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Contents

Tailoring seclusion policies to the patient group

We welcome the review by Gaskin *et al*[1] of interventions to reduce use of seclusion. Although studies reviewed were conducted in adult and child settings, the authors did not differentiate the developmental needs between these patient populations.

The determinants of emotional distress and aggression may differ between children and adults. In adult psychiatric units, aggression is frequently associated with psychosis. Seclusion may reduce staff injury but increases patient distress.[2] In contrast, aggression is typically the most common reason for referral to child psychiatric units. Underlying diagnoses include disruptive behavioural and developmental disorders, and are complicated by high rates of abuse and neglect.[3] Admission goals may include learning prosocial behaviour, necessitating use of behavioural management. Community-based studies indicate that parent management training, using contingency reinforcement and consequences such as 'closed time-out', are effective in reducing aggressive behaviours.[4] Seclusion may function similarly to time-out, in that it can take the child away from a situation reinforcing negative behaviour and it encourages the child to self-regulate.

We agree with Gaskin *et al* that more evidence is needed to guide use of such interventions. We draw readers' attention to a recent study reporting reductions in aggression in a child and adolescent in-patient unit, following the introduction of a behavioural management programme.[3] The intervention incorporated staff training, contingency management and promoted use of less restrictive interventions. In keeping with current practice parameters,[5] if a restrictive intervention was required the preferred intervention was a form of seclusion. This intervention led to a significant reduction in aggressive incidents and injuries to staff and patients. Although the number of episodes of locked interventions did not decrease, there was a significant reduction in the duration of time patients spent in seclusion and a reduction in physical restraint. These outcomes were achieved without reducing admission numbers, changing the types of admissions, increasing staff costs, or increasing utilisation of medication as needed.

We concur with Gaskin *et al* that seclusion may exert counter-therapeutic effects, and that effective alternatives should be identified.[1] However, we remain open to the possibility that predictable, time-limited locked interventions may have therapeutic effects when used within a broader behavioural management programme in young patient populations. In addition, the ultimate goal of interventions in this area should emphasise reducing the demand for seclusion, rather than just the use of seclusion *per se*. We need to acknowledge that some aspects of the in-patient environment can contribute to patient distress and seek to optimise the therapeutic effects of the in-patient milieu. Protocols for use of seclusion and for reduction in demand for seclusion need to be incorporated into the developmental needs of the specific patient group.

1 Gaskin CJ, Elsom SJ, Happell B. Interventions for reducing the use of seclusion in psychiatric facilities: review of the literature. *Br J Psychiatry* 2007; **191**: 298–303.

2 Steinert T, Bergbauer G, Schmid P, Gebhardt RP. Seclusion and restraint in patients with schizophrenia: clinical and biographical correlates. *J Nerv Ment Dis* 2007; **195**: 492–6.

3 Dean AJ, Duke SG, George M, Scott J. Behavioral management leads to reduction in aggression in a child and adolescent psychiatric inpatient unit. *J Am Acad Child Adolesc Psychiatry* 2007; **46**: 711–20.

4 Sanders M. Triple P-Positive Parenting Program: towards an empirically validated multilevel parenting and family support strategy for the prevention of behavior and emotional problems in children. *Clin Child Fam Psychol Rev* 1999; **2**: 71–90.

5 Masters KJ, Bellonci C, Bernet W, Arnold V, Beitchman J, Benson RS, Bukstein O, Kinlan J, McClellan J, Rue D, Shaw JA, Stock S; on behalf of the American Academy of Child and Adolescent Psychiatry. Practice parameter for the prevention and management of aggressive behavior in child and adolescent psychiatric institutions, with special reference to seclusion and restraint. *J Am Acad Child Adolesc Psychiatry* 2002; **41**: S4–25.

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Authors' reply: Reducing seclusion in psychiatric facilities often involves the coordination of a range of interventions to meet the needs of such organisations and their staff.[1] In their response to our review, Scott & Dean have helpfully highlighted the need to tailor interventions to suit specific facilities through reminding readers of the differing determinants of emotional distress and aggression that are present for children and adults. These differences influence the reasons why children and adults are secluded.

In combining the literature on seclusion reduction initiatives at child, adolescent and adult psychiatric facilities, we do not contend that seclusion practices across these facilities, or the reasons for seclusion, are the same. We did, however, find no meaningful differences in the employment of seclusion reduction interventions between child, adolescent and adult facilities. Many of the interventions we found (e.g. monitoring seclusion episodes, staff education, changing the therapeutic environment) were used equally as often in child psychiatric units as they were in adult facilities.

Although the broad interventions for seclusion reduction appear similar between child and adult psychiatric facilities, the content of each type of intervention is likely to differ between facilities that serve specific populations. For example, staff education conducted at a child psychiatric unit to reduce seclusion may well be different to that provided at an adult psychiatric unit.

Our paper has provided the bare bones of a range of interventions that have been successfully used to reduce seclusion in psychiatric facilities. We welcome further comment, such as that from Scott & Dean, and the publication of seclusion reduction initiatives to help describe the ways in which these interventions can be applied in various types of facilities.

1 Gaskin CJ, Elsom SJ, Happell B. Interventions for reducing the use of seclusion in psychiatric facilities: review of the literature. Br J Psychiatry 2007; 191: 298–303.

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