

Balancing the Risks of Seclusion and Physical Restraint

Introduction

Seclusion “Where someone is forced to spend time alone against their will” is a controversial topic, especially within the education system in schools supporting children with Complex Learning Difficulties (CLD) and Social, Emotional and Mental Health (SEMH). This paper will aim to clarify the key issues with the use of Seclusion and physical restraint. Although seclusion is illegal in most cases in the UK it is still a strategy that is used in some services as a method of control.

We work on the premise that people who work in care and education settings are good people, kind people and people who want to do their best for the people they care for. Very few care staff and teachers want to harm children and other users of the service. The healthcare professionals of the past who performed what we now know as quite barbaric procedures such as bloodletting and electroconvulsive therapy were not bad people, on the contrary, they are caring people who want to cure and help people. One major issue in the past was a lack of evidence and a lack of quality training in key areas, this can lead to staff feeling that they are doing the right thing but a lack of knowledge can sometimes leave staff in a legally vulnerable position. Following misinterpretation of legislation such as The Children Act 1989, staff working in care and education setting often felt that they could not touch children through fear of litigation. This could have lead staff to believe that seclusion is a better option than physical restraint to keep people safe who are putting themselves at risk.

Seclusion Definitions

“Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the containment of severe behavioural disturbance which is likely to cause harm to others”.

Mental Health Act Code of Practice (1982)

‘The supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving.’

DoH (2014)

‘Where a person is forced to spend time alone against their will’

DoH & DfES (2002).

Why is seclusion used?

Paley (2009) sets out three possible rationales for the use of seclusion:

- **Positive therapy** – to help a person to calm more quickly and enable them to learn to ‘manage’ their own emotional states by reacting on their behaviour and emotional expression. This approach sees seclusion as leading to a beneficial therapeutic change in the individual.
- **Containment** – placing a person in a room alone preventing them from harming others in a time of crisis. As above, this approach also sees seclusion as leading to a beneficial therapeutic change in the individual.
- **Punishment** – seclusion is an intentional aversive intervention, the intention is to withdraw the individual from all positive experiences.

Seclusion was introduced as an alternative to mechanical restraints in the early 19th century (Alty and Mason 1994) and is used in wide range of service settings.

Legislation Considerations.

Collectively the following pieces of law and guidance state that seclusion must only ever be considered as a last resort.

- Article 5 of the Human Rights Act: The right to liberty and security
- Mental Health Act Code of Practice (2015)
- Mental Capacity Act (2005).
- Children Act (1989)
- Department for Education and Skills (DfES) and the Department of Health (DOH) (2002) The guidance for restrictive physical interventions.
- The SEN Code of Practice (2015)
- National Minimum Standard (2013)

The legislation around the issue of seclusion is well documented and can be accessed by a quick search on the internet. In short seclusion can only be used in emergencies and only for those who are being detained under the Mental Health Act (1983), subject to a Deprivation of Liberty authorisation, or Court of Protection order under the Mental Capacity Act (2005). The Mental Health Act (1983) stated that staff must not use seclusion other than for people detained under the Mental Health Act 1983. [Paras 80, 89]. The guidance for restrictive physical interventions states that seclusion can only be used in an emergency, this means that seclusion cannot be used if the situation was foreseeable.

Although this paper will not focus on the law, more the impact of seclusion on individuals, services should strive to work within the legal parameters set by the law.

It is true that both seclusion and physical restraint have benefits and negative implications. One thing the strategies have in common is that they both aim to control an individual's behaviour to stop them putting themselves and/or others in danger (real or perceived). Both physical restraint and seclusion can be dehumanizing, damage self-esteem and can be seen by individuals as a daily threat but sometimes it is necessary to control individuals who are putting themselves or others in danger.

Physical Restraint

Miller et al. (1989) suggested that physical restraint can shorten a dangerous situation over other interventions such as seclusion, this might be because it is often much easier to support individuals when we are in the same room as them and/or deep pressure touch often lowers the blood pressure and relaxes people. Many other studies have found physical restraint to be effective in reducing severely aggressive behaviour, self-injurious behaviour and self-stimulatory behaviours (Lamberti & Cummings, 1992; Measham, 1995; Miller et al. 1989; Rolider, Williams, Cummings & Van (1991) Lamberti & Cummings, (1992) found that physical restraint can be helpful in treating aggression with dissociative children and is an effective intervention to protect individuals from harm and prevent serious destruction of property.

For physical restraint to be effective it should be used alongside behaviour management techniques with an emphasis on diversion, diffusion and de-escalation strategies and learning from the incident. Mistral et al. found that training in such strategies decreased seclusion episodes by between 67% to 85%.

There are many training packages in the use of restraint and, although many of them seem very similar, they vary widely (Deveau et al 2009). Cotton (2010)

studied the impact of training staff in physical interventions alongside diversion, diffusion and de-escalation strategies and found that the training leads to a reduction in behaviour incidents in most cases. A greater reduction in incidents occurred in services which implemented a Post Incident Learning (PIL) structure following incidents of restrictive physical interventions; this is where individuals use the incident as a learning experience to explore alternative appropriate behaviours. Further research by Cotton (2010b) suggested that PIL should be part of a good Physical Interventions Training Package. The key legal words to be considered when considering seclusion and/or physical restraint are:

- Best interest
- Reasonable
- Necessary
- Proportionate.

The 'Best Interest' of the individual in care should be paramount. One benefit of physical restraint over seclusion is that physical restraint is often used to keep the individual being supported safe, whereas seclusion is often used to keep other people safe.

'Reasonable' suggests that staff have carried out a planned or dynamic risk assessment and weighed up the risk. We have decided that the risk of our intervention outweighs the risk of not intervening. Where the risk is unforeseeable seclusion might be considered as part of a dynamic risk assessment. Some argue that seclusion is used as part of a continuum of restrictive physical interventions if this is the case the psychological impact of the interventions and the restriction and deprivation of liberty should be considered. If seclusion is to be planned a mental health assessment should be conducted under the 2015 Mental Health Code of Practice. Injuries are

sometimes reported incidents involving restraint, services should take steps to assess if injuries may have occurred without the use of restraint.

For something to be necessary all other behaviour strategies should be exhausted (other than in an emergency, for something that was unforeseeable). If service settings have a room which is used for seclusion this suggests that it is not an unforeseeable risk but a foreseeable risk. Therefore, the premise of unforeseeable could be invalid.

Seclusion

Some researchers have argued that the use of seclusion can be beneficial (Cotton, 1995), can prevent injuries and can reduce agitation (Fisher, 1994). Individuals who are hypersensitive to touch or need a low stimuli environment to help self-regulation but Grassian (2006) highlighted that people who are secluded might develop hypersensitivity to external stimuli and experience hallucinations similar to those experienced by prisoners on solitary confinement. Others believe that seclusion can also reduce injuries to the individual and others but the evidence to support the long-term benefits of seclusion is poor and there is little evidence that seclusion provides any benefits in terms of treating symptoms or reducing aggression.

A study conducted by Meehan et al. (2004) found that staff in health care services believed that seclusion is necessary, not very punitive and a highly therapeutic practice that assisted patients to calm down and feel better. People working in services supporting challenging children often believe that seclusion is the best option, they are doing the right thing and little else would work. I have visited many services who use seclusion as a behaviour management strategy but seclusion is illegal in many circumstances and services could be acting outside the legal parameter. Some services I have supported seem to

look at ways of legitimising seclusion, stating that it has been authorised by the head of the service. On some occasions, services have implemented seclusion following advice from Educational Physiologists (EP) or other professionals. Other services sometimes explain how some individuals want to be locked in a room because they feel safer.

Meehan et al. (2004) explained that patients who had experienced seclusion found that it was used as a means of staff exerting power and control and resulted in them feeling punished; although the same could be said for physical restraint, the patients who experienced seclusion felt that it had little therapeutic value. The Mental Health Act 1983 and MHA Code state that all restrictive practices can be a traumatic experience for any individual but can have particularly adverse implications for the emotional development of a child or young person.

In his book *Refusing Care: Forced Treatment and the Rights of the Mentally Ill* Saks (2004) states:

'I do not think that the therapeutic benefits, even if they were shown to be real, justify the costs of seclusion. This is partly because even the benefits alleged are not very great. If seclusion allowed a severely psychotic person to become mentally healthy, that would be one thing. But it actually is alleged only to calm people somewhat; they become a little bit less upset.'

Saks (2004)

Leggett & Silvester (2003) reported that staff secluded people more often when they think an individual had control over a situation or when they felt the individual had no control over the situation. The report also found that seclusion was used as a means of self-defence, rather than as a type of therapy, designed to allow patients time to regain control of their behaviour. Leggett & Silvester (2003) acknowledged that, if staff were unable to regulate their emotions, they may use seclusion as a form of punishment or, in self-

defence to regain a feeling of control over difficult incidents. Fisher (1995) found that there was a relationship between staff's fear and the use of seclusion which resulted in poor therapeutic care. Hoekstra et al. (2004) reported that seclusion can be hard to come to terms with, especially for people with long-term mental health needs.

We sometimes hear of seclusion being used under authorisation on the head of the service or following advice for an educational psychologist or other professional. The head of service settings or other individuals do not have the power to break the law, which means that seclusion could still be illegal with authorization from the head of the service or other professional.

Seclusion cannot be implemented in a variety of environments, this means that when individuals are in environments where seclusion cannot be used other options should be available which might include physical restraint. Physical restraint is not illegal if it is in the best interest of the individual, the risk has been balanced and all other behaviour strategies have been exhausted. Campbell (2004) suggested that seclusion might reinforce the behaviour that is it seeking to reduce and that some individuals may become more frustrated and suffer from intense anger and aggression for some time following the event.

It is difficult to support and de-escalate someone who is secluded and there is a risk of injury or death if staff are not in the room with them. In 2017 Miriam Merten died after falling at least 20 times and hitting her head as two nurses responsible for her care watched from a security monitor.

Summary

Both restraint and seclusion can be used to keep other parties safe but when considering an intervention, the best interest of the individual we are using the intervention with should be paramount. That is not that the best interest of other parties should not be considered but the correct use of restraint can have a therapeutic value if delivered with support and a well thought out plan where there is a foreseeable risk. Seclusion, on the other hand, has no therapeutic value so outside services with statutory powers it is illegal (other than in an emergency) and difficult to keep the individual being secluded safe.

One of the benefits of seclusion is that it can be used in an emergency and would require little or no training, making seclusion a cheaper option in monetary terms. An emergency is one that is unforeseeable so service cannot plan to use seclusion.

The use of seclusion and restraint can be distressing for the child cause long-term mental health damage including Post Traumatic Stress Disorder (PTSD). If restraint is used alongside supportive strategies the risk of PTSD could be reduced and the experience could be more positive than seclusion.

Although seclusion can be easier to implement than physical restraint the technique can rarely be used in isolation. Physical intervention is often used to get the individual to the seclusion room this means that staff might still require training in physical techniques and most training packages would suggest that trying to move an individual who is being restrained would itself carry an elevated risk.

Some argue that seclusion is a useful strategy for individuals who are hypersensitive to touch but research show that individuals who are secluded often become more hypersensitive to touch follow seclusion.

Often seclusion and restraint are only short-term strategies' and neither strategy teaches self-control when used in isolation. In non-residential services, the use of seclusion cannot be used outside the service setting where a seclusion room might not be available. In services where seclusion and restraint are used regularly, there is a risk that individuals might become institutionalized.

One argument for the use of seclusion is that it can take away stimuli for some individuals. Forcing individuals to spend time alone against their will is illegal if the service does not have statutory powers. In services where individuals are taken to low stimulus rooms, it is important that all staff understand that individuals are not forced into rooms and/or they are not alone in the room.

The use of restraint and physical intervention requires highly trained staff who are trained not only in physical interventions but also positive behaviour strategies such as proactive behaviour support and de-escalation techniques. Staff can use de-escalation strategies and show that they care during physical interventions and restraint creating attachment-promoting possibilities building positive relationships. On the other hand, the use of de-escalation strategies can be redundant during the use of seclusion, prolonging the incident and breaching staff's duty of care. Physical Restraint techniques can be adjusted to the level of resistance the individual showing ensuring staff are not using disproportionate force.

Some service users might misinterpret why physical restraint is being used especially if it used incorrectly. It is crucial that physical restraint is delivered with support and services are transparent in its use. Sometimes service users in crisis are removed from rooms in an attempt to maintain the dignity of the individual. Staff should consider that individuals being held in isolation may

The greatest risk during physical restraint is that of positional asphyxia. Positional asphyxia is any position that compromises the airway or expansion of the lungs impairing the individual's ability to breathe, leading to asphyxiation. Most cases of positional asphyxia involve dangerous physical techniques where staff have received no training or poor quality training. The risk of positional asphyxia is greatly reduced if staff receive high-quality training where the techniques have been fully risk assessed however, poor quality training which focuses on physical techniques rather than de-escalation can lead to many implications such as staff becoming overconfident and restraint being used too soon where other strategies might have worked (Cotton 2010).

This paper suggests that physical restraint can be less damaging to individuals and more supportive than seclusion if carried out by highly trained staff. However, poor training in physical restraint and lack of understanding around the issues associated with the use of seclusion can put people at risk in services where the strategies are used. Service settings using seclusion and restraint should issue clear policies that are transparent and include information on the development of individualised plans which are developed by a multidisciplinary team and based on the needs of the individual, these can go some way towards reducing risk and providing the best possible support for individuals. It is important that positive behaviour strategies and post-incident learning are embedded in services supporting individuals requiring either physical restraint and/or seclusion to help the development of alternative strategies, therefore reducing the need for either intervention whilst ensuring they are delivered with support.

The unfortunate reality is that both seclusion and physical restraint are sometimes necessary but both can be damaging and have a huge impact on individuals and their families for years after the intervention, especially if carried out inappropriately. Individuals requiring seclusion should be cared for

in services who have legal statutory powers to use the technique such as secure accommodation, prisons or health care settings with the power to detain people under the Mental Health Act (1983), subject to a Deprivation of Liberty authorisation or Court of Protection order under the Mental Capacity Act (2005). Any use of seclusion is likely to contravene Article 5 of the Human Rights Act: *The right to liberty and security* and its use in any setting should be questioned.

References

Alty A. (1997) *Nurses' learning experience and expressed opinions regarding seclusion practice within one NHS trust. Journal of Advanced Nursing. 25, 4, 786-793.*

Beail N. (2009) *Trauma Informed Care. BILD Positive Behaviour Support Conference. York, 7th May 2009.*

British Institute of Learning Disabilities (2015) *Information sheet on the use of confined spaces and tents in classrooms, www.bild.org.uk/capbs/capbsresources*

Campbell, K., and M. Denov. (2004). *The burden of innocence: Coping with a wrongful imprisonment. Canadian Journal of Criminology and Criminal Justice 46(2): 139-163.*

Children Act (1989), www.legislation.gov.uk/
Department for Education (2014) Behaviour and Discipline in Schools, Advice for Headteachers and school staff
www.gov.uk/government/organisations/department-for-education

Cotton, D, (2010). *The effectiveness of Team-Teach. http://www.teamteach.co.uk/CaseStudies.html. Last accessed 17.10.16*

Cotton, D, (2010). *The effect structured listening and learning has on pupils and schools following incidents involving physical intervention. http://www.pbstraining.co.uk/category/members/*

Cotton, N. S. (1995) *Seclusion as therapeutic management: an invited commentary. American Journal of Orthopsychiatry, 65, 245– 248*

Department for Education (2013) *Residential Special Schools National Minimum standards*
www.gov.uk/government/organisations/department-for-education

Department of Health & Department for Education & Skills (2002). *Guidance for Restrictive Physical Interventions. London: HMSO.*

Department for Education and Department for Health (2014) *Special Educational Needs and Disability 0 to 25 years Code of Practice*.
www.gov.uk/government/organisations/department-for-education

Department of Health (2015) *Mental Health Act 1983 :Code of Practice, The Stationary Office*

Department of Health (2014) *Positive and Proactive Care: reducing the need for restrictive interventions*, www.official-documents.gov.uk.

Deveau, Roy, and Andrew McDonnell (2009). "As the last resort: reducing the use of restrictive physical interventions using organisational approaches." *British Journal of Learning Disabilities* 37.3 (2009)

Fisher, W. A. (1994) *Restraint and seclusion: a review of the literature*. *American Journal of Psychiatry*, 151, 1584– 1591

Grassian, S (2006) *Psychiatric Effects of Solitary Confinement*, 22 *Wash. U. J. L. & Pol'y* 325, [h
p://openscholarship.wustl.edu/law_journal_law_policy/vol22/iss1/24](http://openscholarship.wustl.edu/law_journal_law_policy/vol22/iss1/24)

Harkin T (2014) *Majority Committee Staff Report, US Senate Health Education and Pensions Committee, February 12, 2014, Dangerous Use of Restraints and Seclusion in Schools remain Widespread and Difficult to Remedy - A review of Ten Cases*.

Human Rights Act 1998, www.legislation.gov.uk/

Kirkwood, S. (2003). *Practicing Restraint*. *Children's Voice*, 12 (5), pp. 14-19.

Lamberti, J.S. & Cummings, S. (1992). *Hands-on restraint in the treatment of multiple personality disorder*. *Hospital and Community Psychiatry*, 43 (3), 283-