Office of the Senior Practitioner

Positive Solutions in Practice:

From Seclusion to Solutions

Issue No. 2, 2007

Two years ago, four young men moved into a house together. None of them could communicate, and all were described as 'dangerous' by their previous carers. All had shown behaviours of concern, which had been managed through the use of restraint and seclusion. Staff in the new house noticed that the use of seclusion was leading to more, rather than less behaviours of concern, more aggression and physical assaults. The staff decided to change tack and started to use proactive strategies designed to defuse difficult situations; they turned the seclusion room into a sensory room that was filled with a tent that contained soft sensory objects. The young men were encouraged to go into the sensory room when they felt upset or angry. The sensory room and the use of supportive behaviour techniques lead to significantly fewer behaviours of concern. These positive changes have continued; and two years later, staff report that physical assaults to other young men in the house and staff, as well as property destruction, has decreased to a minimum. The young men have learned to recognise their own personal agitation and to take themselves to the sensory room until they felt calm and in control. (St. John of God Services, Victoria)

What is Seclusion?

According to the *Disability Act (2006)* seclusion is defined as locking a person in a room or any other location. This could include being solely confined and locked and in one's bedroom or in another area of their house or garden. It is important to understand the use of restraint and seclusion in light of both the Victorian Charter of Human Rights and Responsibilities (2007) and the UN Convention on the Rights of Persons with Disabilities (2007). Section 140 of the *Disability Act (2006)* provides guidance in the use of restraint and seclusion and suggests that seclusion can only be used: (1) to prevent people from hurting themselves or others; (2) if it is the least restrictive alternative available; and (3) only while the behaviour of concern is present. Dean and her colleagues[1] recommend that if seclusion is used, the person should be checked every 2-5 minutes and reminded that the door will be opened once he or she has calmed down. They believe that the use of frequent monitoring ensures the effect of isolation is physical rather than psychological. However, people with a disability are vulnerable and disadvantaged in many respects and positive solutions should always be the first option instead of subjecting them to restraint and seclusion.

The Experience of Seclusion

Seclusion is a form of social isolation known to be associated with morbidity and mortality. The harm caused by seclusion includes both physical harm, such as broken bones or soft tissue damage, as well as emotional harm.[2] Social isolation is thought to be one of the worst types of punishment.[3] Moreover, people who are socially isolated have been found to have: (1) difficulty coping with stressors, (2) increased blood pressure, (3) slower wound healing, and (4) poorer sleep patterns.[4]

1. Dean, A.J., Duke, S.G., George, M. & Scott, J. (2007). Behavioural management leads to reduction in aggression in a child and adolescent psychiatric inpatient unit. *Journal of American Academy of Child and Adolescent Psychiatry*, 46 (6), 711-720.
2. *Roadmap to Seclusion and Restraint Free Mental Health Services*. (2005). DHHS Pub. No. (SMA) 05-4055. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.
3. Finke, L. M. (2001). The use of seclusion is not evidence-based practice. *Journal of Child and Adolescent Psychiatric Nursing*, 14 (4), 186-190.
4. Cacioppo, J.T., Hawkley, L.C. (2003). Social Isolation and Health, with an Emphasis on Underlying Mechanisms. *Perspectives in Biology and Medicine*, 46, (3), 39-52.

Not surprisingly, people who have experienced seclusion tend feel negative about the experience and say that the worst aspects were the loneliness, lack of autonomy and violation of trust. The majority of people who undergo seclusion have already been traumatised and seclusion just adds to their trauma.[5]

"The only way to survive in there is to turn inward and that just made me more angry."

"I usually would end up hurting myself more because of what they had done, instead of less."

(*Roadmap to Seclusion and Restraint Free Mental Health Services*, p. 53)

Not surprisingly, in times of crisis most people say that what they need is the support of other people, not to be isolated from them.

Alternatives to seclusion

The majority of effective strategies that can be used to replace seclusion focus on providing therapeutic interventions rather than on punishment. According to the authors of *Roadmap to Seclusion and Restraint Free Mental Health Services*, what is needed are:

1. Therapeutic policies, such as having non-violent and person-centred policies in place.
2. Therapeutic environments, such as providing areas in the home for people to relax, be active, have fun; e.g., sensory rooms, chill-out rooms, comfort rooms as well as more active alternatives such as trampolines and spas etc.
3. Thorough assessment of the behaviours of concern and application of therapeutic interventions, such as teaching de-escalation techniques such as problem-solving strategies or *mindfulness techniques*[6] to reduce the potential for conflict.

Therapeutic Policies and Practice

Having clear policy and good practice guidelines is viewed by many as a useful first step in improving quality.[7] The American Association for Intellectual and Developmental Disabilities'[8] policy statement on *seclusion* is that such restrictive practices should not be used, and should be replaced with positive proactive approaches that lead to self-determination, independence, productivity, improved quality of life and life-long learning. Many mental health facilities throughout the world now use seclusion only in emergency situations and as the response of last choice. Many services in Australia have chosen to discard their seclusion room–the old seclusion room at the McCallum Day Services in Ballarat is now the tool shed and seclusion is no longer an option.

Therapeutic Environments: Sensory Approaches

The idea behind sensory environments is to provide different activities that stimulate different senses. Examples include fish in an aquarium or bubble columns (sight), musical tactile walls (sound), aromatherapy (smell), and vibrating mattresses (touch).[9] Research has shown that adolescents accepted aromatherapy for crisis management, as a result of which less p.r.n. medication was used in managing behaviours.[10]

The use of sensory rooms has been shown to have positive effects on behaviour. Champagne and Stromberg[11] found that people who used a sensory room in a psychiatric unit overwhelmingly report positive effects. Only 10% of people felt it had no effect, and only 1% felt it had a negative effect. Those, who reported high distress at the beginning of sessions showed the greatest improvement after they had used the room.

Singh and his colleagues[12] found that placing people with a severe to profound intellectual disability in a *Snoezelen* reduced self-injury. However, the Snoezelen room had little

5. Steinert, T., Bergbauer, G., Schmid, P., & Gebhardt, R.P. (2007). Seclusion and restraint in patients with schizophrenia: Clinical and biographical correlates. *The Journal of Nervous and Mental Disease*, 195 (6), 492-496.
6. Singh, N.N., Wahler, R.G., Adkins, A.D., Myers, R.E., Mindfulness Research Group. (2003). Soles of the feet: a mindfulness-based self-control intervention for aggression by an individual with mild mental retardation and mental illness. *Research in Developmental Disabilities*, 24, 158-169
7. Jones, E., Allen, D., Moore, K., Phillips, B. & Lowe, K. (2007). Restraint and self-injury in people with intellectual disaibiliites. *Journal of Intellectual Disabilities*, 11, 105-118.
8. American Association for Intellectual and Developmental Disabilities http://www.aaidd.org/Policies/aversive.shtml (accessed 17/08/07).
9. Technical Solutions Australia. www.tecsol.com.au.
10. Fowler, N. A. (2006). Aromatherapy, Used as an Integrative Tool for Crisis Management by Adolescents in a Residential Treatment Center *Journal of Child and Adolescent Psychiatric Nursing* 19 (2), 69–76.
11. Champagne, T., & Stromberg, N. (2004). Sensory approaches in inpatient psychiatric settings: Innovative alternatives to seclusion and restraint. *Psychosocial Nursing*, 42, (9), 34-45.
12. Singh, N.N., Lancioni, G.E., Winton, A.S. Molina, E.J. Sage, M., Brown, S., & Groeneweg, J. (2004). Effects of snoezelen room, Activities of Daily Lving Skills training, and vocational skills training on aggression and self-injury by adults with mental retardation and mental illness. *Research in Developmental Disabilities*, 25 (3), 285-293.

impact on reducing aggression. Martin, Gaffan and Williams[13] found that multi-sensory rooms only had a calming effect on some adults with severe to profound intellectual disability who had showed behaviours of concern. They showed that the effect of the sensory room was the same as interacting socially with another person. Martin et al. found that the sensory room did not have lasting effects; that is, once participants had left the sensory room, behaviours of concern reappeared. Chan, Chien and To[14] also found that multi-sensory therapy had an immediate effect on emotions, but no effect on discharge rate, challenging behaviour or medication use. In addition, they found that some people became bored after a few sessions. **In order to reduce behaviours of concern additional therapeutic strategies are needed**.

Therapeutic Strategies to Reduce the Potential for Conflict and Aggression

Sullivan and colleagues[15] suggest a three-step procedure to replace restraint and seclusion: (1) a thorough assessment of the history and factors leading to aggressive outbursts; (2) a client-clinician agreed-upon definition of how clients express anger and aggression; and (3) options for interventions chosen by clients that could be used when feeling angry or frustrated (e.g., physical options such as walking, deep breathing; cognitive options such as reading; environmental options, such as decreasing stimulation, and spiritual options, such as meditation). The results of Sullivan et al.'s study showed that the majority of clients chose either to talk to staff, go for a walk with staff, call a specific person on the phone, or use the quiet room. They found that these methods led to a dramatic decrease in self-injury and aggressive behaviours and, more importantly, in the use of restraint and seclusion. The findings suggest that appropriate options to defuse explosive situations should be chosen in collaboration with the clients or others who know them well. While a Stress thermometer (see over) may work for one person, playing music may work better for someone else.

Greene, Ablon and Martin[16] found that *Collaborative Problem Solving* was useful in reducing seclusion. They believe that aggressive behaviour is a by-product of poor cognitive flexibility, tolerance and problem solving skills. The goal of their program is to train staff to assess thinking difficulties that may contribute to behaviours of concern, and to teach collaborative problem solving (CPS) skills. They found that CPS helps in two ways by helping: (1) staff identify the factors or triggers that lead to aggressive or unsafe behaviour, and (2) people with a disability to use collaborative problem solving techniques.

Having proactive policies, good practice guidelines and individualised approaches to supporting people who show behaviours of concern are clearly effective in reducing seclusion. *Behaviour support plans* based on good functional analyses of behaviours of concern and positive behaviour support techniques have been shown to reduce the use of restraint and seclusion in the long term.[17] In determining whether seclusion should be used at all, it is important to make sure that:

- it is in accordance with the Act
- the use of seclusion does not compromise the person's rights as described in Victorian Charter of Human Rights and Responsibilities and the UN Convention on the Rights of Persons with Disabilities;
- the use of seclusion does not perpetuate trauma; and
- an effective and more positive way to support the person with a disability is used first, (e.g., a place to calm down).

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13. Martin, N.T., Gaffan, E.A., & Williams, T. (1998). Behavioural effects of long-term multi-sensory stimulation. *British Journal of Clinical Psychology*, 37, 69-82.
14. Chan, S.W.C., Chien, V.T. & To, M.Y.F. (2007). An evaluation of the clinical effectiveness of a multisensory therapy on individuals with learning disability. *Hong Kong Medical Journa*l, 13, 28-31.
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16. Green, R.W., Ablon, J.S., & Martin, A. (2006). Use of collaborative problem solving to reduce seclusion and restraint in child and adolescent inpatient units. *Psychiatric Services*, 57, (5). 610-612.
17. Miller, J.A., Hunt, D.P. & Georges, M.A. (2006). Reduction of physical restraints in residential treatment facilities. *Journal of Disability Policy Studies*, 16 (4), 202-208.

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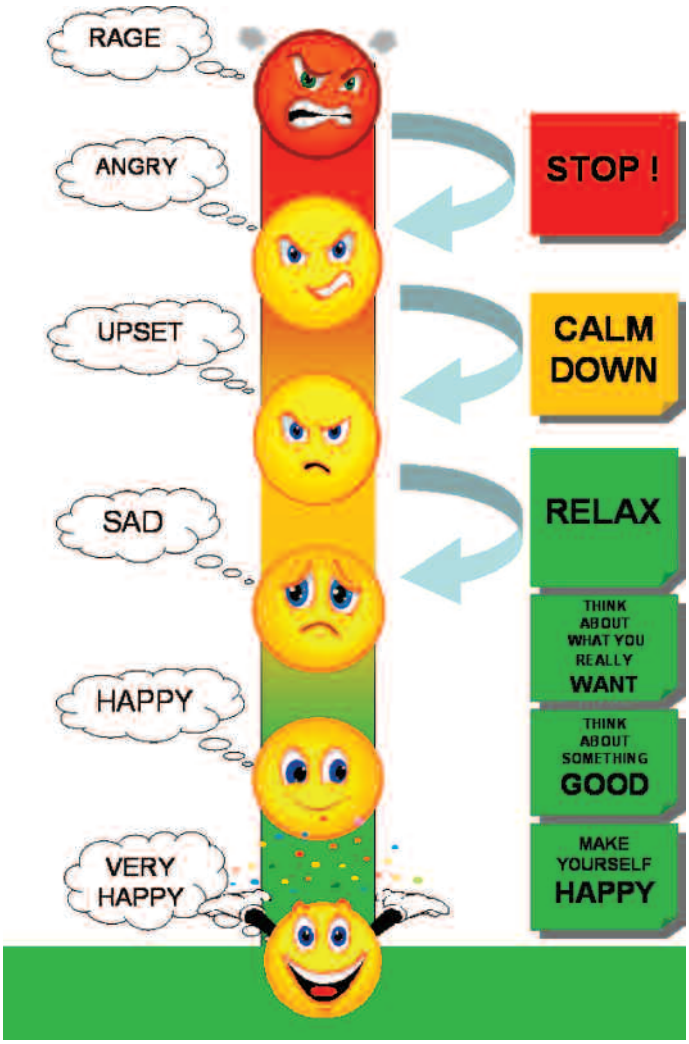
Stress Thermometer



‹BOB›'s Stress Thermometer

SIGNS		*What ‹BOB› can do*	*What We can do*
LEVEL 3			
▪ Punching / hitting others ▪ Punching / hitting himself ▪ …	**Angry** 10 9 8	▪ Go to my room ▪ Go outside ▪ …	▪ …
LEVEL 2			
▪ Shouting ▪ Yelling - No ▪ Talking loudly - repeating himself ▪ Swearing ▪ Lots of banging and sharp actions ▪ Throwing objects ▪ Slamming doors ▪ …	**Frustrated** 7 6 5 4	▪ Sit on the chair ▪ Deep breathing ▪ Ask for a break ▪ Look through happy book ▪ Drink water ▪ Ask for my hat ▪ Fold my arms	▪ Prompt him to ask for a break ▪ *Tell him to relax*[i] (pair with sign) ▪ *Demonstrate* deep breathing ▪ *Count to 10* with ‹BOB›[ii] ▪ *Give time* to calm down ▪ *Re-direct* back to the activity ▪ Tell him *what to do* with the material ▪ Say "hands down" ▪ *Tell him* what you what him to do ▪ Physically *prompt* the expected response ▪ …
LEVEL 1			
▪ Running ▪ Frequently reprimanding himself ▪ … ▪ …	**Worried** 3 2 1	▪ Complete the activity ▪ Ask for a break ▪ Ask for help	▪ Redirect him back to the task ▪ "Provide assistance - prompt him through the activity" ▪ Refer to the thermometer ▪ Talk about what is making him upset ▪ Ask him if he needs a break
LEVEL 0			
▪ Sitting nicely ▪ Working well / concentrating ▪ Talking in a calm quiet voice ▪ Listening to other people ▪ Following instructions ▪ Singing	**Happy**	▪ … ▪ …	▪ Positive reinforcement ▪ Refer to the thermometer ▪ Token System

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"Supporting people to achieve dignity without restraints"

State Government Victoria
Department of Human Services