The use of seclusion: Guidance on good practice
## Contents

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Why is guidance needed?</td>
<td>2</td>
</tr>
<tr>
<td>Legal provisions</td>
<td>2</td>
</tr>
<tr>
<td>Advance statements</td>
<td>3</td>
</tr>
<tr>
<td>Adults with Incapacity (Scotland) Act 2000</td>
<td>3</td>
</tr>
<tr>
<td>Overarching principles</td>
<td>3</td>
</tr>
<tr>
<td>Justification for the use of seclusion</td>
<td>4</td>
</tr>
<tr>
<td>The impact of seclusion</td>
<td>4</td>
</tr>
<tr>
<td>Identifying seclusion</td>
<td>5</td>
</tr>
<tr>
<td>Time Out</td>
<td>6</td>
</tr>
<tr>
<td>Policies for seclusion</td>
<td>6</td>
</tr>
<tr>
<td>Who can make the decision to use seclusion?</td>
<td>7</td>
</tr>
<tr>
<td>Care planning</td>
<td>7</td>
</tr>
<tr>
<td>Restriction of movement</td>
<td>7</td>
</tr>
<tr>
<td>Maintaining the safety of the secluded patient</td>
<td>8</td>
</tr>
<tr>
<td>Maintaining a relationship</td>
<td>8</td>
</tr>
<tr>
<td>Record keeping</td>
<td>8</td>
</tr>
<tr>
<td>The arrangements for continuous assessment and review</td>
<td>9</td>
</tr>
<tr>
<td>The provision of a safe environment for seclusion</td>
<td>9</td>
</tr>
<tr>
<td>How senior management should monitor the use of seclusion</td>
<td>10</td>
</tr>
<tr>
<td>Special situations</td>
<td>11</td>
</tr>
<tr>
<td>Key good practice points</td>
<td>11</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>12</td>
</tr>
<tr>
<td>References</td>
<td>12</td>
</tr>
</tbody>
</table>
Introduction

To be kept apart from others can be a powerful sanction on a person's behaviour. Being locked in a room on one's own and denied freedom is suggestive, to most people, of punishment and solitary confinement. Confinement and being kept apart from other people features large in the history of mental health and learning disability care and in fictional portrayals of the care and treatment of the “dangerous” mentally ill. This picture does not represent the general culture of mental health and learning disability in Scotland today.

Locking someone in a room alone, because of their behaviour, is usually referred to as seclusion. Seclusion is used in a number of mental health and learning disability services in Scotland. However, it is a relatively rare practice.

There is a paradox in providing written guidance on the use of seclusion. The very existence of guidance such as this document can be construed as supporting the practice. The Commission does not advocate the use of seclusion as a first line response to aggressive behaviour. It must only be used in the context of a comprehensive policy on the management and prevention of violence. However, we do recognise that in extreme situations where a patient is aggressive and being violent towards other people, and 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 patient concerned. We believe it is necessary to acknowledge the use of seclusion, 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. The Code of Practice to the Mental Health Act 1983 in England defines seclusion as “…the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour, which is likely to cause harm to others.” 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…”

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.”
Why is guidance needed?
Enquiries from practitioners to the Commission’s advice and information service and consultation with others indicated that 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) and are often asked our views on the use of seclusion in health care settings. While some observers believe that no one receiving care for any form of mental disorder should ever be locked in a room on his or her own, it is a reality that seclusion is used in a number of hospitals in Scotland. In some situations, it may well be the safest option available to both the patient and those providing care. However, locking someone alone in a room is such a serious intervention it must be carefully regulated and monitored. 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. The use of seclusion must always have the benefit of the patient concerned at its heart.

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 staff who are fully trained in the prevention and management of violence and aggression. Seclusion itself can carry risks to the patient. 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 stress on a disturbed and distressed person and increase the risk and opportunity to self-harm.

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

Legal provisions
The Mental Health (Care and Treatment) (Scotland) Act 2003 authorises the use of compulsory measures, including situations where a person’s mental disorder makes him or her 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. The Commission’s view is that seclusion without a person’s consent is detention. Anyone subject to seclusion must be detained under the 2003 Act, or the relevant mental disorder provisions of the Criminal Procedure (Scotland) Act 1995. Due regard must be given to all of the Principles of the 2003 Act, in particular those of least restriction, benefit and participation.

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
an informal patient at that point then an immediate assessment must be made to consider whether an Emergency or Short-Term Detention Certificate is appropriate.

Medical examination must be carried out as soon as possible. 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 S299).

Seclusion should only be applied to patients subject to detention in hospital unless in emergencies. In such circumstances assessment for detention under the 2003 Act must take place urgently.

Advance statements
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
As the Commission takes the view that seclusion of an incapable person constitutes detention, we do not believe that it can be authorised by the 2000 Act.

Overarching principles
The Mental Health (Care and Treatment) (Scotland) Act 2003 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 for and safeguards in the use of seclusion. We use the following principles throughout this guidance:

- The past and present wishes and feelings of the patient.
- The views of relevant others.
- The participation of the patient.
- Provision of information and support to the patient.
- The range of options available.
- Maximum benefit to the patient.
- Non-discrimination.
- Respect for diversity.
- Minimum necessary restriction of freedom.
- Needs of carers.
- Provision of appropriate services.
Justification for the use of 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 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 team. Consideration of the full range of options available must be made. There must be clear benefit to the patient for whom seclusion is being considered. While seclusion is usually seen as a protective measure for others, clearly, it would not be in the interests of the patient concerned if he or she were allowed to harm another person.

In the Commission’s experience seclusion is largely justified on the basis of containing behaviour that is a risk to others. Staff can be faced with a situation where a patient is extremely disturbed as a result of some form of mental disorder. The patient is threatening or actively violent to others, requires restraint and possibly tranquillisation. In this type of situation, seclusion may be seen by staff as a way of reducing the impact of prolonged physical restraint.

Seclusion is also used in situations where a person with learning disability/autistic spectrum disorders/developmental disabilities and associated disturbed and challenging behaviour requires isolation for long periods of time. 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 violent behaviour has been reduced by their mental disorder. The patient’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 patients and be very hard to come to terms with. A small study by Hoekstra et al7 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 patient must participate in the decision-making process about seclusion and in the follow up and subsequent care planning.

**Identifying seclusion**

High-level observation and supervision may involve restricting patients to their bedroom or a part of a ward. Some patients subject to special observation can spend considerable periods of time heavily restricted in their movements. While recognising some of this guidance may apply to patients in this kind of situation we do not consider these interventions constitute seclusion. During our consultation there was a clear view expressed that, where staff are in the unobstructed physical presence of the patient 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 patient concerned. We recommend that this should be considered as a form of restraint and that the principles set out in the Commission’s restraint guidance 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.

In high security settings the general arrangements for security may mean that where a patient 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 patient can ask to leave the room at any time.

Again, in certain high security settings patients 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 patient cannot leave their room then 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 patient to leave their room on request then this restriction would not constitute seclusion.
Time Out

Seclusion can be confused with Time Out, a behavioural intervention occasionally used in the management of aggressive or violent behaviour. However, Time Out is a form of treatment that is generally planned in advance, and, where practicable, discussed and agreed with the patient. Time Out behavioural therapy programmes are usually of a short duration where the undesired behaviours are eliminated by not being reinforced. Such programmes are part of an overall care plan. Where Time Out interventions are being used and the patient is locked in the room without his or her consent or where he or she is incapable of giving consent, then the care providers must carefully consider whether this intervention constitutes seclusion and whether the use of the 2003 Act is appropriate.

Policies for seclusion

In a care setting where seclusion is 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 on the principles of reducing violence and aggression and on 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 disturbed and dangerous behaviour.

Physical restraint, rapid tranquillisation and use of seclusion of a person who is disturbed, aggressive and violent can potentially be very dangerous and has led to fatalities in a number of care settings in the United Kingdom. Senior management of health services should pay particular attention to the use of seclusion and ensure that it is carefully monitored in their area of responsibility.

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 patient.
- Maintaining the safety of the secluded patient.
- 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 patient debriefing.
- Staff training.

The use of seclusion should be considered in the light of a range of alternatives.
Who can make the decision to use seclusion?
The decision to use seclusion 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 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 duty consultant.

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.

Care planning
Once a period of seclusion has commenced, it should not continue for any longer than is necessary. Therefore, care planning should involve an exit strategy with a target end point, indicating the criteria required for this to be reached, the nature and frequency of reviews and the personnel to be involved. Should the seclusion continue beyond 30 minutes, plans for meeting the patient’s need for eating, drinking and toileting should be clearly recorded. Consideration should also be given to how the patient will be helped to reintegrate into the ward environment. Best practice would also be to inform the named person or carer, with the patient’s consent.

The Commission does not believe that the use of seclusion in itself should feature in individual care plans. 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.

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 a patient’s freedom of movement. This can, in the absence of careful planning and review, lead to untoward physical and psychological consequences for the patient. In particular, it can have a significant effect on a patient’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 patients are able to exercise their basic human rights.
Maintaining the safety of the secluded patient

The nurse allocated to the patient must remain within sight and sound of the seclusion room at all times during the period of seclusion. The nurse must be able to communicate with other staff without having to leave the area. The nurse must ensure that the patient is safe and pay particular attention to the consciousness level of the patient, particularly if he or she has been tranquillised and/or physically restrained immediately prior to the seclusion. The nurse who is in attendance must be aware of the particular needs of the patient, the immediate care plan and the antecedents to the seclusion.

Maintaining a relationship

While being sensitive to the situation and to the patient's mental state staff should maintain communication and discussion with the person being secluded. The person secluded must be told, as far as is possible, the reason for the seclusion and the conditions for its ending. Great efforts must be made to dispel any perception by the patient that he or she is being punished. Seclusion is an isolating procedure and can be lonely and frightening for the person concerned. The seclusion may have immediately followed an incident resulting in restraint by staff. The patient 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 nurse in attendance must keep the patient under constant observation and make regular written reports on the patient's observed mental and physical state. We believe that a written record should be made at least every 15 minutes. Review discussions by clinical staff and decisions made must be recorded. These records are part of the patient's individual medical records. Managers must maintain and hold a record of the general use of seclusion in any particular health care setting. Independent healthcare providers registered by the Care Commission 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.
Where seclusion is likely to be used, there must be a safe environment available.

The arrangements for continuous assessment and review
The nurse in charge of the ward and other staff in attendance must continuously review the need for the seclusion. Medical staff should formally review the need for seclusion at least every four hours. Over and above this, the RMO must complete a multi-disciplinary 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 and be in accord with the principle of least restriction and benefit.

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. Curran, Adnett and Zigmond could not identify any detailed reference to the design of seclusion facilities in the past 20 years. 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.

The room should be discrete from other patients but not isolated. It must be large enough to accommodate the patient 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 patient. 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 patient becomes overheated. This is very dangerous, particularly in the context of a patient having received high doses of medication.

The room must be as non-threatening as possible and be decorated in a calming manner. It must be kept clean and fresh. Bedding must be safe but as non-institutional as possible. Patients’ clothing should be risk assessed prior to being secluded to ensure that any potentially dangerous items are removed. While safety is vital, due regard must be paid to the patient’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 patient or to others. Personal items of religious or cultural significance should remain with the patient unless these may compromise safety.

The patient must have easy access to toilet facilities, and drinking water must be available at all times.

Any room identified for use in seclusion 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 of the patient in the event of a fire.

**How senior management should monitor the use of seclusion**

The use of seclusion must be closely scrutinised through clinical governance processes. These processes should ensure that there is oversight of the use of seclusion by clinical and management staff distinct from the direct clinical 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 (in aggregated and anonymous form) to members of the local NHS Board. Similar arrangements should be made for reporting to senior managers of independent healthcare providers.

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

For people with learning disability/autistic spectrum disorders/developmental disabilities and significantly challenging or dangerous behaviour there may be circumstances where their care plan requires that they be managed in isolation from their peers for many days or weeks. 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 relevant specialists.
- 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 multi-disciplinary team with appropriate expertise.
- It is inadvisable to put in place any such arrangements without the use of the Mental Health Act.

Key good practice points

- The use of, or threat of, seclusion must never be used as a punishment.
- 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.
- The principles of least restriction and benefit must always be applied.
- Staff who may be involved in managing violence and aggression must be fully and regularly trained in methods of risk reduction and safe restraint.
- Seclusion must only be considered when 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 as, or more, safely by any other means.
- The decision to seclude a patient must be made by a senior member of the clinical team, either a member of medical staff or the nurse in charge of the ward.
- Where the decision has been made by a nurse, 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).
- A member of nursing staff must be in attendance immediately outside a seclusion room at all times.
- The seclusion environment must not increase risk to the patient.

Seclusion should never be used as a punishment.
• 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.

• Any seclusion must be for the minimum necessary length of time.

• The general use of seclusion must be recorded and monitored in any clinical area where it may be used.

• NHS Health Boards, or the management boards of private hospitals, must monitor the use of seclusion in their area of responsibility.

• Any patient subject to seclusion must be told, as far as is practicable, the reason for the seclusion and how it might come to an end.

• Any person who has been subject to seclusion must be given the opportunity to be “de-briefed” after the event to help him or her understand why the seclusion took place.

• Regular safety inspections of the environment of designated seclusion rooms must be carried out.

Acknowledgements

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

References


3. 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.


