USE OF SECLUSION IN PSYCHIATRIC INTENSIVE CARE UNITS

Understanding the factors that influence whether or not staff seclude service users will help reduce instances of this controversial intervention, say Janet Kai Ling Wong and colleagues.

Abstract

This literature review aims to discover the factors that influence staff working on psychiatric intensive care units (PICUs) to implement seclusion. Identifying these factors may help to reduce the use of seclusion and improve client care. A comprehensive search of available publications was undertaken, with relevant articles analysed and discussed. The main factors identified were staff and service-user characteristics, with an increase in shift workload, aggression on both sides and client-to-staff ratio contributing to an increased use of seclusion. Environmental factors also played an important part, with smaller unit size leading to lower rates of seclusion.

A re-evaluation of the design and layout of PICUs may enable a decrease in the use of seclusion. In addition, increasing the number of staff working on a unit might improve issues such as organisation, staff confidence and the ability to adopt alternative de-escalation techniques. This review shows that further study is needed in this area, particularly on the different health professional roles in a PICU.

Keywords
Mental health nurse-to-client ratio, psychiatric intensive care, psychiatric nursing, psychiatric unit design, seclusion

PSYCHIATRIC INTENSIVE care units (PICUs) are specialist inpatient mental health wards that aim to provide a secure environment for clients who cannot be nursed safely on an open ward. PICUs typically have higher staffing levels than open wards, and other environmental aspects are generally in place, such as locked entry/exit doors, restricted opening of windows and restricted kitchen access. Clients might be transferred to a PICU for several reasons, but primarily the risks people pose to their own and others’ safety are considered.

The low-stimulus environment that a PICU provides can be of considerable benefit to some other client groups as well, for example, those experiencing mania or paranoia.

Most of those transferred to a PICU will have a relatively short admission, with the accepted model allowing for transfer back to an open ward when the person’s mental state has stabilised. In most PICUs a seclusion room is available. This allows service users to be confined alone, reducing potential harm to themselves and providing protection for other clients and staff. This article will further describe the role of seclusion, exploring which factors contribute to its use.

What is a seclusion room?
Seclusion is defined as ‘the forcible confinement of a patient alone in a room for the protection of others from serious harm’ (Dix et al 2008) and is...
an emergency intervention. In the UK, for a room to be considered a seclusion room it must follow set criteria, with slight variability between NHS trusts. For example, an NHS trust in the north west of England lays out seclusion room criteria such as those shown in Box 1. It is also useful to note that the design and decoration of the rooms are usually modified to increase adherence to national guidelines and improve effectiveness (Dix and Williams 1996).

The use of seclusion rooms in clinical practice is an increasingly controversial and widely discussed topic, with recent research and programmes aiming to reduce its implementation in psychiatric care (Huckshorn 2004, Smith et al 2005). It is considered a therapeutic measure: used to separate a service user from others on the ward by removal to a low-stimulus area, sometimes termed a ‘seclusion suite’. Reasons for the use of such a method range from protection of the individual from imminent harm to self (O’Brien and Cole 2004) as well as to others (Sullivan et al 2004), and avoiding damage to property (Ahmed and Lepnurm 2001) or the environment (Kaltiala-Heino et al 2003). It is also used to reduce the risk of absconding (Morrison et al 1997), because locked doors are required to meet seclusion criteria.

The interest in the topic has been mostly negative in recent years, with growing pressure to reduce or stop the practice; Donat (2003) suggested that an over reliance on it rendered the mentally ill inpatient incapable of developing the skills necessary to function away from the unit. Another paper commenting from the client’s point of view reflected intensified feelings of rejection, exclusion and abandonment during the unwell period, mainly due to a lack of nurse-client contact (Holmes et al 2004). Meanwhile, Moran et al (2009) highlighted the emotional distress that nurses experienced in terms of fear and guilt and their attempts to suppress these feelings. The move to limit this treatment also raises ethical questions – since the act of secluding might infringe the person’s autonomy, beneficence and non-maleficence – while preserving treatment options in the long term (Taxis 2002).

Given the shift in attitude to the practice, it is helpful to understand the reasons given for its use, especially as it evokes strong feelings among service users and practitioners. Factors that influence how staff react to people with challenging behaviours may be a subject for study: it might be possible to reduce the use of seclusion by reducing aggravating factors affecting all parties. Such research and scrutiny might also uncover inherent deficiencies in the PICU environment, so that changes can be made to promote safer and more effective care.

Evidence
Relevant databases were searched to identify studies discussing factors contributing to the use of seclusion in PICUs. Three of the most relevant papers are discussed in more detail. None of these papers are based on evidence from UK mental health services, and this highlights the paucity of research in this area. However the authors believe the papers represent the best available evidence in this field, gathered from psychiatric services that are comparable, and of relevance, to those delivered in the UK.

The first article was entitled, 'Factors influencing seclusion rates in an adult psychiatric intensive care unit’ (O’Malley et al 2007). This New Zealand study focused mainly on change in unit size and its relation to seclusion episodes, as well as shift and nursing staff variables. The study design was a mix of retrospective and prospective data collection, examining the change from a 20-bed PICU to two ten-bed units. There was a significant reduction in seclusion rates when the unit was split into two smaller wards, dropping again slightly at six months. Increased use of seclusion was associated with night shifts, and total nursing hours and caseload showed a statistically significant negative association. Therefore, the size of units and caseloads, and duration of shift hours and total nursing hours, could explain 23% of the variance in seclusion rates. No significant association between nursing experience levels and seclusion rates was found.

The second paper was titled, 'Factors contributing to mental health professionals’ decision to use seclusion’ (Mann-Poll et al 2011). This study used vignettes of cases that had client, staff and environmental characteristics as the main focus. Approachability of the service user and whether or not the practitioner could communicate with the person effectively were found to influence the level of seclusion use by 7.6% (leading to higher levels for ‘unapproachable’ individuals). The strategy was implemented more if acute danger was perceived

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**Box 1 Example of the seclusion room criteria of an NHS trust**

Seclusion rooms must:
- Provide privacy from other service users.
- Be safe and secure.
- Have a bed mattress thick and firm enough to prevent suffocation, with a waterproof and tear proof cover.
- Not contain anything that could cause harm to the service user or others.
- Be adequately furnished, heated, lit and ventilated.
- Have a strong, robust and lockable door that opens outwards.
or if practitioners regarded it as part of routine. Seclusion levels were increased during night shifts and in areas with a lack of private space. Professionals who worked on a crisis-intensive care unit were more likely to use this method.

The final paper, ‘Staff perceptions and organisational factors as predictors of seclusion and restraint’ (De Benedictis et al 2011) included data from 2008-2009. A total of 309 staff members in Quebec, Canada, participated from eight different psychiatric units. The study was concerned with socio-demographic characteristics, staff perceptions of interactions with clients and between the team, and organisational factors. Statistically significant associations were found between increased staff aggression and higher use of seclusion, whereas improved organisation on the unit was associated with less seclusion. The type of unit was also a factor, with intensive care units and emergency departments associated with increased use of the strategy.

Discussion

Staff characteristics All three publications showed an association between staff characteristics and the use of seclusion on PICUs. The first two articles (O’Malley et al 2007) imply that increased workload for staff can be linked with an increase in seclusion rate; possibly because the mental health professionals have less time to spend on de-escalation techniques. This could be remedied by an increase in the number of staff present on the ward; staff-to-client ratio was also identified as a factor affecting seclusion rate.

The third paper showed that better organisation was associated with fewer cases of seclusion, and this also may be linked to staffing levels, hours and shifts. An increase of seclusion use during night shifts was discussed, revealing a possible need to look at changing the standard practice of decreasing staffing levels at night.

The association between staff experience and willingness to employ seclusion was noted in one paper (Mann-Poll et al 2011), with the authors implying that those who view seclusion as a routine bring about higher rates of use. This suggests that professionals become complacent. A possible method of decreasing seclusion due to this factor could be the introduction of reminders or regular checks and records to justify its initiation and continuation as the most appropriate option in the given scenario. Practitioners could also be moved between wards on a monthly/yearly basis, so that the act of seclusion is no longer routine and there is more reflection on the subject.

Another factor involved in staff use of the intervention appeared to be confidence in colleagues. The second paper (Mann-Poll et al 2011) suggested that those who had more confidence were less likely to use seclusion, and the last paper supported the idea that if staff felt adequately safe then the practice decreased. A method of reducing seclusion could therefore focus on increasing staff members’ trust in themselves, the organisation and each other by using exercises or group work, as well as training and supervision. Reduction in the use of bank staff may also help with this factor.

One study (De Benedictis et al 2011) found a positive association between staff aggression and use of seclusion. This finding might be explained by a separate study that discovered care providers with a positive attitude were more able to control their own emotions and therefore coax their clients, whereas those with a negative attitude were inclined to feel out of control and were more likely to escalate treatment to seclusion (Bowers et al 2007).

Patient characteristics Some papers (De Benedictis et al 2011, Mann-Poll et al 2011) showed an association between client aggression and seclusion. With an increased threat of danger (acute or imminent) and increased aggression, the seclusion rates rose. With this in mind, to reduce seclusion a more robust strategy for correct treatment and medication options could be considered. Another link identified was approachability of the client – more approachable individuals are less likely to be secluded. To correct this, staff could be trained in how to communicate more effectively with the unwell person and taught techniques to calm service users and de-escalate such situations.

Environment The physical environment of the PICU proved a factor in the decision to seclude, with all the investigations finding a statistically significant association between unit type/size and seclusion use.

The first paper (O’Malley et al 2007) described a reduction in the use of seclusion due to a decrease in unit size, which could have a possible influence on the design and re-evaluation of PICU units. Mann-Poll et al (2011) also supported this view, as it reported an increase in seclusion when rooms were shared and less private (this was due to greater numbers of service users on wards).

Another factor affecting the use of seclusion was the type of ward: intensive care and emergency wards were more likely to record higher levels of seclusion (De Benedictis et al 2011). Of course this
could also be due to the fact that more acutely unwell individuals are accepted onto these wards. In another study that spanned 12 months on a PICU, statistical analysis demonstrated the relationship between seclusion use and ward characteristics. It found that increased visibility of inmates and comfort of the ward environment were associated with lower rates of seclusion. Therefore ideas to increase patient comfort should be suggested and needled (Van der Schaaf et al 2013).

Limitations. A major limitation of this review is the lack of similarity between the study types used; the variation from cross-sectional to vignette to retrospective studies meant that it was challenging to find directly comparable characteristics. In the vignette study it could also be argued that the practitioners may not react in real-life situations in the way they stated in their answers to questions, demonstrating responder bias.

One of the studies (De Benedictis et al 2011) looked at both seclusion and restraint, which could skew the data set; however, many of the factors were clear in the association with either one or both of the variables, so it is less likely that restraint statistics have adversely affected analysis of seclusion in this review. In addition, due to the specification of the subject and sparseness of available research, the studies reviewed were not standardised in that they did not all directly address the PICU as the sole ward.

Finally, the broad title of ‘staff’ used throughout this article and the papers discussed mean that the types of participants in each study varied; this could lead to a bias, because some professionals may react differently and therefore the factors identified would not affect all staff or all situations equally.

This could project misleading importance onto the weight of certain influences on the use of seclusion.

Conclusion. This review of relevant literature surrounding the practice of seclusion in PICUs concludes that factors contributing to staff implementing it include a number of service user and staff characteristics, with the environment also playing a role. It is apparent that size of unit, staff-to-client ratio and aggression were main influences. Other factors, such as shift time and workload, also contribute. However, some may point out that having fewer staff leads to higher workloads, resulting in increased seclusion rates during shifts such as night time.

The studies reviewed suggest many options that could be trialled to reduce the rates of seclusion in PICUs. These options include more staff, ensuring that units are small wards, an improvement of trust within multidisciplinary teams to boost confidence, and better organisation between staff members.

In this article limitations were highlighted. The research discussed in this paper often identifies mental health professionals as a whole, and so possibly future research could focus on the separate professional roles in psychiatry (for example, consultant, junior doctor, nurse, healthcare support worker). By determining which factors are more significant per profession, those that are common to a certain role could be addressed through policy, guidelines or training. Crucially, more research is needed on factors specific to PICUs because this would allow for an in-depth understanding of how these affect staff decisions, and as a result the use of this strategy may be refined and client care improved.

References


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Conflict of interest
None declared