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# Factors influencing decisions of mental health professionals to release service users from seclusion: a qualitative study

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- **Short running title**

Releasing service users from seclusion

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## ABSTRACT

### Aim

This study aims to explore and understand factors influencing the decisions of mental health professionals releasing service users from seclusion.

### Background

Seclusion should only be used a last resort and for the minimum possible duration. Current evidence outlines which service users are more likely to be secluded, why and what influences professionals' decision to seclude. Little is known about factors professionals consider when releasing service users.

### Design

A qualitative study was undertaken to explore factors which influence decision-making of mental health professionals when terminating episodes of seclusion.

### Methods

Semi-structured face-to-face interviews with twenty-one professionals were undertaken between May 2017 - January 2018. Framework analysis was used to systematically manage, analyse and identify themes, whilst maintain links to primary data and provide a transparent audit trail.

**Results**

Six themes were identified where professionals looked for service users to demonstrate co-operation and compliance before they would be released. Decisions were subjective, being influenced by the experience and composition of the review team, the availability of resources plus the emotional tone and physical environment of the ward. Release could be delayed by policy and protocol.

**Conclusion**

Professionals should have greater awareness of factors that hinder or facilitate decisions to release service from seclusion and an understanding of how service user views and involvement in decisions regarding seclusion should be explored.

**Impact**

Senior staff should be available to facilitate release at the earliest opportunity. Staff should ensure that policy and procedures do not prolong the time service users remain secluded.

**KEYWORDS**

nurse, nursing, seclusion, restrictive intervention, coercion, decision-making, multi-disciplinary working

## INTRODUCTION

Worldwide healthcare services have expressed alarm at increasing levels of violence and aggression aimed at staff (Edward et al. 2016, Bulgari et al. 2018). Incidence in psychiatric settings is higher still (Department of Health (DOH) 2014, Duxbury 2015, Renwick et al. 2016). Evidence regarding the most effective way to manage violence and aggression in inpatient mental health settings is lacking (Georgieva et al. 2012) and the use of restrictive interventions continues to be sanctioned under law as a means by which staff can respond. One such intervention is the use of seclusion. Research indicates which service users are most likely to be secluded, for what reasons and how the decisions to seclude them are made. Currently there is no best practice guidance, no specific risk assessment and only minimal reference in the literature relating to decision-making around releasing service users back into communal ward areas (Jackson et al. 2018).

## BACKGROUND

Seclusion is defined as:

> 'The supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour that is likely to cause harm to others.'
>
> (DOH, 2015)

Seclusion may breach service users' human rights and cause lasting trauma (Recupero et al. 2011, World Health Organisation (WHO) 2017). It should be avoided wherever possible but if used, should only be for the shortest time possible (National Institute for Clinical Excellence (NICE) 2015). Episodes of seclusion in the UK must follow policy and procedure (DOH 2015, NICE 2015) which outline the responsibilities of staff including offering support, undertaking

regular reviews and facilitating release as soon as possible (see Figure One). However, it fails to state how this can be achieved safely and effectively.

Aggression in inpatient wards is of concern (Lewis et al. 2009, Maguire et al. 2012, Moylan 2015) and staff have ethical, professional and legal requirements to maintain safety (General Medical Council (GMC) 2013, American Psychiatric Nurses Association (APNA) 2014, Nursing & Midwifery Council (NMC) 2015). On occasion, security and use of seclusion takes precedence over therapeutic consideration (Happell and Harrow 2010, Ramluggan 2018). Globally, there are drives to reduce and eventually prohibit seclusion. Although initiatives have been successful in reducing seclusion use (Ching et al. 2010), efforts to date have focused on reduction rather than elimination (Kinner et al. 2016). An international review estimated the number of seclusion events varied between 7.99 and 79.35 per 100 admissions per month, whilst the length of time service users remain secluded ranged between 3.66 hours to 55 hours (van der Merwe et al. 2009). Yet meaningful comparison is problematic due to differing definitions, clinical settings and recording practices (Janssen et al. 2011). Studies have indicated being younger, male, psychotic (Dumais et al. 2011), with a history of substance misuse (Renwick et al. 2016) and violence (Soliman and Reza 2001), carries an increased risk of being secluded, although others have argued demographic factors are not accurate predictors (Lepping et al. 2016). In fact use has been shown to vary both between and in organisations at ward level (Boumans et al. 2015), appearing to be strongly influenced by individual staff differences (Happell et al. 2012, Kalisova et al. 2014, Renwick et al. 2016, Doedens et al. 2017) and local cultures (Husum et al. 2010, Lai et al. 2018).

Staggs (2015) found the mean duration service users spend secluded was decreasing. Shorter durations may be attributable to changes in national policies (DOH 2014, APNA 2014, Australian National MH Commission 2015), the growing number of international and local restraint reduction programs, plus changes in staffs' attitudes towards restrictive practices (Kinner et al. 2016). Whilst research has demonstrated evidence based risk assessment tools aimed at predicting likelihood of violence can reduce durations service users may remain secluded (van de Sande et al. 2017), as with decisions to seclude it is plausible durations are strongly influenced by a multifactorial mix of team cultures and staff characteristics rather than based solely on service user presentation. In fact, Nagayama and Hasegawa (2014) demonstrated changes to nursing care and improved management of seclusion episode (Nagayama and Hasegawa 2014) cut durations. Plus, in a study examining the discontinuation of mechanical restraint, the quality of the service user-staff relationship was shown to affect the length of time service users remained restricted (Nielsen et al. 2018). However, there remains a lack understanding regarding the factors professionals consider when deciding to terminate an episode of seclusion (Jackson et al. 2018). An exploration of the issues considered by mental health professionals when making decisions may further support initiatives to reduce both time spent in seclusion and strategies to cut overall use.

## THE STUDY

### Aim

To explore and understand factors which influence the decision-making of mental health professionals to terminate episodes of seclusion.

### Design

The study used a pragmatic qualitative descriptive design with semi-structured interviews. Such studies are suited to health research allowing participants to provide experience, emotional and social beliefs (Denzin and Lincoln 2018), whilst exploring reasons for and factors that facilitate phenomena (Colorafi and Evans 2016).

### Participants

The work was undertaken in a mental healthcare service in the North of England. Four mental health units with seclusion facilities were identified (see Table 1). Two units were on the same site and two on individual sites. All units were subject to the same policies, procedures and the Code of Practice (DOH 2015). Multidisciplinary teams (MDTs) staffed all units and participated in seclusion reviews. MDTs include professionally registered Medical, Nursing and Allied Health Professionals (AHPs) from psychology, occupational therapy (OT) and social work (SW), plus non-registered Healthcare Assistants (HCAs). AHPs are the third largest healthcare staff group in the UK and make a significant contribution to mental health services (NHS England 2017). The disciplines bring a range of perspectives, skills and experience to support the planning and delivery of care in mental health teams. A sampling frame (Ritchie et al. 2014) was devised to represent and identify a range of professionals working in MDTs. This ensured the sample had features and characteristics of the population to

support detailed exploration and understanding (Bryman 2012). Participants were required to be working on wards with a seclusion facility and have recent experience of involvement in a review or discussion regarding release of a service user from an episode of seclusion.

**Data collection**

Twenty-one staff, 16 females and 5 males, with experience ranging from 7 months to 34 years, participated in a face-to-face interview (see Table 2). Interviews took place between May 2017 and January 2018. A semi-structured interview guide (See Figure 2) was developed using findings from a literature review examining possible factors considered with regard to decisions to terminate an episode and a seclusion decision-making model (Jackson et al. 2018). Interviews were conducted by the lead author at the participants' workplace, digitally recorded and transcribed verbatim. Sufficient interviews were undertaken to ensure saturation of the data and incorporate the range of professionals in the sample frame (Saunders et al. 2018). The first two recordings were pilot interviews and their quality discussed by the authors. Both were included for purposes of analysis. The mean length of interviews was 41m 44s, with a range of between 23m 52s and 57m 52s.

**Reflexivity**

The lead author was an experienced Research Nurse working in the service and known to the participants. All were aware the study was part of an educational project. The authors were mindful that interviewing peers provides methodological challenges (Coar and Sim 2006), as participants may hold pre-existing views about the researcher which may result in them giving socially desirable answers or affect their willingness to disclose (Richards and Emslie 2000).

## Ethical considerations

Ethical approval was obtained from the UK Health Research Authority (HRA) and university committee. Participation was voluntary. Prior to interview participants received verbal and written information, were advised safeguarding concerns would be dealt with as per local policy, data could be withdrawn until analysis commenced and support was available should interview cause distress.

## Data analysis

Data analysis followed Ritchie et al.'s (2014) five stage Framework Analysis process of familiarizing, constructing thematic frames, indexing and sorting, reviewing and then summarizing data. This offered a flexible pragmatic approach whereby agreed topics are explored but thought given to new insights and inconsistencies which warrant further study (Gale et al. 2013). Rigour was supported as codes and themes were discussed by all the authors, plus a clear and transparent audit trail was provided (Ritchie et al. 2014). The authors read and coded the data independently. Codes and categories were developed by considering each line, phrase or paragraph to summarise key phrases (in-vivo codes) to retain the authenticity of data. Initial thoughts were developed into data summaries within Microsoft Excel (2010). The coding index and matrices enabled changes to be tracked allowing the authors to move through the data summaries back and forth to the original transcripts, checking and re-checking (Ritchie et al. 2014) and identifying verbatim quotes (Whittemore 2005). Expert nurses outside the study were invited to review the themes to ensure findings were credible.

## FINDINGS

The following findings explore the 21 participants' experience of involvement in a decision to terminate an episode of seclusion. They described release as a gradual and tested process dominated by six themes.

### *Do as you'*re told

Staff indicated service users need to 'to calm down' and 'do as you're told':

> …we have decided that you can… if you do… then we will… if not you will not be released. It's horrible isn't it, you have got to say these things, but it's also a case of if you don't, you are not going to get anywhere… you don't really have much choice. (Nurse 8)

Staff questioned this approach but where unsure of how else to manage:

> I am looking that a patient understands that we cannot allow them to be violent, we have a ward full of vulnerable patients and staff are not here to be assaulted? Come out when you're ready? Here are the keys. (Medic 1)

Taking an authoritarian stance staff stated they listened, negotiated with and respected the views of service users. However, ultimately service users were required to follow direction, being seen as 'not in a position to be dictating terms' (HCA 2):

> I think we set the rules and the patient has to do what we ask because we are controlling their access, I don't think we negotiate as such. We ask and see what they think but we do talk to them as much as possible, offer reassurance and tell them what we are planning. (AHP 4)

Service users need not necessarily agree with reasons for being secluded but were expected to acknowledge why, plus demonstrate co-operation and compliance. If not, staff thought they were not ready to be released and so would be reluctant to the open door.

**Do I believe you?**

Staff looked for a guarantee from the service user they would control their behaviour, remain stable and not be aggressive if they were released. They wanted to trust but took care 'not to be played'. It was suggested service users were not always honest:

> …they may throw you a curve ball…we have all seen patients who say the right things to get out, can hold it together for so long then it all spills out. I've come across patients who to all intents and purposes tick the box for perhaps coming out of seclusion but there is that gut feeling that they are holding something back, trying to get one over on you. It's a whole raft of things that I personally prefer to see met before I am satisfied that person will come out. (Nurse 6)

Trust was linked to diagnosis, as although staff stated it shouldn't make a difference, it did:

> …people with a personality disorder, who are sat there all sweetness and light and they're very, very sorry and they'll never happen again, and you know full well it's different. You can't always take everything at face value… (Nurse 4)

Decisions were more difficult if the service user was under the influence of illicit substances as they were unpredictable. Potential for future violence was considered although staff felt the emphasis should be current presentation the service users' calmness, tolerance, control over emotions and temper were viewed as indicators of readiness for release. These were rated higher than expressions of remorse which could sometimes be seen as insincere or temporary:

> … after having smashed ten windows, thrown furniture, smashed the place up, assaulted staff members … within an hour, I'm very sorry I'll never do it again with a smile on her face. That's a situation where you think, potentially we are going to be back in the same situation half an hour after we let you out and on occasions that is exactly what happened. (Nurse 4)

In some instances, staffs' willingness to trust was broken as the service user might exploit the power imbalances which exist within MDTs:

> He was all, you deserved what you got. I'll get you again when I come out. 5 minutes later when doctor walked in, he was pleasant and appropriate. (HCA 2)

***In the end it's your choice***

Service users were not viewed as passive recipients. Staff thought in the end release was in 'their [the service user*s'*] hands', '… they have a certain amount of power to manage their own behaviour' (AHP 1), choice to take control, choose whether or not to engage, accept the consequences of their actions and offer a guarantee they will not be aggressive. As stated by HCA 2, '… they know the game, they know how it goes'.

A willingness to engage and communicate indicated the service user was, 'moving in the right direction', (Nurse 8). 'If they can't talk to you about it then I don't think they should be coming out and that's that' (HCA 1):

> … in the longer-term patients are positive towards staff, it is in their interest to be. (Nurse 7)

Furthermore, 'No matter how distressed they are, they can process at least enough of it to know what's expected of them' (Nurse 3). The quality and level of engagement set the timescale for re-entry to the ward, thus service users with poor communication skills might end up being secluded longer.

Staff thought deciding not to release sometimes felt punitive but argued service users needed to take responsibility for their actions. Service users should acknowledge they may have raised anxieties of others on the ward, plus understand staff have other things to manage:

> It's all too easy to forget that you have got someone in there…. I was the only qualified on, been ten days off. I didn't know a single patient on the unit. I was trying to do meds, keep everybody safe, decide who should go out, if they should have this that or the other and I hadn't got the best of teams on around me… out of sight out of mind. (Nurse 4)

***Do I, don't I?***

Decisions were guided by subjective judgments: 'Generally you know, you get a feeling it is coming to an end' (Nurse 6). Things start to level out, there were fewer negatives, more positives and periods of stability got longer. Staff described having 'the luxury of time' and release being gradual and tested. Initially service users accessed a controlled area outside the locked-room under supervision, although technically they were still secluded. For staff, opening the inner locked door was a test of approachability allowing them to gauge the service user's response to stimuli:

> Maybe the door should stay open to see how he managed, if he remained okay, settled and talking, had his medication then he would be able to go back to ward. (Medic 3)

Staff were conflicted describing a climate of 'political correctness' and the organisation discouraged seclusion and wanted release to be as quick as possible, against their responsibility to maintain safety:

> Once the patient goes back on the ward, the team on have to deal with the consequences of your decision, if that is wrong you're not going to keep their and trust in you, there goes your credibility. (Nurse 4)

One nurse reflected 'it is difficult to get the service user back in if they are released too early'. 'This might 'involve a scuffle' (HCA 1), cause further distress or risk of injury to those involved.

Decisions were made jointly by two or more professionals who may hold differing professional perspectives. Nurses talked about being guided by gut feeling and intuition. Did the service user show understanding, where they communicating, had their behaviour peaked and anger resolved? AHPs felt somewhat detached from nurses and medics. Rather than influencing decisions, AHPs thought they offered independence and safeguards. They questioned their role:

> …sometimes you're only there to dot the i's and cross the t's. It's because you need to have an MDT review that you are there rather than because your opinion is valued. (AHP 3)

Similarly, Medic 2 stated when on-call '…decisions are made by ward team. I am there to monitor physical health and support nurses who are keen to tell you what they want'.

Getting two professionals or an MDT together out of hours might inadvertently prolong seclusion durations. One nurse reflected changes to practice meant the process had become 'onerous' and 'counterproductive':

> …the policy provides safeguards but years ago it was different. We once used a low stimulus room, after around 20 minutes went in. We de-escalated through the door. Got him to move back, put his weapon down. Now it would be more formal, get a doctor, start the paperwork. It would probably would have turned out different and lasted longer and affected our relationship with him. (Nurse 1)

Confidence taking decisions came with experience. Less experienced staff where more cautious, found it difficult to challenge senior staff and relied on colleagues:

> …inexperienced nurses who may lack confidence, trying to maintain safety of everybody, sometimes it is safer in their eyes to place person in seclusion and keep them there rather than risk injuries, but with more experience, skills and knowledge they learn to deal with people. (Nurse 3)

Nurse 9 stated, 'I would never want to bring them out without having discussion, see a good couple of hour's minimum settled presentation…'. Less experienced staffs' anxieties were raised, especially on a night and a weekend. Senior staff understood this as junior medics were told, 'make sure you do not make the decision on your own', (Medic 1).

Seniors had greater ability to move resources which could reduce time in seclusion. Plus one experienced nurse thought they would be more likely to take positive risks resulting in a quicker release, even breaking policy:

> I'll be very honest and say that if I want to bring somebody out then I'll do that and I'll let a medic know then that is what I have done. (Nurse 4)

**Can we cope?**

Staff wanted to be certain they would 'cope' post release. The number and skills of staff on shift was strongly connected to perceptions of coping or 'managing safety'. Whilst Nurse 6 stated 'I would be horrified if thought for any moment I made the decision to keep a person secluded longer than needs be on the back of external factors [staffing]'. Another felt 'staffing was often stated as the biggest issue':

> …we didn't have enough staff, so he wasn't released at that time. We needed to wait until next shift arrived. Plan was to bring out when more staff around, later that morning he came out. (HCA 2)

If there are not enough on shift, staff would attempt to bolster numbers '…what I don't want to do is to try and keep a patient in seclusion unnecessarily because we don't have staff', (Medic 1). Facilitating release might take:

> …may be six [staff] at least depending on activity so difficult to do on a night shift but we plan ahead. You have to manage, go with what you've got. You could ring other units, everyone is in the same boat, the on-call manager might offer suggestions but nothing you haven't thought of already, get on with it and release them when you think their ready. (Nurse 10)

HCAs thought despite it being qualified staff making the decision, the responsibility to cope was more likely to fall on them 'they say what's what and it's us HCAs who have to manage it' and 'we get the backlash':

In addition to enough staff, permanency and skills of the team were also relevant:

> This is a difficult ward to work on, some days you have got two bank staff, you have just got to get on but it's difficult for a nurse to trust judgement of somebody who has never worked here before… then you probably get somebody [Nurse] who has got five

> long term elderly geriatrics like me [HCAs], they know verbally we would handle it, they would be comfortable to let that individual out because they know we would be able to diffuse it… (HCA 1)

Furthermore, coping was influenced by environmental and clinical pressures. Staff aimed to manage service users in the safest and least restrictive environment but acknowledged if safety could not be met on an open unit, a transfer to a PICU might be arranged.

The acuity or 'emotional tone' of the ward was also factored in as staff were reluctant to return the service user to 'chaos', balancing the likelihood the service user could remain settled Other service users may have witnessed the preceding incident or there may have been an altercation which was important to resolve. Lastly, seclusion might represent a safe place for the service user, 'if you suddenly take it all away and put them back out on ward then they can be overwhelmed and end up back in quite quickly'. (AHP 1)

**Covering our back**

Finally, staff felt they needed to 'cover their backs'. They felt exposed, that their practice was under scrutiny when they initiated or managed a seclusion episode. Nurses feared 'getting it wrong', 'being judged incompetent' and having to 'protect yourself':

> If you make the decision [for the service user] to remain in there and someone says you shouldn't have you think to yourself 'Oh God' I am now in a whole barrel load of trouble. (Nurse 4)

Nurse 10 stated they felt criticised by management if procedures were not followed correctly and they would be 'taken down a formal capability route'. Whilst another thought It difficult to keep up with policy changes and 'feared not being up to date'.

Staff accepted seclusion had the potential to be misused, could be too lengthy and have a detrimental effect on service users, but perceived their responsibility to maintain safety negated concerns. They also considered the moral and ethical basis of using seclusion. Although all those interviewed disliked using seclusion, all felt there to be 'no other option' and were unable to come up with any acceptable alternative actions:

> It's not that it gets more comfortable, but I suppose if you can justify your decision… (Nurse 3)

As stated by Nurse 2: 'In the end all you can do is tell your staff to make sure the patient is all right, adhere to policy and get them out as soon as possible'.

## DISCUSSION

As in other literature, this study found professional staff working in mental health settings did not like secluding service users but continued to justify it asking what was the alternative? (Roberts et al. 2009, Duxbury 2015). Their involvement left them feeling their clinical practice was under scrutiny. Decisions to seclude are often nurse-led and reactive to actual or threatened violence (Riahi et al. 2016), whereas we found decisions to release are multi-disciplinary, discussed, considered and tested over a period of time. Gradual reintegration was a common theme discussed as integral to the process of release by all the professionals. Although it was difficult to define the actual point the service user was ready for release, nurses in this study stated the requirement to assemble and involve a larger MDT review team at times curtailed the autonomy of the nurse in charge to quickly manage and de-escalate situations. Thus potentially, service users might remain in seclusion even though aggression had subsided, which was seen as counter-productive as, if episodes of restraint are prolonged, service users become trapped in escalating spirals of frustration and protestation

(Gildberg et al. 2015). Although group or MDT decisions may be subject to tensions from differing personalities, perspectives and goals (Kontio et al. 2013), the inclusion of the wider MDT was supported as it provided a range of opinions and options. AHPs interviewed suggested they offered safeguards and were able to bring a range of holistic triggers and goals aligned to their differing professional focus. Whilst the psychologists discussed 'formulation' (a conceptual view of the service users' past and present), OTs set goals to engage and distract, whereas social workers considered triggers and the service users' wider social support. The less experienced AHPs felt disempowered and their opinions overlooked as seclusion reviews where led by senior medics or nursing staff whose primary focus was to assess the service users' physical status, ability to follow direction and the teams' capacity to manage the safety of the ward.

The clinical experience of the professional in charge, especially the nurse or medic, managing and reviewing the progress of the service user in seclusion appeared to have a major influence on when the decision to release might be made. Other research suggests lesser experienced nursing staff are more likely to use and support seclusion (Green et al. 2018). Likewise, this work found junior nurses and medics expressed anxieties and appeared more hesitant to take the decision to terminate episodes, being more likely wait for a medic or for MDT support rather than releasing the service user between reviews. It is unclear if this was lack of confidence or more related to enhanced communication and relationship skills, higher tolerance for risk or the use of bolder management ideas, as was found with experienced nurses delivering nursing care to secluded service users by (Nagayama and Hasegawa 2014). Furthermore, it may be that senior professionals also have greater authority to source extra staff or move service users to different wards if appropriate.

Professionals stated their access to resources was important as they considered factors beyond the service users' behavioural presentation. These included the physical layout and acuity of the ward plus did they have enough staff with the right skills to manage safety. Professionals were not always clear what would constitute 'enough' staff and, as suggested in other research, it is perhaps not only the number of staff but the skills and permanency of the team that has a positive or negative impact on containment decisions (Bowers 2007). In fact the effect individual staff differences (Laiho et al. 2014) or team cultures (De Benedictis et al. 2011) have on seclusion practices cannot be understated. However, the actual characteristics, qualities and skills of professionals supporting a quick and safe release from seclusion remain to be evidenced.

The Code of Practice (DOH 2015) states service users' views should be considered and they should be involved in decisions about their care, support and treatment. Yet this work found they were asked to comply and co-operate with the demands of professionals. Service users appeared to have little involvement or choice in decisions regarding their release. This suggests seclusion practices remain paternalistic (Goulet and Larue 2016) and, if patients do not feel their opinion is valued (Soininen et al. 2013), it will reinforce tensions regarding the management of restraint (Felton et al. 2018) and counter principles of shared decision-making central to the recovery movement (Slade 2017). Furthermore, as decisions to use seclusion are not therapeutic interventions, it seems professionals find the ideal of equality and service user involvement at this stage of their journey unrealistic. This suggests further work is not only necessary to understand the effect that team and staff characteristics may have on facilitating release, but also how service user views could be listened too and incorporated into decision making at this time.

### Limitations

The study was part of a PhD researching seclusion use in an NHS Trust. The work focused on adult inpatient mental health units with seclusion facilities in the service and recruited a small purposive sample of staff, thus transferability is limited. Furthermore, although the setting and professional groups represented are subject to pressures and policies similar to other parts of the UK, the views expressed are not necessarily representative of the wider mental health workforce. The lead author was known to many of the participants being employed in the same service and having worked as a nurse at the settings. Whilst it gave contextual and cultural insight, plus facilitated intimacy and flow within researcher-participant interactions (Bonner and Tolhurst 2002), insiders risk introducing personal biases, may overlook routine experiences, assume rather than clarify thoughts or actions and miss the bigger picture (Holian and Coghlan 2013). The co-authors had no connection to the participants thus offered an independent view and a counterbalance to the analysis of the data.

## CONCLUSION

This study outlines factors that influence mental health professionals' when deciding to release a service user from seclusion. Professionals and their organisations should be aware of factors that may delay release such as policy and procedure, the lack of experienced staff and the responsibility professionals feel to maintain safety in inpatient settings. Although agreement should be reached by two or members of the MDT, the views and involvement of all professionals was not evenly balanced as AHPs suggested their focus and influence differed to their nursing and medical colleagues. The work also found it is not only aggressive behaviour displayed by the service user but their willingness to co-operate; the effect of their release may have on the ward milieu and the availability of resources in the

service. Despite professionals reporting they negotiated with service users, there was little evidence of shared decision-making regarding issues around the use of seclusion and release.



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Table 1 Participating units

| Ward | Patient group |
|---|---|
| **1** | 14 bedded mixed sex adult mental health admission unit |
| **2** | 10 bedded mixed sex PICU (Psychiatric Intensive Care Unit) |
| **3** | 18 bedded male adult mental health treatment unit |
| **4** | 18 bedded female adult mental health treatment unit |

Table 2 Sample of interviewees

| Participant descriptor | Role | Gender | Years Experience working in MH |
|---|---|---|---|
| Medic 1<br>Medic 2<br>Medic 3 & 4 | Medical Staff<br>Consultant Psychiatrist (Senior Medic)<br>Core trainee<br>GP trainee | 2 Male<br>2 Female | 6 months to 25 years |
| Nurse 1<br>Nurse 2 to 5<br>Nurse 6 & 7<br>Nurse 8, 9 & 10 | Mental Health Nursing Staff<br>Modern Matron (Senior Nurse)<br>Charge Nurse (Senior Nurse)<br>Deputy Charge Nurses<br>Staff Nurses | 2 Male<br>8 Female | 7 months to 34 years<br>Mean = 11 years 5 months |
| AHP 1 & 2<br>AHP 3 & 4<br>AHP 5 | Allied Health Professionals<br>Psychology<br>Occupational Therapy<br>Social work | 5 Female | 4 years to16 years<br>Mean = 7 years 6 months |
| HCA 1 & 2 | Healthcare Assistants | 1 Male<br>1 Female | 6 years 6 months to 21 years<br>Mean = 13 years 9 months |

Figure 1: Review Schedule: Mental Health Code of Practice (DOH, 2015)

Seclusion should immediately end when a MDT review, a medical review or the independent MDT review determines it is no longer warranted. Alternatively where the professional in charge of the ward feels that seclusion is no longer warranted, seclusion may end following consultation with the patient's responsible clinician or duty doctor. (DOH 2015, p306)

• If not authorised by a psychiatrist, there must be a medical review within one hour or without delay if the individual is not known or there is a significant change from their usual presentation

• Seclusion area to be within constant sight and sound of staff member

• Documented report by person monitoring every 15 minutes

• Nursing reviews by two nurses every two hours throughout seclusion

• Continuing medical reviews every four hours until the first [internal] multi-disciplinary team

• First (internal) multi-disciplinary team as soon as is practicable

• Independent multi-disciplinary team after eight hours consecutive or 12 hours intermittent seclusion (within a 48 hour period)

• Following first (internal) multi-disciplinary team continuing medical

(DOH 2015, p302)

Figure 2: Study Interview Guide

| |
|---|
| Question: Can you tell me about your experience of working in mental health services? |
| *Prompts: Profession, length of service, work history* |
| Question: You were recently part of an MDT seclusion review team. Will you talk me through what happened? |
| *Prompts: How you became involved, your role in the review, your knowledge of service user / incident prior to review, what did team say to the service user, how did service user respond, what did staff do, what did the service user do, service user awareness, understanding, engagement* |
| Question: What things did the team consider import when making their decision? |
| *Prompts: Service user presentation, risk assessment, safety, other factors* |
| Question: Can you describe what happened during the release? |
| *Prompts: What expectations were set, what did the staff do, what did the service user do* |
| Question: What involvement did the service user have? |
| *Prompts: Service user awareness, understanding, engagement* |
| Question: What involvement did the service user's family or advocacy have? |
| *Prompts: Awareness of seclusion, involvement in decision* |
| Question: Do you have anything else you want to say about seclusion? |
| *Prompts: Was this episode typical/atypical, thoughts about seclusion in general* |