

GUIDANCE LEAFLET

Seclusion in general psychiatry

Placement of a patient in a critical phase of his/her therapeutic management into a room, from which he/she cannot exit freely and which is separated from other patients, in order to protect him/her. Any seclusion must only take place in a dedicated and suitable location.

Seclusion is a time-limited measure, which is implemented at the decision of a psychiatrist, in accordance with the law on the modernisation of the French healthcare system of 26 January 2016, as part of a therapeutic approach, after a multidisciplinary consultation, which imposed the prescription for intensive monitoring and support. The use of seclusion is a complex process, which is justified by the clinical situation and used as a last resort. The process itself includes numerous elements, decision, patient support, provision of care, monitoring, etc., which are implemented by various healthcare professionals from a care team in accordance with their fields of competence and responsibility.

KEY POINTS

- Seclusion is indicated as a last resort, for a limited period and solely in a manner that is appropriate, necessary and commensurate with the risk, after assessment of the patient.
- Only patients who are subjected to involuntary psychiatric care may be secluded.
- Seclusion is implemented at the decision of a psychiatrist, either from the outset or as a secondary measure.
- An interview and medical examination are performed at the time the seclusion is initiated.
- A specific prescription form for the follow-up of the decision should be present in the patient record.
- At the initiation of the measure, the indication is limited to 12 hours. If the state of health makes it necessary, the decision and prescription form must be renewed within these 12 hours. In the event of prolongation, the decision and prescription form must be renewed every 24 hours. Seclusion beyond 48 hours should only occur in exceptional cases.
- The patient receives a minimum of two medical visits every 24 hours.
- It is essential that, at the time the seclusion measure is implemented, the patient is given a clear explanation of the reasons for the seclusion and the criteria that will enable it to be terminated.
- A seclusion measure must be implemented in conditions of adequate safety for the patient and the healthcare team.
- The seclusion measure takes place within a designated room, dedicated for that purpose, so as to provide a caring and secure environment, particularly in architectural terms.

KEY POINTS (CONTINUED)

- The seclusion should be terminated, by medical decision, as soon as its continuation is no longer clinically justified.
- After the patient has left seclusion, he/she is offered the opportunity to review the episode with team members.
- This results in a clinical analysis outlined in the patient record.
- After the end of a seclusion measure, the multidisciplinary team must take time to review it.
- Each seclusion measure must be recorded in a logbook, with the patient's anonymity maintained. This logbook provides the name of the psychiatrist who decided on the measure, the date and time thereof, its duration and the names of the healthcare professionals monitoring the patient.
- It is desirable to create calming rooms within the care units, namely places where the door is kept unlocked, which are designed to provide a low-stimulation room in order to enable a decrease in a patient's stress levels.

INDICATIONS

- Prevention of imminent violence by the patient or as a response to immediate, uncontrollable violence, with underlying mental disorders, with a serious risk to the safety of the patient or others.
- Only when less restrictive alternative measures have been ineffective or inappropriate, and where behavioural disorders lead to a substantial and imminent danger to the patient or others.
- As a last resort, for a limited period and solely in a manner that is appropriate, necessary and commensurate with the risk, after assessment of the patient.
- The measure is completely justified clinically.

CONTRAINDICATIONS

- Never in order to punish, inflict suffering or humiliation or establish dominance.
- On no account to resolve an administrative, institutional or organisational problem, or in response to the shortage of interveners or healthcare professionals.
- The clinical condition does not require seclusion.
- A risk-benefit assessment should be performed when there are risks associated with the patient's physical condition, an organic condition for which the diagnosis or prognosis may be serious.

PERSONS HELD IN CUSTODY

These situations are regulated by article L. 3214-1 of the Code of Public Health, which provides for these persons to be sent to a specially equipped hospital unit (UHSA, unité hospitalière spécialement aménagée).

However, in practice, some prisoners are hospitalised in general psychiatry departments.

Regardless of the place of hospitalisation, resorting to seclusion is a medical necessity (see the methodological guide to the health management of persons held in custody, published by the Ministry of Justice and Ministry of Social Affairs and Health, which specifies the conditions in its latest version - October 2012).

METHODS OF IMPLEMENTATION

- Only patients who are subject to involuntary psychiatric care may be placed in seclusion.
- Seclusion is implemented at the decision of a psychiatrist, either from the outset or as a secondary measure. In the latter case, the decision, which may be taken by the care team, must be confirmed within the hour following the start of the seclusion, after a medical examination to determine whether the seclusion is justified and whether it should be continued or terminated.
- An interview and medical examination are performed at the time the seclusion is initiated, in order to:
 - assess the patient's mental, emotional and physical status, with particular attention being paid to the cardiac and respiratory status;
 - explain to the patient the reasons for the seclusion and the criteria that will enable it to be terminated;
 - explain the monitoring that will be performed;
 - discuss, with the care team involved in implementing the measure, the factors that triggered the episode, the less restrictive measures used, the clinical reasons for the seclusion and the clinical course of the patient in seclusion;
 - identify and implement the care that will hasten the seclusion being terminated.
- The doctor should preferably be the psychiatrist treating the patient in the care unit. If the decision is taken by a resident or by a doctor who is not a psychiatrist, and during on-call periods, this decision must be confirmed by a psychiatrist within the following hour. This confirmation may be made by telephone on the basis of the information exchanged. This confirmation must be documented in the patient record.
- A specific prescription form for the follow-up of the decision must be present in the patient record and should include:
 - the patient ID;
 - the start and end date and time of the seclusion;
 - the name of the unit, the conditions of hospitalisation;
 - the reason for the seclusion, the risks of imminent or immediate uncontrollable violence towards others or towards themselves, clearly outlined;
 - details of what was unsuccessfully implemented beforehand, in order to document that the measure is being taken as a last resort;
 - investigation of contraindications to seclusion;
 - the methods by which pharmacological treatment is administered, favouring oral route whenever possible, in an emergency, by completing the treatment form;
 - the methods used for monitoring, adjusted to the assessment of physical and psychological risks;
 - the instructions allowing the patient to eat, drink, go to the toilet or wash, clearly outlined.
- The patient should be ensured access to food, hydration and hygiene.
- At the initiation of the measure, the indication is limited to 12 hours. If the state of health makes it necessary, the decision and prescription form must be renewed within these 12 hours. In the event of extension, the decision and prescription form must be renewed every 24 hours in consultation with the care team. The care team shall reassess the clinical status and may ask the psychiatrist to terminate the measure at any time. The measure should not be continued for longer than necessary. Seclusion beyond 48 hours should only occur in exceptional cases.
- The patient receives a minimum of two medical visits every 24 hours.
- In no case should seclusion become a routine procedure for a patient with at-risk behaviour. Every time a patient displays such behaviour, the authorised professionals must examine the underlying causes of this behaviour.
- Planned seclusion measures are to be forbidden. The measure "as needed" may never apply.
- Exceptionally, and solely in emergencies, seclusion may be possible for reasons relating to the safety of a patient in voluntary care. The duration of this seclusion must be as short as possible, appropriate and proportional to the risk, and cannot exceed 12 hours, this being the maximum time required to resolve the emergency situation or the initiate a change in the care regimen.

MONITORING

- Each examination or monitoring must be recorded in the patient record, where a sheet may be identified listing the name of the carer, the date and time as well as the examinations or monitoring performed. In particular, this concerns:
 - observations and care performed during monitoring;
 - medical examinations performed;
 - food and drink consumed;
 - personal care (hygiene, elimination);
 - treatments administered;
 - visits by the care team and a statement of clinical status.
- The patient received at least two medical visits every 24 hours in order to:
 - assess the patient's physical and mental condition and behaviour;
 - assess the need to continue the measure;
 - assess the effects of the pharmacological treatments;
 - reassess the frequency and nature of the monitoring to be performed.
- The care team may request the medical assessments to be performed more frequently if a change has been observed that would permit seclusion to be terminated or if there is a deterioration in the patient's physical or mental condition.
- The frequency with which the physical and mental condition will be monitored by the care team shall be defined by the doctor and shall be based on the therapeutic requirements and risk(s) presented by the patient. It therefore reflects the clinical judgement of the doctor.
- Monitoring of the mental condition by the care team shall be performed at least every hour and may even be continuous.
- The monitoring of physiological parameters (blood pressure, heart rate, oxygen saturation, etc.) shall be performed by the care team according to the medical prescription.
- Withdrawal syndromes are taken into account by offering substitution treatments, particularly for tobacco.
- This regular monitoring of the patient should enable contact to be re-established, the alliance to be worked on, and risks of physical complications to be prevented. It is performed by at least two members of the care team:
 - with particular attention being paid to the patient's mental condition and to any potential signs of exacerbation of the physical condition;
 - with particular attention being paid to signs of cardiac or respiratory failure;
 - taking into account hydration, nutritional status, hygiene and toilet needs.
- Any incident must be documented in the patient record.
- Particular attention is given to patients with the highest physical or mental risks, particularly:
 - extremely agitated patients;
 - patients intoxicated with alcohol or psychostimulants;
 - patients with a history of cardiac or respiratory disorders, morbid obesity, neurological and/or metabolic disorders;
 - elderly patients;
 - women during pregnancy and in the postnatal period;
 - patients who have been abused in the past.

PATIENT INFORMATION

- It is essential that, when the seclusion measure is implemented, the patient is given a clear explanation of the reasons for the seclusion and the criteria that will enable it to be terminated.
- The explanation must be presented in terms that the patient can understand and must be repeated, if necessary, to facilitate understanding.

INFORMATION GIVEN TO THE PATIENT (CONTINUED)

- It is necessary to explain to the patient what will happen during the seclusion period (monitoring, medical examinations, treatment, washing, meals, drinks).
- In the pursuit of a therapeutic alliance with the patient, except in accordance with legislative provisions (adults under guardianship, minors) and in compliance with the code of ethics, the patient is asked whether they wish to notify their nominated representative or relative. In this case, the most appropriate means for delivering this information must be sought.

PATIENT AND CARER SAFETY - CONDITIONS OF SECLUSION

- A seclusion measure must be implemented in conditions of adequate safety for the patient and the healthcare team.
- Departments should possess care teams tailored to daily needs with respect to psychiatric care and safety.
- A sufficient number of carers must be present to ensure that the crisis situation is managed in a safe and effective manner.
- In highly tense situations, the team must be able to identify the moment when the patient is still accessible and available for dialogue and the moment when this is no longer the case. This is the time when the team must act, while maintaining verbal communication.
- Part of the team is dedicated to the crisis situation, another part of the team cares for and reassures the other patients. A healthcare professional must provide leadership and coordinate the management of interventions.
- It is necessary to delineate, as quickly as possible, a care room that is separated from other patients and to position the carers within the room near an exit.
- If the unit doctor or on-call doctor is not present, he/she must be informed of the situation and asked to intervene as quickly as possible. If it is a doctor who knows the patient, he/she must be informed of the factors that have been identified as potentially being able to explain the crisis situation (frustration, ingestion of toxins, hallucinatory exacerbation, etc.). If an on-call doctor is involved, briefly explain the patient, the existence of contact persons, potential alliance factors, etc.
- At the same time, reinforcements are requested for a support intervention. A healthcare professional from the unit concerned meets and informs the reinforcement team. The intervention by reinforcements must be subject to a written procedure, which specifies the role of reinforcements in a team strategy and can provide for scaled responses.
- The teams must be educated and trained in the prevention and management of violence and in defusing techniques.
- The care team must be trained in first aid, and the doctors should be trained in the use of resuscitation equipment.
- The seclusion measure must respect the rights of patients to dignity and respect of their physical integrity.
- Depending on the hospital, a patient in seclusion should be able to keep his/her clothing and certain personal items of significance, or should be in pyjamas for his/her safety.
- Depending on the patient's clinical condition, brief exits from the seclusion room may be offered, in the presence of carers.
- The patient's entrance into and exit from seclusion are reported in real time to the fire safety services of the establishment.
- The start and finish of every seclusion measure is brought to the attention of the on-call hospital practitioner, the resident and the on-call supervisor.

THE SECLUSION ROOM

- The seclusion measure takes place within a designated room, dedicated for that purpose, so as to provide a caring and secure environment, particularly in architectural terms.
- The absence of all dangerous objects within the seclusion room as well as on the patient should be verified. In the event of a dangerous object being present, appropriate measures shall be taken.
- The patient's privacy and dignity should be respected and he/she should be enabled to rest and calm down.
- It is necessary to ensure that the patient's room is available at all times.
- The seclusion room shall be sufficiently large to accommodate the patient and a sufficient number of carers.
- The seclusion room shall have access to toilets and a shower.
- The seclusion room shall be serviced and clean.
- The seclusion room shall be equipped with high-quality fixtures that do not represent a danger to the patients, particularly furniture (bed, seat, etc.) that is comfortable, but secured and robust and not capable of becoming a dangerous object.
- The seclusion room shall be equipped with means for temporal orientation: time, date, news or information, etc.
- It shall enable the team to observe and communicate easily with the patient.
- It shall be situated near to the nurses' office in order to allow for close monitoring and it shall have two entrances.
- It shall be equipped with a call device that can always be accessed by the patient.
- It shall be well insulated and ventilated with a temperature control outside the room.
- It shall be equipped with a lighting device that can be controlled from outside to enable monitoring, but also including lighting that can be controlled by the patient.
- The management of the patient requires physical monitoring and a relational interaction, which cannot be replaced by a video surveillance system.

TERMINATION OF THE SECLUSION MEASURE

- The seclusion should be terminated, by medical decision, as soon as its continuation is no longer clinically justified.
- The care team can ask the doctor to terminate the measure at any time.
- The seclusion cannot be continued for organisational or institutional reasons, or as a response to the shortage of health professionals.
- The reason, time and date the seclusion is terminated must be documented in the patient record.

ANALYSIS WITH THE PATIENT AT THE TIME THE SECLUSION MEASURE IS TERMINATED

- After the patient has left seclusion, he/she is offered the opportunity to review the episode with team members. This results in a clinical analysis outlined in the patient record.
- This analysis should enable:
 - to mobilise the ability for self-control and identifying, together with the patient, possible alternative interventions in subsequent episodes and the factors that can be quickly identified to reduce the risk of a new incident;
 - listening to and recording the patient's perceptions of the seclusion episode and their relationship with the care team;
 - ensuring that the patient's rights and physical and mental integrity were taken into account throughout the duration of the measure.
- As soon as possible when the seclusion measure is terminated, and if the patient is accessible, it is important to help them understand the recent events that they experienced during one or more interviews that have several objectives:
 - to support and manage the patient after the episode;

ANALYSIS WITH THE PATIENT AT THE TIME THE SECLUSION MEASURE IS TERMINATED (CONTINUED)

- to provide the patient with emotional support and to validate their feelings about the event: helping them talk about their distress and experience before, during and after the crisis;
- to reinforce the relationship with the patient;
- to inform the patient about the event;
- together with the patient, to understand the event better so as to prevent its recurrence;
- to help the patient understand, if possible, the internal factors that led to this crisis, as well as their symptoms;
- to identify the contextual factors that could have contributed to the crisis;
- to initiate or continue therapeutic education concerning the recognition of warning signs and the identification of calming factors and resource persons;
- to identify what went wrong, what information was missing, what could have been done differently and what should be done in future to avoid resorting to seclusion;
- to discuss with the patients the possible alternative strategies in order to prevent the recurrence of the event and to use the results of this discussion to develop the care plan and the shared prevention plan.

REVIEW PERIOD BY THE MULTIDISCIPLINARY TEAM

After the end of a seclusion measure, a review period by the multidisciplinary team must take place, consisting of:

- performing initial preliminary analysis with various points of view;
- defining the clinical dimension;
- recontextualising the patient's behaviour;
- performing an analysis of all the factors; making a distinction between what pertains to the team, to the institution and to the patient;
- identifying what could have been prevented and/or what enabled a resolution without violence;
- letting carers express their difficulties in the face of this practice, which is sometimes experienced with guilt; also allowing expression of fear or of the difficulty of taking care of a patient, who is or was behaving violently;
- reviewing what led to the seclusion measure; the information on the seclusion measure as well as its termination must be given to the entire team with full transparency, particularly to the members present on the day of the event;
- allowing the expression of difficulties encountered in the face of contradictory requirements and ethical dissonance;
- reflecting on the alternatives to seclusion: reworking on prevention as a team, improving the relational capacity through the availability, reinforcement and qualification of the care team,

DATA COLLECTION AND ORGANISATION POLICY

- An administrative logbook should be kept at each licensed psychiatric facility designated by the director general of the regional health authority to provide psychiatric care without consent, pursuant to Article 72 of Law 2016-41 of 26 January 2016.
- For each seclusion measure, this logbook, while maintaining the anonymity of the patient, provides the name of the psychiatrist who decided on the measure, the date and time thereof, its duration and the names of the healthcare professionals who monitored the patient.
- The logbook, which may be in digital form, must be presented on request to the departmental committee for psychiatric care (CDSP), to the Controller-General of Prisons or their delegates, and to Members of Parliament.

DATA COLLECTION AND THE POLICY OF THE ESTABLISHMENT (CONTINUED)

- From the data collection, the care units, departments, sectors and the HCO medical committee (CME, commission médicale d'établissement) review the evolution in the number of seclusion measures. The committee for hospital care, rehabilitation and medical technology (CSIRMT, commission des soins infirmiers, rééducation et médicotechnique) is involved in this work. The licensed psychiatric facility designated by the director general of the regional health authority to provide psychiatric care without consent should use this review as a basis to define a policy aimed at reducing the use of seclusion. This policy should be supported by the presence of multidisciplinary care in healthcare units, which is adapted to the needs of relationship-based care. This shall be based, particularly in the case of new graduates, on a training programme in clinical matters and psychopathology as well as on training in the prevention of violence and in de-escalation. The criteria for evaluating this policy should be defined (including in particular: number of carers trained in de-escalation, number of professional practice evaluations [PPE], specific protocols, etc.).
- Every year, the licensed psychiatric facility designated by the director general of the regional health authority to provide psychiatric care without consent establishes a report on seclusion practice, the policy defined to limit its use and the evaluation of its implementation. The HCO medical committee makes it a focus of its policy on the quality and safety of healthcare and a part of its medical plan. This report must be presented for an opinion to the supervisory board and to the user committee (CDU, commission des usagers).
- Any adverse event subsequent to the seclusion must be reported and be subject to team review, and possibly of feedback in serious cases (see Decree 2016-1606 of 25 November 2016 concerning the notification of serious adverse events associated with healthcare and regional facilities to support quality of care and patient safety).

THE CALMING-DOWN ROOM DURING DE-ESCALATION

- It is desirable to create calming rooms within the care units.
- The calming room is a place where the door is kept unlocked and which is designed to provide a low-stimulation room in order to enable a decrease in a patient's stress levels.
- It is used voluntarily, most often at the request of the patient or at the suggestion of the care team, in accordance with a defined framework for its use.
- The patient may elect to leave the calming room at any time.
- It may contain mattresses, equipment to listen to music, comfortable armchairs, books, soft lighting, etc.
- With the patient's consent, his/her room, which he/she may leave at any time, may also be used for support by caregivers for the purpose of de-escalation.