mental welfare
commission for scotland

Good practice guide

Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

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> *"Seclusion in health settings refers to the supervised confinement and isolation of a patient or resident, away from other patients or residents, in an area from which the patient or resident is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others.*
>
> *It does not matter whether the place of isolation is an enclosed room (rather than, for example, a part of a larger space), or whether the door to such a space is closed or open, locked or unlocked."*
>
> UK National Preventive Mechanism Guidance: Isolation in detention
> 2017

Acknowledgements

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

Who is this guidance for?

We have written this guidance for health and social care professionals working with people who are being treated for mental illness, dementia, learning disability or related conditions in health and social care settings. This guidance is for situations where those professions may be considering using seclusion.

Introduction and background

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.

The guidance was reviewed in 2014 as it became clear that various restrictions were being applied in a range of hospital and community settings but were often not subject to any legal authorisation despite there being a clear infringement of an individual's right to freedom of movement.

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

A Cochrane review in 2000 revealed that there was a dearth of published studies of note evaluating the value of seclusion or restraint in the management of behaviour likely to cause harm[1]. However, more recently, efforts have been made to introduce information and guidance for staff in this area.

Following the uncovering of abuses at Winterbourne View Hospital in 2012[2] and a critical report on the use of restraint[3], the Department of Health published 'Positive and Proactive Care: reducing the need for restrictive interventions'[4]. This was designed to promote therapeutic environments across all adult health and social care services, with restrictive practices used as a last resort.

The Royal College of Nursing produced a guide for the development of staff to be able to work in a positive and proactive way to minimise the use of restrictive practices in health and social care[5]. The National Institute for Health and Care Excellence (NICE) published updated guidance in 2015 on violence and aggression: short-term management in mental health, health and community settings[6]. The update took into account new information on patients'/service users' views on the use of restrictive practices.

In Scotland, the Scottish Patient Safety Programme is grounded in quality improvement methodology. 'Violence, restraint and seclusion reduction' is one of the change packages in the Scottish Patient Safety Programme for Mental Health.[7]

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[1] Sailas EES, Fenton M (2000) Seclusion and restraint for people with serious mental illness. Cochrane Database of Systematic Reviews. Issue 1. Art. No.: CD001163

[2] Department of Health (2012) DH Winterbourne View Review Concordat: programme of action. London: Department of Health, England.

[3] Mind (2013) Mental health crisis care: physical restraint in crisis: a report on physical restraint in hospital settings in England. London: Mind.

[4] Department of Health (2014) Positive and Proactive Care: reducing the need for restrictive interventions. London: Department of Health, England.

[5] Skills for Care & Skills for Health (2014) A Positive and Proactive Workforce: a guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health. Leeds: Skills for Care & Skills for Health.

[6] National Institute for Health and Care Excellence (2015) Violence and Aggression: short-term management in mental health, health and community settings. NG10. London

[7] Hall D (2016) Reducing Harm in Mental Health Settings: the Scottish Patient Safety Programme's approach. International Society for Quality in Healthcare webinar 11 August.

The Mental Welfare Commission's view

The Commission does not advocate the use of seclusion as a first line response to aggressive and/or violent behaviour. Seclusion should not be regarded as a therapeutic intervention but, in certain situations, it may be an option for managing extremely difficult behaviour.

Our view is that it must only be used in the context of a comprehensive policy for the management of behaviour where there is serious risk of harm to others. We would expect that, in most instances, proactive behavioural support plans would largely negate the need for such restrictive measures.

It is essential that services try to minimise the use of all forms of restrictive practice and work to find other, less restrictive, care arrangements for people as alternatives to the use of seclusion. Failure to do this has the potential to lead to inhuman and degrading treatment of some of the most vulnerable people in our society.

Without the necessary legal authorisation, seclusion may also amount to an infringement of a person's human rights, and we discuss this further in the legal section at page 20.

We recognise that where all other options have been considered, in some situations, seclusion may be the one that presents the lowest risk and is likely to be of short term 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.

To help us in the writing of this guidance, we have incorporated views from a wide range of stakeholders.

In addition to written contributions, we held a consultation event in November 2018 with over 70 attendees including representation from a wide range of clinical staff, people with lived experience of mental illness, carers, health and social care regulators and educators. At this event we explored how seclusion is used in a range of situations and heard about good practice already in place.

Something which emerged from these discussions was that there are commonly two distinct levels of seclusion to which an individual may be subject, depending on whether the person is restricted by explicit means or by implication via instructions from staff. We will return to this later in the guidance.

Our engagement and participation officer (lived experience) also consulted with ex-patients/service users at a series of meetings across the country to hear about individuals' experiences and to listen to their views.

Defining seclusion

There is no definition of seclusion in the Mental Health (Care and Treatment) (Scotland) Act 2003.

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"*.[8]

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"*.[9]

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…"*[10]

The United Kingdom National Preventive Mechanism (NPM) has adopted the following specific definition: *(Seclusion) "In health settings refers to the supervised confinement and isolation of a patient or resident, away from other patients or residents, in an area from which the patient or resident is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others"*. It is further highlighted that it does not matter *"…whether the place of isolation is an enclosed room (rather than, for example, a part of a larger space), or whether the door to such a space is closed or open, locked or unlocked."* [11]

This is a comprehensive definition which would encompass all scenarios where seclusion is used and is the definition applied to frame this guidance.

Seclusion implies use of a locked door. However, where someone prevents a person from leaving a room, for example, by physically blocking the exit, this should still be considered seclusion.

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. An individual may prepare an advance statement[12] advocating use of seclusion over other treatments and careful consideration should be given to how this would be managed, bearing in mind the potential infringement of their human rights.

Why is guidance needed?

The Commission has published guidance applying to use of restraint in all care settings (Rights, risks and limits to freedom[13]) whereas our specific guidance on the use of seclusion has previously limited its application to hospital settings. Most research and guidance also tends to focus the area of concern on individuals detained in hospitals. Research and

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

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

[10] 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

[11] National Preventive Mechanism Guidance: Isolation in detention (2017) p9

[12] https://www.mwcscot.org.uk/sites/default/files/2019-06/advance_statement_guidancesep2018revision.pdf

[13] http://www.mwcscot.org.uk/media/125247/rights_risks_2013_edition_web_version.pdf (This guidance will be updated in autumn/winter 2019)

guidance on restricting an individual's freedom of movement in settings other than hospital is scarce.

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 clear from observation and inquiries that seclusion is used in a number of hospitals in Scotland, and in other settings. In some situations, especially when there is a risk of harm to others, it may be an option preferred by both the individual and those providing care. For instance, where the alternative may involve long periods of restraint with an increased risk of injury, seclusion may be a safer option. Similarly, where a person may have a respiratory problem or bone density issues, the risk of injury during physical restraint 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 intervention should be carried out after each episode of seclusion.

Seclusion, whether in hospital or other settings, is a form of restraint that requires careful management by an agreed decision-making process and monitoring by mental health and learning disability professionals and support staff who are fully trained in the prevention and management of behaviour which may cause harm to others.

Seclusion itself can carry risks to the individual, both physical and psychological. It is often used in association with physical restraint and rapid tranquillisation, sometimes in confined spaces. Moreover, inappropriate seclusion in substandard environments will increase the level of stress experienced by a person in serious distress and increase the risk of, and opportunity to, self-harm. In all situations where seclusion is being considered, there needs to be careful consideration of the balance between the risk of self-harm and the risk of assault on others.

Scope of this guidance

This guidance relates to the care and treatment of people with mental illness, personality disorder, dementia or learning disability or related conditions ('mental disorder' under the legislation[14]) in health and social care settings. It is not intended to cover seclusion in other areas including prisons, young offender's institutions, other custodial care settings and schools, which will all have their own guidance, written for those specific settings.

Restrictions in community settings

The Keys to Life[15] is Scotland's learning disability strategy and was launched in 2013. A priority within the strategy is that all adults with learning disabilities, including those with complex needs, experience meaningful and fulfilled lives.

[14] Section 328 of the Act provides that "mental disorder" means any mental illness; personality disorder; or learning disability, however caused or manifested

[15] Scottish Government (2013) *The keys to life - Improving Quality of Life for People with Learning Disabilities*
https://keystolife.info/wp-content/uploads/2019/03/Keys-To-Life-Implementation-Framework.pdf

Enhanced community services have reduced the need for in-patient admissions and many people with a learning disability who previously were in hospital for extended periods of time are now living in their own tenancy or social care setting.

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. Practices such as physical restraint and 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.

When seclusion could be considered

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 the situation cannot be managed more safely or appropriately by any other means. The use of seclusion must always be a proportionate response to any identified risk and 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 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 justified by staff 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 distressed 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 and associated stress and distressed behaviour requires isolation for longer periods of time. This would always require legal authorisation except where the doctrine of necessity would immediately apply.

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 because there is a 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 al[16] 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 should participate and be supported in the decision-making process about seclusion and in the subsequent review and care planning process.

"I was put into the IPCU and put straight into seclusion without knowing why – it was gym mats and barred windows and concrete walls – no one told me why I was in it. I didn't understand and, when I asked, I was told it was calming. I wondered who it was calming for: me or them. The door was open with two people facing me. I don't know how long I was in there. There was no clock and no routine that I could make sense of."
Comment from ex-patient/service user consultation meeting.

Identifying seclusion

Observation practice may involve restricting individuals to their bedroom or to a part of a ward or residential unit. Some people subject to enhanced levels of observation can spend considerable periods of time heavily restricted in their movements.

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 can be highly intrusive and limit 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 in this situation the principles set out in this guidance are followed.

NHS Scotland guidance on observation of people with acute mental health problems was recently published. The main focus of this document is to help move away from more restrictive practices in line with the other published work of the Scottish Patient Safety Programme.[17]

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.

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

[17] https://ihub.scot/media/5508/spsp-iop-from-observation-to-intervention.pdf

Again, in certain high security, 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 or where clinically indicated, then this restriction would not constitute seclusion.

The practice of night time confinement in high security settings is contentious and its use in the UK was criticised by the Committee for the Prevention of Torture in its report to the UK government[18].

Night time confinement is in place at the State Hospital (as it is in all high security hospitals within the UK). We are aware of this practice and view it as different to seclusion.

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

Positive support
Positive support is 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.[19]

Given the NPM definition of seclusion, the following practices should be recorded as seclusion:

Seclusion – Level 1

- Where staff lock a person alone in a designated seclusion room or seclusion suite;
- Where staff lock a person alone in a room or suite of rooms;
- Where staff place a person alone in a room and prevent them from leaving either by holding the door shut, standing in the doorway or instructing them not to leave.

Seclusion – Level 2

- Where staff remain with a person in a room or suite of rooms and prevent them from leaving or instructing the person not to leave;
- Where staff place restrictions on the physical environment the person can move to with the intention of keeping them separated from others.

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[18] European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment, Report to the Government of the United Kingdom, Council of Europe, 2017.

[19] *Problems: A Good Practice Statement*. 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.*

Policies for seclusion

The following guidance refers to both levels of seclusion. Where particular safeguards are indicated for level 1 seclusion, these are clearly highlighted.

In a hospital or care setting, including individual tenancies, we believe there must be a policy and associated procedures for the prevention and management of violent and aggressive behaviour.

Physical restraint, rapid tranquillisation and the seclusion of a person who presents with harmful behaviour can potentially be very dangerous and has led to fatalities in a number of care settings in the United Kingdom.[20]

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 and the use of physical restraint.

Where seclusion may be used, the service should develop a policy and protocol for its use and should only consider it as an option in the light of a range of alternatives to manage potentially harmful behaviour.

Managers 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.

The policy must address:

- 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 during a period of seclusion;
- 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.

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. That risk must be clearly recorded.

For level 1 seclusion, 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 and record the decision. A senior member of nursing staff must be notified, and should visit as soon as practicable, to

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

consider whether additional resources are required to enable an alternative and less restrictive intervention.

In community settings, decisions to apply seclusion should only be authorised by the senior manager of the service or someone delegated to act in their absence. 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 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 relative/carer where practical, 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.

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

Staff allocated to the individual must remain within sight and sound of the person at all times during the period of seclusion either directly through observation or via CCTV. Hospitals and care homes that use CCTV must have clear policies in place regarding its use.

Staff must be able to communicate with other staff without having to leave the area and 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 member of staff 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 where the person cannot consent will require powers to be granted under the AWI Act.

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.

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

For level 1 seclusion

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. 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 use of seclusion in any particular health or social care setting.

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.

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.

The arrangements for continuous assessment and review

The local manager and other staff in attendance must continuously review the need for seclusion.

For level 1 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 the 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.

The provision of a safe environment for seclusion

There can be no justification for placing someone in a room that increases the potential for harm to others or self-harm. The decision about whether an individual needs to be in a purpose designed seclusion facility or their own bedroom (with or without adaptations) will be dependent upon the risk assessment carried out.

Curran, Adnett and Zigmond[21] 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 room should be set apart 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.
- 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.
- 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.

[21] Curran, C., Adnett, C. and Zigmond, D. (2005), “Seclusion: factors to consider when designing and using a seclusion suite in a mental health hospital”, Hospital Development, Vol. 36 No. 1, pp. 19-26.

In addition, the Royal College of Psychiatrists Quality Network for Psychiatric Intensive Care Units, Standards for PICU's state that[22] in wards where seclusion is used, there is a designated room that meets the following requirements:

- It allows clear observation;
- It is well insulated and ventilated;
- It has adequate lighting, including a window(s) that provides natural light;
- It has direct access to toilet/washing facilities;
- It has limited furnishings (which include a bed, pillow, mattress and blanket or covering);
- It is safe and secure – it does not contain anything that could be potentially harmful;
- It includes a means of two-way communication with the team;
- It has a clock that patients can see.

"Maybe they could set aside a room as a seclusion room. I would like some sort of safe room where it is almost impossible to harm yourself or anyone else. It should have something comfortable to lie on; maybe even a comfortable chair rather than a bed, something calming on the walls; a painting of scenery or something soothing; preferably insulated from sounds from the outside. I would possibly also appreciate it even though I was ill, some sort of music or sound, I can stop liking music when I am ill, but maybe the sound of the sea on a beach or something".
Comment from ex-patient/service user consultation meeting.

How managers 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.

Where use of level 1 seclusion extends beyond 72 hours, in order to safeguard the individual's rights, it should be subject to external review. This could take the form of peer review by a senior clinician/manager from a separate part of the service or from a different service.

Local policies should also specify how often external reviews should be repeated, should seclusion be assessed as necessary to continue beyond this time.

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.

Hospitals

The vision of the Scottish Patient Safety Programme for Mental Health (SPSP-MH) is to ensure people in wards or units in Scotland are both safe and feel safe. One of the resources developed by the SPSP-MH to help achieve this vision are the safety principles in mental

[22] RC Psych standards https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/picu/picu-qn-standards-qnpicu/qnpicu-standards-for-psychiatric-intensive-care-units-2017.pdf?sfvrsn=2c6614a2_2 standard 142- type2

health; one of which, Least Restrictive Care, includes seclusion monitoring and training. SPSP-MH promotes implementation and spread of the interventions in the safety principles through the sharing of best practice, identifying opportunities for improvement through appropriate measurement and responsive improvement support. SPSP-MH aims to extend and build on existing good practice, providing an improved model of person-centred care that can be applied in any healthcare setting.

SPSP-MH advocate that the use of seclusion should be a proportionate response, should respect the individual's human rights, and only be employed by highly-trained staff as a last resort to avoid a greater harm occurring to the individual or others.

Registered care providers

The Care Inspectorate (CI) expect seclusion in any form or coercion to be used only as a last resort where there is no viable alternative and that the appropriate legal processes would be in place.

Where people need support as their behaviour is assessed as challenging to the service or as they can experience stress or distress the CI expect to see this in a person centred personal plan that details:

- What brings about the behaviour (triggers);
- What helps to calm a person;
- What should staff never do as this will make the situation worse.

If the person's behaviour puts themselves or others at risk the plan should also contain:

- What is the action service takes;
- If seclusion or control where does this take place;
- Observation: how do staff stay in regular contact and observe person;
- Who authorises the action taken;
- Recording of the incident including authorisation, monitoring carried out.

The person using the service where possible should be involved in agreeing the person centred plan and be involved in the planning of the intervention and has agreed the intervention. If the person cannot be involved the CI expect to see involvement of family or carers and of people who hold legal powers for example Welfare Power of Attorney or Guardianship.

In line with the Care Inspectorate Notification Policy the service must notify the CI of any incidents of seclusion or control.

The Care Inspectorate would expect any seclusion or control to be the last course of action after other interventions have failed and expect to see how the intervention was agreed and the aims of the intervention clearly stated. The aims of the intervention should support self-management rather than focus on compliance and be supported by clearly stated strategies to achieve this.

Special situations

For people with learning disability/autistic spectrum disorders 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, albeit with their own staff team but 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 safeguards.

The use of seclusion involving young people in mental health settings should adopt the same principles as those relating to the care of adults. Detention under the Mental Health Act in hospital rather than parental consent should be considered on an individual basis where the criteria for detention are met. This would offer the child and their named person the safeguards of the Act including the right of appeal to the Mental Health Tribunal for Scotland.

Key good practice points

- 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.
- 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.[23]
- The general use of seclusion must be recorded and monitored in any area where it may be used.
- NHS 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.
- Post seclusion debrief sessions should be arranged for staff.
- The person who was secluded should be offered the opportunity, at a time suitable to them, to discuss what happened and be offered appropriate support.
- Staff should involve family/carers as appropriate in relation to the use and review of the use of seclusion.

The principles of least restriction and benefit must always be applied: we have provided some case examples. These can be found in the Appendix 1.

[23] 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*

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.

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.

There is very little in the 2003 Act and the Code of Practice that deals with the use of force, but it is accepted that the powers of detention and compulsory treatment may involve a degree of force.

Our view is that seclusion without a person's consent amounts to detention and a deprivation of liberty in terms of ECHR Article 5. 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).

In emergencies, it may be necessary for staff to take immediate steps to contain a dangerous situation and that intervention may involve use of seclusion. If the person is not in hospital and subject to compulsory treatment under the 2003 Act at that point, an immediate assessment must be made to consider whether an Emergency or Short-Term Detention Certificate is necessary and 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.[24]

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

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.

In a community setting, any form of seclusion 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, and the individual lacks capacity, 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.[25]

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 welfare 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 would be sought and used. 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.

Part one of the 2000 Act 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.

[24] Mental Health (Care and Treatment)(Scotland) Act 2003 Code of Practice Volume 1 p96/97

[25] 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

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.

Ms CG

Ms CG is a woman with treatment resistant schizophrenia who lives in a self-contained flat within a locked hospital ward environment, having been a patient in hospitals for many years. She is detained on a Compulsory Treatment Order (CTO) and has 2:1 staffing at all times with additional staff when out of the ward. She also has access to her own garden space. The bedroom is lockable and nursing staff can observe her through a window to both bedroom and bathroom. She has a well-furnished living room with DVD and TV.

Ms CG has very little communication, has persistent psychotic delusions and hallucinations and her illness has proven to be fairly resistant to treatment with medication. She is now mainly compliant with her care and treatment.

Ms CG can be very assaultive, mainly kicking, spitting and if close enough, biting. She is less inclined to damage her environment. Nursing staff have a management plan, which mainly involves them removing themselves from her proximity as most of the harm is done to those who are in close contact with her. She can be impulsive, unpredictable and aggressive, mainly towards staff and other patients.

When Ms CG is distressed to the extent that staff or other patients are felt to be at at risk, the door to her private flat suite is locked in accordance with the locked door policy. When it is felt to be necessary for her to be locked in her bedroom on her own she is observed through the viewing windows.

A record of the door being locked is kept with the reason for it being locked recorded. Nursing staff lock the bedroom door when she is distressed for her to have time alone in her bedroom with access to the ensuite bathroom.

We consider that this situation amounts to use of level one seclusion and should be managed with reference to this guidance. Managing it in any other way, potentially infringes human rights and obviates the need for scrutiny and proper evaluation and review.

Mr AF

Mr AF has epilepsy and severe learning disabilities and autistic spectrum disorder. He has no verbal communication. He attended school before having his own accommodation with support provided when he reached adulthood. His family have welfare guardianship. They feel that he did not fully understand that when he left school he was no longer able to attend the placements he previously had and so reacted badly to this.

He started absconding, developed repetitive behaviours, severe aggression, disrupted sleep and reduced appetite. He developed behavioural patterns which made it difficult to sustain his placement. Staff were no longer able to support him in his accommodation and he was admitted to hospital for further assessment.

Since admission to hospital Mr AF's behaviour has not responded to medication and he recently assaulted another patient leading to him being placed in seclusion for periods when his behaviour became unpredictable. He has assaulted staff leading to serious injuries and

contributed to staff leaving the service. Due to his behaviour, he is unable to participate in many activities.

Care plans indicate triggers and reactive strategy and these are evaluated and reviewed on a regular basis. There is a plan for use of seclusion and at these times he occupies a self-contained area at one end of the ward with bedroom, sitting room and toilet designed with most internal objects removed as risk factors in self-harm.

Mr AF is on a constant 3:1 level of observation when not in seclusion. His presentation is unpredictable and he is often violent. Several members of staff are currently on long term sick leave following injury. His behaviour has resulted in extensive environmental damage to the area he lives in and to the exterior of the building when in the garden area. This has become so problematic that he is being referred to a more secure service to try to manage the increased levels of violence and aggression. His family believe that it is the environmental setting which triggers the behaviour and that he should be in accommodation which properly meets his autistic needs.

We agreed the use of seclusion in this case was appropriate and the service developed a policy and protocol for its use. We advised that the accommodation was inappropriate and supported the view that alternative community accommodation which fully met his needs be sought.

Mr RS

Mr RS has a moderate learning disability and frequently displays behaviour likely to cause harm to others. He lives in a community placement with support and is subject to a welfare guardianship order.

On occasions he is restrained by staff and regularly secluded in his flat for his and others' safety. There was a concern that alternatives to seclusion were not being considered by regular review and there should be some move towards trying to manage without seclusion.

Staff have come to recognise trigger signs to Mr RS's behaviour and attempt de-escalation techniques. During seclusion they record their observations every five minutes and keep a dialogue going. They seek direction from senior staff every 15 minutes and there is a comprehensive plan to detail this and record events.

Mr RS has a weekly programme of activities much of which takes place out with the flat with 2:1 support. He has a full programme including getting out most days. This includes outings in the car, bowling, exercise, baking, drawing, coffee and cake, shopping, and every night he goes for a walk. Mr RS says he enjoys his programme. He also enjoys the fire drill which he helps to organise each week.

There are care plans for daily support, self-care, menu plan, and monitoring weight. Staff have found that constipation can lead to aggressive behaviour so they monitor bowel movements. He takes part in household chores and enjoys visiting neighbours. He also receives visits from his cousins.

We thought that the management of this individual's behaviour met the definition of seclusion. However there were no guardianship powers to authorise use of restraint or seclusion and, being subject to an indefinite order, no opportunity for the court to review. We advised that additional powers to authorise restraint and seclusion be sought from the sheriff.

Mr VY

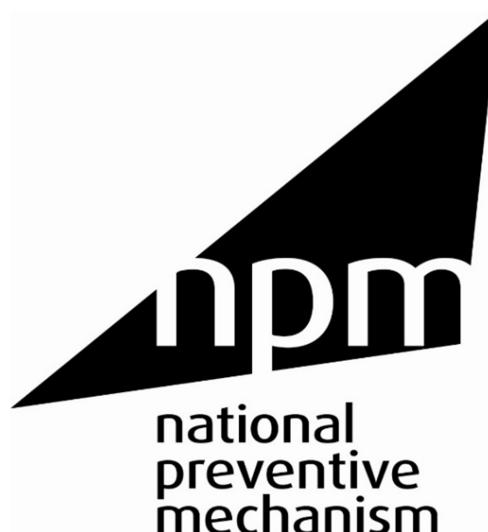
Mr VY has a diagnosis of schizophrenia and was admitted to hospital in a secure setting following a serious incident. He is subject to a CTO under the Mental Health Act. Mr VY is stated to be impulsive and unpredictable. It can be difficult to identify the drivers for this, some of it being psychotically driven. He develops 'paranoid' ideation about individual members of the nursing staff, and, when he assaulted a staff nurse, he had thought that two staff members were implicated in the world ending. The psychologist has been involved and has instigated with staff and Mr VY a formal arrangement whereby he receives two ten minute one to one episodes with nursing staff per day.

He has exhibited frequent episodes of self-harm and there have been numerous assaults in the form of lunging and punching at staff and, as a result, Mr VY required to spend numerous periods of time in a seclusion room.

Mr VY has made some positive progress but he continues to be nursed in seclusion and separate from other patients. He has been able to spend increasing amounts of time out of the seclusion room and has been able to engage in some activities (such as playing cards) with staff. He was previously nursed in strong (anti-ligature) clothing but in the last month he has been able to return to wearing his own clothes. He continues to be nursed very intensively, with three nursing staff with him at all times when he is out of the seclusion room. Staff progressed from moving him around the ward in full secure holds to using loose holds and eventually to no holds.

Mr VY continues to receive medical treatment in the form of antipsychotic and mood stabilising medications with which he fully complies. In addition, he receives regular input from a clinical psychologist and other members of the multidisciplinary team, including occupational therapy. More recently, he commenced a regular anxiolytic medication which may have contributed to the improvement in his behaviour towards others. Mr VY continues to have very limited insight into his illness or need for treatment.

This example demonstrates the difficulties involved in longer term management of behaviour likely to cause harm and the additional problems and risks involved when attempting to reduce the restrictions in use. Here, there was a policy on use of seclusion in place, good record keeping and robust systems for evaluation and review.



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