Archives of Psychiatric Nursing xxx (xxxx) xxx–xxx

Contents lists available at ScienceDirect

Archives of Psychiatric Nursing

journal homepage: www.elsevier.com/locate/apnu

# Implementing Seclusion in Forensic Mental Health Care: A Qualitative Study of Staff Decision Making

Rachel Green[a], Catriona Shelly[b], Jonathan Gibb[c], Tammi Walker[d,*]

[a] Greater Manchester Mental Health NHS Foundation Trust, Prestwich Hospital, Bury New Rd, Manchester, M25 3BL, United Kingdom
[b] Manchester Metropolitan University, Department of Psychology, 53 Bonsall Street, Manchester M15 6GX, United Kingdom
[c] University of Manchester, Division of Psychology and Mental Health, School of Medical Sciences, Oxford Road, Manchester M13 9PL, United Kingdom
[d] The University of Huddersfield, Human and Health Sciences, Queensgate, Huddersfield HD1 3DH, United Kingdom

ARTICLE INFO

*KEYWORDS:*
Seclusion
Decision-making
Nurses
Forensic

ABSTRACT

Forensic mental health nursing is a complex role and there is a tension between maintaining safety and promoting a therapeutic and patient centred approach. The use of restrictive practises such as seclusion is an issue. Two focus groups with registered nurses exploring attitudes and factors used in decision-making about seclusion use were analysed using interpretive description. Participants described the need to reduce the use of seclusion and the problematic nature of its utility as an ongoing intervention in contemporary mental healthcare. It was clear that there were complexities and competing variables involved in the decision-making process.

## INTRODUCTION

The management of aggression, violence and behavioural disturbance remains a challenging problem for mental health services. However, the need for hospital-based management of 'difficult-to-manage behaviours' in in-patient settings remains and part of this in-patient care requires the use of seclusion and restraint to ensure safety and enable recovery.

Seclusion and restraint has its origins in the inhumane treatment of individuals with psychiatric disorders in the 18th century and earlier. During this period, service users were locked up in unclean rooms with little daylight and/or held in restraints (Newton-Howes, 2013). Towards the end of the 18th century there were improvements for individuals confined to the asylums such as banning the use of manacles and chains.

More recently, the movement in mental health has been towards a more service user focused and community centred approach, which has led to a gradual reduction in hospital bed figures over the past three decades (Newton-Howes, 2013). As a result of this trend this has meant the number of acutely ill or highest-risk service users in in-patient settings remains high, as does the need to provide safe and appropriate care. In this context, seclusion continues to remain an important clinical device.

Defining the term seclusion depends on who is putting forward the definition i.e. policy makers, medical bodies or legal sectors. In 1990, the Royal College of Psychiatrists defined seclusion as:

'*the supervised confinement of a patient specifically placed alone in a locked room…for the protection of the patient, staff or others from serious harm*'

From a pragmatic perspective, seclusion can be defined as the voluntary or involuntary short-term isolation of a service user in either a specifically designed room, usually low-stimulating, bare or sparsely decorated (seclusion room), locked from the outside with a window for observation. The aim is to minimise the harm a service user can do to themselves and to others.

In spite of its wide use, seclusion continues to be seen as a controversial method (Kontio et al., 2010; Soininen et al., 2013; Soininen et al., 2013) and there is no agreement about its usefulness (Sailas & Wahlbeck, 2005). The use of seclusion represents an ethical dilemma for mental health nurses - the dual role of caring and of implementing coercive measures gives particular rise to complexity and therapeutic challenges for nurses (Gustafsson & Salzmann-Erikson, 2016) and there is an inherent conflict in balancing ethics and safety (Riahi, Thomson, & Duxbury, 2016). The legitimate use of control is a fundamental responsibility and is key to ethical practise and professional integrity (Cleary, Hunt, & Walter, 2010).

In the last few years a series of mental health documents such as 'Mental Health Crisis in Care: physical restraint in crisis' (Mind, 2013) have identified an urgent need for change with prevalence rates of physical restraint and seclusion noted as being of significant concern. In 2014, 'Positive and Proactive Care: reducing the need for restrictive

* Corresponding author.
*E-mail addresses:* rachel.green@gmmh.nhs.uk (R. Green), C.Shelly@mmu.ac.uk (C. Shelly), jonathan.gibb-2@student.manchester.ac.uk (J. Gibb), t.walker@hud.ac.uk (T. Walker).

https://doi.org/10.1016/j.apnu.2018.04.008
Received 8 December 2017; Received in revised form 27 March 2018; Accepted 18 April 2018

interventions' (DoH, 2014) was published and this document prescribed a framework for adult health and social care services to develop and promote cultures where restrictive interventions were to be used only as a last resort and for the shortest duration possible. The document defines restrictive interventions as:

> 'deliberate acts on the part of other person(s) that restrict and individual's, movement, liberty and/or freedom to act independently in order to reduce significantly the danger to the person or others' (p.14).

With regard to medium and low secure services there is a national focus to reduce the frequency of restrictive interventions over the next two years, which include a reduction in the use of seclusion (NHS England, 2016).

To understand the reasons behind the use of seclusion, studies have typically been undertaken into the characteristics of patients but there is an increasing awareness of the effect of staff factors and local organisational/ward cultures on the use of seclusion and on reduction strategies (Boumans, Egger, Bouts, & Hutschemaekers, 2015Larue, Piat, Racine, Ménard, & Goulet, 2010). Some research has noted the need to understand attitudes towards seclusion as an important factor in reducing the use of seclusion (Happell & Harrow, 2010; Mann-Poll, Smit, van Doeselaar, & Hutschemaekers, 2013; Okanli, Yilmaz, & Kavak, 2016). There is a suggestion that the attitudes of nurses are of particular interest as they are the professional group most likely to implement/make decisions about seclusion and so should be involved in strategies and efforts to reduce seclusion within organisations (Happell et al., 2012; Happell & Koehn, 2011; Kontio et al., 2010).

The aim of the present paper was to specifically explore the decision-making process behind qualified nurses' decisions to implement the use of seclusion in forensic mental health care.

## METHOD

This study explored the decision-making process behind nurses' decision to use seclusion. An inductive approach was chosen, i.e. interpretive description (Thorne, Kirkham, & O'Flynn-Magee, 2004), which was based on applied as well as theoretical nursing. The study was a qualitative investigation of a clinical phenomenon (decision-making behind seclusion) which captured themes and subjective perceptions. Therefore, interpretive description was a well-suited approach to inform clinical understanding.

### *SETTING, CHARACTERISTICS, AND SELECTION OF PARTICIPANTS*

Data collection was undertaken at a mental health service in the North of England in March 2017. For the purpose of this study, the research was conducted at the medium secure service site. Within secure services, many but not all of those admitted have been in contact with the criminal justice system and will have either been charged with or convicted of a violent criminal offence (NHS England, 2013).

Participant recruitment was purposive (Given, 2008). Purposive sampling is a form of non-probability sampling undertaken when strict levels of statistical reliability and validity are not required because of the exploratory nature of the research. The inclusion criteria were registered nurses who had implemented seclusion within the preceding 12 months and currently working on a medium secure ward. This information was gained by the first author who reviewed completed incident reporting forms which recorded seclusion as an intervention and noted the registered nurse involved in the decision-making process. Twenty-three participants were identified and invited to take part in the two focus groups being conducted. The first author sent individual e-mail invitations and a participant information sheet to each participant two weeks before data collection commenced. Participants had up until the day before data collection began to consider participating in the research. They responded with their reply via email to the first author.

**Table 1**
Participant characteristics.

| Demographic factors | *n* |
|---|---|
| Gender | |
| Male | 3 |
| Female | 9 |
| Job role | |
| Team leader | 9 |
| Ward managers | 2 |
| Staff nurse | 1 |
| Total | 12 |

A total of 12 participants agreed to take part in the research. Table 1 describes the demographic information for the participants in more detail.

### *DATA COLLECTION*

The two focus groups were conducted in a building separate from the medium secure ward areas. The first focus group consisted of four participants; the second focus group had eight participants. The focus groups were conducted over a period of one week in 2017; they were tape-recorded and transcribed verbatim by an administrator at the service. Focus groups lasted approximately 30 min each. The questions for the focus groups schedule consisted of nine questions which provided a semi-structure format for the focus groups. A semi-structured format grants the researcher leeway to pursue angles of the dialogue they deem important to the research (Leavy, 2014). The schedule guide can be found in Table 2.

### *DATA ANALYSIS*

Each transcript was analysed using thematic analysis (Braun & Clarke, 2006). Thematic analysis provides a flexible approach to data analysis that identifies, analyses and reports on patterns within data (Braun & Clarke, 2006). After reading and re-reading the transcripts to familiarise themselves with the data, the author coded and organised the data into themes. Throughout the analytic process, thematic maps were used to capture the relationships between codes, between themes and between different levels of themes (Braun & Clarke, 2006). As outlined by Braun and Clarke (2006), the analytic procedure was characterised by a process of 'defining and refining' themes. This ensured each theme captured the intended aspect of the data set.

### *RIGOR*

There has been a great deal of unresolved debate about rigor in qualitative research (Grbich, 1999). In assessing the quality of the data collected in this study several factors were considered. Credibility or confidence in the data was gained by the first author's prolonged engagement with the data (Lincoln & Guba, 1981). Consistency was

**Table 2**
Focus group schedule guide.

1. Why is seclusion necessary/What make seclusion a necessary intervention?
2. Can anyone describe a situation when you would typically use seclusion as an intervention?
3. What types of behaviours do patients display when you decide to seclude them?
4. Are there any specific behaviours that need to be present?
5. Do you try other interventions before using seclusion?
6. If so, which ones would you use first?
7. Apart from patients' behaviour, are there other factors that can influence your decision to use seclusion?
8. Have you ever felt unsure about your decision to seclude a patient?
9. Are there any support/resources you believe could help staff in using seclusion as a last resort?