. (2002) *Statutory Interpretation*, 4th edition, section 174

In emergencies, it may be necessary for staff to take immediate steps to contain a dangerous situation and that intervention may involve seclusion. If the person is not subject to compulsion under the 2003 Act in hospital at that point, then an immediate assessment must be made to consider whether an Emergency or Short-Term Detention Certificate is appropriate.

Some people may decide to make an advance statement about the use of seclusion. This might involve anticipating situations where they would or would not find seclusion acceptable. If seclusion is considered, the advance statement should be taken into account. If the period of seclusion is in conflict with the advance statement, the actions set out in section 276(7) of the 2003 Act must be taken. Staff should adopt appropriate statutory measures even if seclusion is consistent with an advance statement.

Adults with Incapacity (Scotland) Act 2000 (The 2000 Act)

In a community setting, any form of environmental restriction imposed on individuals should be legally authorised. The 2003 Act cannot be used to sanction physical or environmental restraint in the community. Therefore, if it is foreseen that it may be necessary to use a form of environmental restriction such as seclusion beyond dealing with an initial emergency in a community setting, an application for welfare guardianship under the 2000 Act should be considered.

Part five of the 2000 Act defines medical treatment as “any healthcare procedure designed to promote or safeguard the physical or mental health of the adult”. Considering treatment from this perspective, the Court of Appeal in England is of the view that use of seclusion could constitute medical treatment.⁹

Under the 2000 Act, part five, the medical practitioner (or sometimes another healthcare professional) certifies incapacity in relation to the medical treatment in question. A “section 47 certificate” authorises the practitioner or others under his or her direction to provide reasonable interventions related to the treatment authorised. The authority is limited in a number of ways. Most importantly, it does not authorise force, unless immediately necessary and only for as long as is necessary.

However, part six of the 2000 Act allows for intervention orders and guardianship. Both could be used to authorise a restrictive intervention although the Act and Codes of Practice do not provide much guidance on why and how this power might be sought and used. In relation to the present topic, welfare guardianship might be more suited to a foreseeable series of restrictive interventions, e.g. use of restraint, seclusion or similar environmental restrictions where the adult resists treatment.

⁹ See footnote 4 above

Overarching principles

The Mental Health (Care and Treatment) (Scotland) Act 2003

The 2003 Act has a set of principles that anyone providing treatment must “have regard to”. We believe that these principles provide an ideal foundation to underpin decisions about procedures and safeguards in the use of seclusion and other environmental restrictions. We use the following principles throughout this guidance:

- Maximum benefit
- Minimum necessary restriction of freedom
- Past and present wishes and feelings
- Views of relevant others
- Participation
- Provision of information and support
- Range of options available
- Non-discrimination
- Respect for diversity
- Needs of carers
- Provision of appropriate services

Adults with Incapacity Act (2000)

There are also relevant provisions within the 2000 Act that have a bearing on the issue of seclusion.

Part one outlines the principles that govern any intervention and are especially relevant in the use of seclusion:

- Benefit to the adult
- Least restriction of freedom
- Account taken of adult’s past and present wishes
- Consultation with others where reasonable and practicable
- Encourage use of existing skills/development of new skills

The Human Rights Act (1998)

The Human Rights Act is founded on the articles of the European Convention for Human Rights (ECHR). Under the Human Rights Act, all legislation (including the Adults with Incapacity (Scotland) Act 2000; Adult Support and Protection (Scotland) Act 2007; Mental Health (Care and Treatment) (Scotland) Act 2003) must be interpreted in a way which is compatible with Convention Rights.

Relevant articles of the ECHR in the use of seclusion include:

Article 3 – the right to be free from torture and cruel, inhuman or degrading treatment. This means that treatment which is grossly humiliating or undignified and causes severe physical or psychological harm is prohibited. Whether treatment reaches this threshold of severity depends on various factors including the age, physical or mental health of the individual and the relationships involved. This right is fundamental and reminds us that individuals must be treated with dignity and respect.

Article 5 – the right to liberty and security of person. The protections under this right means that nobody should be detained against their will except as set out in circumstances provided for in the legislation, with consideration given to the alternatives and with the proper safeguards. “Deprivation of liberty” includes situations other than formal detention in hospital. Any person deprived of liberty must be able to challenge this in a court or tribunal.

Article 6 – the right to a fair hearing. The protections of this right apply in circumstances where an individual’s civil rights are at stake and will apply to guardianship and capacity determinations. The person must have the right to legal representation and an independent opinion via the provisions and appeals procedures of the 2000 or 2003 Acts.

Article 8 – the right to privacy and respect for family life. This right is broad in scope and covers protection of privacy, family relationships, physical and psychological well-being including the right to autonomy. Interferences with this right are permissible only where there is a legitimate aim and the interference is proportionate.

Competing rights should be taken into account in the decision-making involving the use of seclusion. Any right can only be limited where it can be demonstrated that it is necessary, reasonable and proportionate. It should be noted, however, that article 3 is an absolute right and cannot be overridden.

Seclusion as deprivation of liberty

Seclusion can be seen as a form of deprivation of liberty, albeit of relatively short duration. From this perspective, it may be useful to look at ways in which benefit, least restriction and best interests can be considered alongside an apparent infringement of a basic human right.

In the Bournemouth case, it became apparent that there was widespread practice of treating people who lacked capacity but were compliant as voluntary patients in hospital. This is sometimes referred to as a form of “*de facto*” detention¹⁰. The issue is whether this constituted detention and therefore a deprivation of liberty. Interestingly, neither “deprivation of liberty” nor “detention” are clearly defined by the ECHR.

The key factor in Strasbourg’s ruling on deprivation of liberty was “that the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements.”

¹⁰ HL v UK (2004) (The “Bournemouth” Case)

The European Court of Human Rights stated that: "...the right to liberty is too important in a democratic society for a person to lose the benefit of Convention protection for the single reason that he may have given himself up to be taken into detention..., especially when it is not disputed that that person is legally incapable of consenting to, or disagreeing with, the proposed action."

Consideration needs to be given to whether doors are locked and whether contact or communications are restricted. A balance needs to be struck between a person's welfare and their ability to exercise their legal rights. There are different interpretations of what deprivation of liberty means in the context of an adult with incapacity. The purpose behind the measures used is key – if it is to safeguard and protect the individual rather than exercise control over them, then it may not amount to deprivation of liberty. Crucially, there should be evidence in support of this. However, because of the intensity of its effect on the individual, we would consider that seclusion would always be a deprivation of liberty.

The Adults with Incapacity (Scotland) Act 2000 deals with powers of attorney and guardianship as forms of proxy decision-making. In the former, the person is appointed by an adult whilst having capacity and it is anticipatory. In the latter, someone is appointed by the court after the individual is assessed as lacking capacity.

However, in neither of these instances is there an explicit process or criteria for authorising deprivation of liberty and the 2000 Act does not mention it at all. Therefore, in order to protect an individual's human rights in certain situations of deprivation of liberty, it could be argued that a legal safeguard is essential. This would be particularly relevant where an adult is compliant with a regime of measures, but is legally incapable of consenting to or disagreeing with this.

In our Rights risks and limits to freedom guidance, we refer to the following factors employed by the European Court of Human Rights when deciding whether someone has been deprived of their liberty:

- the degree and intensity of control over the individual's movements;
- the length of time for which such controls might be needed;
- the intentions of those controlling the person;
- how the control is exercised;
- the extent of the individual's access to the outside world;
- whether the cumulative effect of restrictions on their life amounts to detention; and
- whether the person is likely to indicate that they wish to leave.

Viewed from a perspective of deprivation of liberty, it is clear that, in order to protect the individual's human rights, any measures employed in the use of seclusion should be legally authorised.

Why use seclusion?

Seclusion should only be considered where:

- there is a clear and identified risk that the person who is to be secluded presents a significant degree of danger to other people;

and

- that the situation cannot be managed more safely or appropriately by any other means.

In practice, the decision to use seclusion should only be made where the balance between the potential risks of seclusion and any other intervention, such as prolonged physical restraint, indicates that it would be safer to use seclusion. The robust assessment of those risks must take into account all available information and should be made, as far as possible in the circumstances, by the clinical and social care team. Consideration of the full range of options available must be made and recorded. There must be clear benefit to the individual for whom seclusion is being considered. Whilst seclusion is usually seen as a protective measure for others, clearly, it would not be in the interests of the person concerned if he or she were allowed to harm someone else.

In most instances, seclusion is largely justified on the basis of containing behaviour that is a risk to others. In some cases, it could be resolved by staff removing themselves from a situation. However, staff can be faced with a situation where an individual is extremely disturbed as a result of some form of mental illness, learning disability or related condition. This can be where they are threatening or actively violent to others, may require restraint and possibly receive medication. In this type of situation, seclusion may be seen by staff as a way of reducing the impact of prolonged physical restraint or use of medication. Seclusion is also used in situations where a person with learning disability/autistic spectrum disorder/developmental disabilities and associated stressed and distressed behaviour requires isolation for longer periods of time. This would always require legal authorisation except where the doctrine of necessity would apply. We discuss the management of these situations later.

The impact of seclusion

In our experience the person, who has been secluded, often interprets the event that preceded the seclusion in a very different way to staff. The person secluded may describe being forced into aggressive and violent behaviour because of the way he or she has been treated. The person may be extremely angry about being detained, or having had their behaviour challenged and contained by staff. Those beliefs may be directly as a result of delusional ideas, misinterpretation of the intent of others, or because the person's threshold for controlling their behaviour has been reduced by their mental illness, learning disability or related condition. The individual's reaction may be a disproportionate one to a situation where there is justifiable reason for him or her to think they have been treated unfairly.

Seclusion can be seen as a negative experience by individuals and be very hard to come to terms with. A small study by Hoekstra et al¹¹ describes factors that can help in coming to terms with the experience of seclusion, including understanding the reason why it took place and the opportunity to discuss the event with others. Factors that adversely affect the process of coming to terms with seclusion include the danger of re-occurrence (seclusion seen as a daily threat) and "iniquitous" treatment by care providers during seclusion. There appears to be no doubt that clear processes for "debriefing" and support of the person who has been secluded are essential. As far as possible, the individual must participate in the decision-making process about seclusion and in the follow up and subsequent review and care planning.

11 Hoekstra T., Lendemeijer H.H.G.M. & Jansen M.G.M.J. (2004) *Journal of Psychiatric and Mental Health Nursing*, 11, 276-283

Identifying seclusion

High-level observation and supervision may involve restricting individuals to their bedroom or to a part of a ward or residential unit. Some people subject to special or 1:1 observation can spend considerable periods of time heavily restricted in their movements. While recognising some of this guidance may apply to individuals in this kind of situation, we do not consider these interventions alone constitute seclusion. Where staff are in the unobstructed physical presence of the individual being supervised, then the nature of the relationship and restriction is different from seclusion because of the presence of direct human contact. However, this level of supervision is highly intrusive and severely limits the freedom of the person concerned. Where the individual has their freedom of movement seriously curtailed, this could be considered as a form of restraint. We recommend that in this situation the principles set out in the Commission's guidance on this issue are followed. NHS Scotland guidance on observation of people with acute mental health problems "Engaging People" gives a framework for the classification of observation levels and review processes within hospitals.¹²

In high security settings, the general arrangements for security may mean that, where an individual voluntarily wishes to be in their room, the door is locked. We do not believe that this constitutes seclusion as it is not for the management of individual risk and the person can ask to leave the room at any time.

Again, in certain high security settings individuals may be locked in their room overnight, depending on the general level of restrictions in a particular ward. There is an argument that, if the person cannot leave their room, this could be seen as constituting seclusion. The Commission believes that in this situation the principles of least restriction and of benefit should apply. If staff are available to allow the person to leave their room on request, then this restriction would not constitute seclusion.

The use of seclusion should be considered in the light of a range of alternatives

Positive support

Positive support is defined as an approach which incorporates the safe use of reactive strategies (including restrictive practices) alongside other targeted, proactive preventative approaches. The sole purpose of any reactive strategy is to make a situation safe and return an individual to a state where they can resume their normal activities.

Written support plans ensure a consistent and shared proactive approach to meeting the person's needs so that they are supported to develop alternative approaches to situations which cause distress. The support plan also details those reactive strategies to be used when the person's agitation further escalates to the point where behaviours are presented which place either themselves or others at significant risk of harm. These may include the use of restrictive practices.¹³

¹² NHS Scotland Clinical Resource and Audit Group (2002) *"Engaging People" Observation of People With Acute Mental Health Problems: A Good Practice Statement*. The Stationery Office

¹³ Royal College of Nursing (2013) *Draft guidance on the minimisation of and alternatives to restrictive practices in health and adult social care, and special schools*. Royal College of Nursing

Policies for seclusion

In a hospital or care setting where seclusion or other forms of environmental restriction are likely to be considered, there must be a policy and associated procedures for the prevention and management of violent and aggressive behaviour. This policy should set out clear courses of action for staff and managers.

Staff must be trained and regularly updated in:

- the principles of positive behavioural support;
- how to reduce aggression and its consequences;
- the use of physical restraint.

When seclusion is used, it should form a part of that policy and should only be considered in the light of a range of alternatives to manage potentially harmful behaviour.

Physical restraint, rapid tranquillisation and seclusion of a person who presents with harmful behaviour can potentially be very dangerous and have led to fatalities in a number of care settings in the United Kingdom.¹⁴ Senior management of health and social care services should pay particular attention to the use of seclusion and ensure that it is carefully monitored in their area of responsibility. This would include an adverse incident review process with recommendations and learning outcomes.

The policy must address:

- the situations where seclusion can be considered and guidance on risk assessment;
- who can make the decision to use seclusion?;
- communication with the individual;
- maintaining the safety of the secluded person;
- care planning during seclusion;
- record keeping;
- the arrangements for continuous assessment and review;
- the provision and maintenance of a safe environment for seclusion;
- how senior management in any care setting monitors the use of seclusion;
- the impact of seclusion;
- staff and service user debriefing;
- staff training.

¹⁴ Paterson, B., Bradley P., et al (2003) – *Learning the Lessons Mental Health Practice* 6(9), 10-17

Who can make the decision to use seclusion?

The decision to use seclusion in hospital should only be made by a member of medical staff or the nurse in charge of the ward. The decision should be made in the light of available information and consideration of alternative interventions. The decision to use seclusion must be in response to a clearly identified risk of significant harm to others. That risk must be clearly recorded.

Where the decision in hospital is taken by someone other than the Responsible Medical Officer (RMO) then the RMO (or duty doctor) should be notified at once and should attend as soon as practicable, unless the seclusion has been for a very brief period (less than five minutes). Where the duty doctor is a junior member of medical staff then he or she should discuss the seclusion with the senior on-call doctor.

A senior member of nursing staff must be notified, and should visit as soon as practicable, to consider whether additional resources are required to enable an alternative and less restrictive intervention.

In community settings, decisions to apply environmental restrictions of this kind should only be authorised by the senior manager of the service or someone delegated to act in their absence, following multidisciplinary discussion and agreement. The restrictions should only be applied in exceptional circumstances, where other methods to reduce risk have been considered and rejected. There is a danger that individuals may be particularly vulnerable to overly restrictive treatment in settings where supervision of support staff is not appropriately monitored.

Care planning

Once a period of seclusion has commenced, it should not continue for any longer than is necessary. Therefore, care planning should involve:

- a clear treatment goal and an exit strategy with a target end point, indicating the criteria required for this to be reached; and
- the nature and frequency of reviews and the personnel to be involved.

Should the seclusion continue beyond 30 minutes, plans for meeting the individual's need for eating, drinking and toileting should be clearly recorded. Consideration should also be given to how the person will be helped to reintegrate into the unrestricted environment. Best practice would also be to inform the named person or carer, with the person's consent.

Where the management of aggression or violence is a feature of a person's care then this should be managed in line with local policies on the management of aggression and violence. Seclusion may be an option in that policy and care should be managed accordingly with all other options considered prior to its use. Any decision to use seclusion in an individual's care should incorporate an exit strategy to end its use.

The point of this approach is to minimise the likelihood of seclusion being routinely used as a first option for managing violence. Each episode of violence and aggression should be dealt with using minimum restriction.

Restriction of movement

The use of seclusion can place severe restrictions on an individual's freedom of movement. This can lead, in the absence of careful planning and review, to untoward physical and psychological consequences for the person. In particular, it can have a significant effect on a person's ability to take exercise, to communicate needs and to have needs met. During a period of seclusion, consideration should be given to how these issues will be addressed so that vulnerable individuals are able to exercise their basic human rights.

Maintaining the safety of the secluded individual

Care staff allocated to the individual must remain within sight and sound of the seclusion room at all times during the period of seclusion either directly through observation or via CCTV. The carer must be able to communicate with other staff without having to leave the area. The carer must ensure that the person is safe and pay particular attention to their consciousness level, particularly if he or she has been given sedative medication and/or has been physically restrained immediately prior to the seclusion. The carer who is in attendance must be aware of the particular needs of the individual, the immediate care plan and the antecedents to the seclusion. The legality of using CCTV in a community setting must be considered and requires powers to be granted under the AWI Act.¹⁵

Maintaining a relationship

While being sensitive to the situation, and to the individual's mental state, staff should maintain communication and discussion with the person being secluded, where indicated. The person secluded must be informed, as far as is possible, of the reason for the seclusion and the conditions for its ending. Great efforts must be made to dispel any perception by the person that they are being punished. Seclusion is an isolating procedure and can become lonely and frightening for the individual concerned. The seclusion may have immediately followed an incident resulting in restraint by staff. The person concerned may want to talk about what has happened. It is vital to maintain contact to ensure that the need for seclusion is continually assessed. Involvement of an independent advocate should be considered. Seclusion must not go on for any longer than is absolutely necessary and keeping communication open can help towards an early resolution.

Record keeping

The care staff in attendance must keep the person under constant observation either directly or via CCTV and make regular written reports on the individual's observed mental and physical state. We believe that a written record should be made at least every 15 minutes. Review discussions by care staff and decisions made must be recorded. These records are part of the individual's record of care. Managers must maintain and hold a record of the general use of seclusion in any particular health or social care setting. Independent health or social care providers registered by the Care Inspectorate or HIS have a statutory requirement to record any incident of restraint or control, the reason why it was necessary and the name of the person authorising it. An audit procedure should also regularly monitor the reason, frequency and duration of all episodes of seclusion. This will allow the effectiveness of such measures to be properly reviewed.

¹⁵ Joint statement on the use of CCTV in care facilities MWC, SCSWS, SHRC

The arrangements for continuous assessment and review

The local manager and other staff in attendance must continuously review the need for seclusion. A senior member of staff should formally review the need for seclusion on a regular basis (at least every four hours). Over and above this, the RMO or senior manager must complete a multi-professional review if the seclusion continues for longer than a period of time specified in local policies. We believe that this should certainly take place within a 12 hour period. Seclusion must be for the minimum necessary period of time required and be in accord with the principles of least restriction and benefit in the 2000 and 2003 Acts.

Where seclusion is likely to be used, there must be a safe environment available

The provision of a safe environment for seclusion

Taking into account all the safeguards described above, it is evident that where seclusion is likely to be used then there must be a safe environment available. There can be **no justification** for placing someone in a room that increases the potential for harm to others or self-harm. Curran, Adnett and Zigmond could not identify any detailed reference to the design of seclusion facilities in the past 20 years.¹⁶ They also noted that there is very little specific Government or NHS estates building guidance available to healthcare professionals and their architects in respect of the design and furnishings of seclusion facilities. They set out guidance on seclusion room design and associated facilities, including staff alarm systems and communication facilities. The guidance is aimed at the construction of new seclusion facilities, but provides a useful basis for the risk assessment of existing facilities.

The Commission is not expert in seclusion room design but we believe the following points are essential to consider in the provision of a safe environment for seclusion or other environmental restrictions.

The room should be discrete from other people but not isolated. It must be large enough to accommodate the individual and the maximum number of staff who may be involved in any restraint procedures. The construction of walls, windows, doors, hinges and locks must be robust enough to withstand high levels of violence aimed at damaging the physical environment. There must be no ligature points or access to electrical fixtures and fittings that pose a risk of shock. There must be no opportunity to barricade the door to prevent entry. Furnishings must be comfortable but safe and robust and not be of use as a weapon.

Observation into the room should be clear and effective. It should not be possible for onlookers to view into the room from the outside. However, there should be a clear view to the outside for the person. If CCTV is in use, respect for the person's privacy should be taken into account in terms of camera location.

Lighting should be externally adjustable to accommodate observation, but should also include a light that is controllable by the person in the room. It is essential that there is effective control of temperature and ventilation with temperature sensors to ensure effective monitoring. There is a high risk where restraint involving a number of staff has taken place that the individual becomes overheated. This is very dangerous, particularly in the context of someone having received high doses of medication.

¹⁶ Curran C., Adnett C. & Zigmond T. (2005) *Seclusion: factors to consider when designing and using a seclusion suite in a mental health hospital*, HD: Hospital Development **36**(1), 19-26

The room must be non-threatening and should be decorated in a calming manner. It must be kept clean and fresh. Bedding must be as safe as possible. Clothing should be risk assessed prior to seclusion to ensure that any potentially dangerous items are removed. While safety is vital, due regard must be paid to the individual's dignity. The principle of least restriction should be applied to the removal of items. Nothing should be removed unless there is clear justification on the basis of risk of harm to the person or to others. Personal items of religious or cultural significance should remain unless these may compromise safety.

Any room identified in the care and support plan for use in seclusion or environmental restraint must be regularly risk assessed by staff. Great care must be taken to ensure that no items that may pose danger are left in the room.

Attention should be given to procedures for safe evacuation in the event of a fire.

How senior management should monitor the use of seclusion

The use of seclusion or other environmental restrictions must be closely scrutinised through clinical governance or other similar monitoring processes. These processes should ensure that there is oversight of the use of seclusion by clinical and management staff distinct from the direct care team. The Commission also believes that, because of the seriousness of seclusion as an intervention and the associated risk, reports on its use should be regularly made to senior managers and, for NHS facilities (in aggregated and anonymous form) to members of the local NHS Board. Similar arrangements should be made for reporting to senior managers of independent health and social care providers.

The Commission, when visiting services where seclusion is used, may ask to inspect records of the use of seclusion in that area.

Seclusion should never be used as a punishment

Special situations

For people with learning disability/autistic spectrum disorders/developmental disabilities and significantly stressed or distressed behaviour there may be circumstances where their care plan requires that they be managed in isolation from their peers for lengthy periods. Such circumstances may require significant modification to their environment, both physical and social, and may lead to them being managed in isolated settings, with their own staff team and very little, if any, social contact with others.

The following are regarded as good practice in these circumstances:

The arrangements should only be put in place as the result of carefully considered risk assessment and management, carried out by practitioners with relevant specialist qualifications.

The arrangements should be reviewed on a frequent and regular basis.

Staff involved in caring for people in such circumstances should receive appropriate specialist training and support from a multidisciplinary team with appropriate expertise in this field.

It is inadvisable to put in place any such arrangements without the use of the Mental Health Act or Adults with Incapacity Act.

The use of seclusion in mental health settings should adopt the same principles as those relating to the care of adults. However, it may be less restrictive in most cases to authorise restrictive measures by use of parental consent.

Detention under the Mental Health Act in hospital should be considered on an individual basis where there is disagreement or dissent and the criteria for detention are met. This would offer the child or their Named person the right of appeal. Where restrictive measures are applied in social and educational settings, Mental Health Act detention would not apply. Managers of those services should develop a local policy on the prevention and management of aggression and violence which incorporates guidance on the use of seclusion.

Key good practice points

The principles of least restriction and benefit must always be applied:

- There should be a clear positive support plan in place to minimise the need for restrictive measures.
- Any seclusion must be for the minimum necessary length of time.
- Seclusion should not be used as an intervention for suicidal or self-harming behaviour.
- Seclusion must never be used solely to protect property.
- Seclusion must only be used in the context of a clear policy on the prevention and management of aggression and violence.
- Seclusion should never be used to compensate for insufficient staffing or an inadequate environment
- The use of, or threat of, seclusion must never be used as a punishment.
- The decision to seclude an individual must be made by a senior member of the care team in discussion with paid and informal carers.
- Where the decision has been made by a nurse in hospital, then a member of medical staff must attend as soon as practicable.
- Any person who is secluded must be subject to compulsory powers of detention in hospital (except in emergency situations) or to Welfare Guardianship in a community setting. The use of CCTV must be legally sanctioned as per guidance.
- A member of care staff must be in attendance immediately outside a seclusion room at all times.
- The seclusion environment must not increase risk to the individual.
- There must be a clear plan to identify when the risk that led to the seclusion is no longer present and the seclusion should end.
- Staff who may be involved in managing violence and aggression must be fully and regularly trained in methods of risk reduction and safe restraint.¹⁷

¹⁷ Recommendation Rec (2004)10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder (*Adopted by the Committee of Ministers on 22 September 2004 at the 896th meeting of the Ministers' Deputies*) Article 11

- The general use of seclusion must be recorded and monitored in any area where it may be used.
- NHS Health Boards, or the management boards of private hospitals or care providers, must monitor the use of seclusion in their area of responsibility.
- Regular safety inspections of the environment of designated seclusion rooms must be carried out.

In devising this guidance, we have provided some case examples. These can be found in the Appendix 1.

Acknowledgements

We would like to thank the individuals and organisations who participated in the consultation and contributed their expertise, experience and views to the development of this guidance.

Appendix 1

These case examples relate to people cared for in both hospital and community settings. They have been altered to protect the anonymity of the individuals concerned. They illustrate areas of good practice and areas of poor practice for learning purposes.

James

James has treatment resistant schizophrenia and is detained in hospital under the Mental Health (Care and Treatment) (Scotland) Act 2003. We visited him in hospital but he declined to be interviewed. His behaviour had deteriorated over time, becoming more aggressive towards staff and fellow patients. James has numerous convictions for assault and use of objects as weapons. It has been necessary for him to be managed in seclusion for prolonged periods.

Prior to the most recent episode of seclusion, James was floridly psychotic and voicing delusions. He believed staff had been involved in abduction and murder of young children and voiced other delusions. He subsequently punched and spat on staff and was placed in seclusion.

James has been managed in seclusion on and off over a 6 month period. Periods not in seclusion have been fairly brief. This is due to the fact he has been very assaultive towards staff.

James is not distressed in seclusion and states that he wants to be there. When he was out of seclusion he would not tolerate a normal bed and wished to sleep in the room, even though he was not on seclusion. Seclusion continues because he is hostile and aggressive and cannot guarantee he will not assault staff, regularly threatening to do so.

Staff do not look through the window in the door of the room at all times, they sit outside the suite, looking through the viewing window in the door a minimum of once every 15 minutes, documenting their observations. They would also hear sound from the room. One nurse is allocated to be responsible for the observations at all times.

Staff go into the seclusion room to give James medication four times per day, three staff use prevention and management of violence and aggression (PMVA) holds to hold him and one gives his medication. Food is left in his room. He is taken to the room next to the seclusion room for a shower, and is locked in alone for this.

Staff had discussed reducing to less restrictive holds, and there had been attempts to discuss future plans with James. However, he immediately smeared faeces on the wall and when staff next approached, he expressed thoughts of assaulting nurses. Staff said that even when he is not in seclusion he wishes to sleep in the room as he feels safe there. He regularly has auditory and visual hallucinations.

The seclusion is reviewed daily by nurse manager on call and medical reviews as per the local seclusion protocol. A weekly meeting is held for James attended by nurses, the RMO, occupational therapist, psychologist, and local manager.

This appears to be an appropriate use of seclusion with regular monitoring and review. There is input from all clinical staff involved in James' care and, at the time of our visit, attempts were being made to try to determine the precipitants which trigger the stressed and distressed behaviour.

Julie

Julie suffered brain damage due to alcohol and complications of diabetes. This resulted in significant cognitive impairment, poor short term memory, episodic and unpredictable behavioural problems, including frequently shouting and screaming and attempts to assault the staff assisting her. She also has epilepsy and her diabetes remains unstable. She spent two years in hospital in a general ward.

Julie's physical health improved over time and she was able to mobilise with supervision but needed assistance with all aspects of personal care and daily living. She has intermittent but severe behavioural problems characterised by both verbal and physical aggression. When Julie became frustrated and angry, she could be a risk to staff, herself and other residents. She was moved to a care home which provided care for people with a mix of complex needs and there she was frequently placed in seclusion when there was a danger that she would harm others.

When visited by the Mental Welfare Commission, we found that at these times she was persuaded to go to her room for a 'cooling off' period and on some occasions the door was locked by staff for short periods (not more than 30 minutes.) A CCTV camera operated at these times to ensure she could be observed and was safe.

We had a number of concerns when we initially looked at Julie's care and support:

1. There had been no multidisciplinary involvement in the support plan or behaviour management plan since she left hospital. She had had a number of assessments by Occupational Therapy and Speech and Language Therapy (SALT) staff whilst in hospital but little Multi Disciplinary Team (MDT) input since discharge. We considered that further multi-professional assessments were required, particularly from psychology and SALT, to help the staff develop more positive intervention strategies and more consistent routines when working with Julie.
2. Due to lack of MDT involvement there was no detailed protocol on when and how environmental restraint should be used, and no regular audit and review of the effectiveness of the intervention.
3. The room where she was secluded had not been properly risk assessed and had a number of items that potentially could have caused injury or self-harm. The windows were partially covered by boards to prevent her breaking these and to stop people looking in. This affected the availability of light and increased the impression of imprisonment.
4. There was no window in the door to the room, which would have allowed verbal contact with Julie to monitor her mood and wellbeing. There was a CCTV camera in place to allow observation whilst she was in the room. The monitor, however, was in a busy corridor and could be observed by other service users.¹⁷
5. There was no legislative basis for the restrictions in place. There should have been specific powers in a guardianship order for restraining Julie in order to escort her to her room, for environmental restraint in locking her in her room or preventing her leaving her room and for using CCTV to observe her.

These issues were taken up with the support service, NHS and the local authority. Julie is now in alternative accommodation with a different care provider, there is regular MDT involvement and legal powers are in place to sanction the current restrictions.



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