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Who experiences seclusion? An examination of demographics and duration in a public acute inpatient mental health service

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ABSTRACT
Restrictive interventions such as seclusion may occur during an acute mental health crisis. Such interventions are experienced by people as traumatic and counter to recovery. The current study aimed to investigate the use of seclusion and who was secluded amongst patients presenting with psychotic symptomology. All acute inpatient admissions were examined across a 12-month period January–December 2013. Electronic and paper records were accessed and audited for all 655 admissions. There were 91 admissions that included a seclusion and 200 seclusion events. There were 79 unique patients who experienced seclusion. For those experiencing seclusion: two-thirds were male, 49% were either homeless or had no fixed abode, 32% received case management in the community prior to their inpatient stay, and 56% were unemployed or not in the workforce. The median and mode duration of seclusion was 4 h. By understanding seclusion interventions better, changes can be made to enhance practice. This descriptive research into seclusion has clarified the demographics of who is most likely to experience seclusion, for how long, and the implications for reducing restrictive interventions. How the social work role could contribute to reforms to protect and enhance the rights and well-being of marginalized members of our communities, at their most vulnerable, is considered.

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Introduction

This study will focus on what is already known in Australia and worldwide about restrictive practice and how to reduce it and clarify foundation research in the area of seclusion.

Within the field of mental health, there have been significant pushes to improve observance of human rights for those in care (Mayers, Keet, Winkler, Flisher, 2014). Research suggests that respect for the rights of patients and progress in their recovery journey are intrinsically linked (Ross, Campbell, &

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Dyer, 2014). There are human rights issues that need to be addressed within mental health wards, and a key area to focus on is the use of restrictive practices (Mayers et al., 2014). Restrictive practices are actions staff take to limit physical movements of patients who appear to pose a threat to themselves or others (Mayers et al., 2014). This may be in the form of chemical restraint, physical restraint, and/or seclusion.

According to the Mental Health Act (2014), in Victoria, Australia, restrictive intervention is "seclusion or bodily restraint" and seclusion is defined as "the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave" (p. 12). Mechanical restraint is perceived as a serious restrictive practice, and seclusion sometimes seen as a softer option; however, consumers who have experienced both have reported significant traumatization from both (Mayers et al., 2014). Although there are some examples in the literature which states positive outcomes for those who have experienced restrictive interventions, such as seclusion, much of the literature has noted adverse reactions and experiences (Mayers et al., 2014; Ross et al., 2014).

Although there have been reductions in restrictive interventions in the last 5 years, evidence suggests that seclusion and other restrictive practices continue to play a role in the re-traumatization of patients and hinder the recovery process (Hamilton & Love, 2010; Ross et al., 2014). Research suggests that both those who experience seclusion and their supporters advocate for the reduction of the use of restrictive interventions (Brophy, Roper, Hamilton, Tellez, & McSherry, 2016).

Why is seclusion used?

Ross et al. (2014) suggest that the use of seclusion stems from two main reasons: the behavior of patients (which is the reason usually reported) and the attitudes of staff (which also have an impact of whether seclusion is the chosen method of action) as found in the aforementioned UK-based studies (Ross et al., 2014). There has been evidence to suggest that the less a staff member practices recovery based and therapeutic methods of care, the more likely they are to resort to seclusion (Happell & Koehn, 2011a). Those who are more optimistic about recovery care also tend to view seclusion in a negative way (Happell & Koehn, 2011a).

Seclusion is a useful protection from violence against staff, and that most nursing staff still see it as necessary. It can be seen as a secondary protection against staff burnout (Happell & Koehn, 2011b) that can result from the complex nature of working on the wards, including being overworked, having a lack of training and theoretical understanding of their role, a lack of training regarding alternatives to seclusion, and low staff rates; all contribute to utilizing restrictive measures as a way to deal with serious issues that occur, instead of taking time to use alternatives (Happell & Koehn, 2011b).

The implications of seclusion: Re-traumatization

Many of those who require acute inpatient care have suffered significant trauma, and seclusion can actually re-traumatize patients (Ross et al., 2014). When unwell people are at their most vulnerable, they are isolated and left with their thoughts and emotions, with no support, and old patterns of coping are reenforced (Ross et al., 2014).

Recovery-oriented practice

Restrictive practices directly contradict recovery principles, which increasingly shape mental health policy and practice (Mayers et al., 2014). Recovery involves recognizing lived experience as a useful skill, autonomy as a core requirement, and utilizes hope to assist with the process (Bland, Renouf, & Tullgren, 2009). Recovery can be defined as

> *A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic events of mental illness.*
>
> (Anthony, 1993, p. 12)

International human rights policy: United Nations

UN: The Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care ('MI Principles' 1991)

The use of seclusion is shrouded in a dilemma around human rights: whether services have a responsibility to seclude in order to protect or the very act of seclusion is a human rights violation. The peak body for international rights of people, The United Nations (UN), is committed to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small (UN, 1948). Australia is a member of the UN and a signatory of the Universal Declaration of Human Rights charter. There are three areas in particular relevant in relation to the use of the restrictive measure of seclusion: freedom and rights, dignity, and protection.

Fundamental freedoms and basic rights

> *All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person … [and] have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.*
>
> (UN, 1991, p. 92)

Treating patients with dignity while they are in care makes "all the difference to someone's wellbeing and self-esteem and hastens recovery" (Farmer, 2007, p. 1). Seclusion can resist someone's autonomy which creates difficulty in fitting within the UN's principles for caring with people in mental health care.

The UN Principles also include protection from exploitation, abuse, and degradation for people in care. A Canadian research group investigated the impact seclusion had on patients, they found

> *In general, we can summarize the emotions experienced by patients as follows: anger, sadness, fear, abandonment, anxiety, frustration, boredom, confusion, safety, disgust, peace, quiet, entrapment, punishment, resentment, humiliation, improvement of the condition, ill, hurt, cut off, degradation, dehumanization, guilt, relief.*
>
> (Holmes, Kennedy & Peron, 2004, p. 566).

Also found during their study was

> *A prevailing belief among participants was that they were placed in confinement because they were "bad" and were being punished for their undesirable behavior. This belief was reinforced by the limited contact they were afforded by staff and the perceived neglect and degradation they experienced while in seclusion.*
>
> (Holmes et al., 2004, p. 571)

This study highlights emotional impact that seclusion has on patients and is important to consider when attempting to adhere to these principles.

Standards of care

> *Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort...*
>
> (UN, 1991, p. 94).

Harm and seclusion are often debated in terms of what is worse: the harm seclusion causes or the harm seclusion prevents (Cleary, Hunt & Walter, 2010; Kontio, Valimaki, Putkonen, Kuosmanen, Scott & Joffe, 2010). There are many alternatives to seclusion, involving the humanization of patients and tuning into their needs as is the goal in individualized, patient-centered care (Kontio et al., 2010).

Treatment

> *Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.*
>
> (UN, 1991, p. 94)

The very nature of seclusion is restrictive, which creates tension with this principle. However, it is useful when a person himself is restricting or risking the rights and safety of others.

Practice-based research and policies: United Kingdom

The United Kingdom has been at the forefront of progressive interventions in the area of reducing restrictive practices including length of time and circumstances in which restrictive practices can be used (Ward, Keeley, & Warr, 2012).

The "Helping Health and Care Services Manage Difficult Patient Behaviour" policy and the Safewards initiative have utilized training, debriefing, and reporting practices (Ward et al., 2012). For example, through one training program, which also involved casual staff, one service was able to reduce restrictive interventions by half (Ward et al., 2012). Previously, training for safety has focused on restraint, but this was found to exacerbate the situation. Everyone was too prepared to use restraint, instead of seeing other avenues of de-escalating the situation. Strong, organized leadership is needed to implement changes with training including all workers to have an impact (Ward et al., 2012).

Safewards (UK): "Increasing safety, reducing coercion"

The Safewards initiative is a UK-based model aiming to combat restrictive interventions, primarily in clinical mental health units. It focuses on conflicts, which are patient actions resulting in harm, and containment, which are staff actions which arguably also result in harm (Bowers, 2014a; Safewards, 2015). The staff involved—their training, approach, and actions—are a key focus to reduce conflict rates (Bowers, 2014a). The staff and patients influence each other and it is this relationship that is the key to reducing restrictive interventions. Second, origination domains, which are aspects of the wards which are known to harbor flashpoints (times or situations where things could go wrong), are also a key part of this model (Bowers, 2014a). In order to reduce violence in the wards, areas in which violence occurs must be examined and manipulated.

Safewards is focusing on what staff and services can do to reduce violence, or risks of violence, in the mental health wards (Bowers, 2014b). Patient characteristics are something which has previously been looked at in terms of violence. Research shows that those who display the highest forms of confrontational behavior are younger males who have been diagnosed with schizophrenia. Knowing the characteristics of individuals can be useful in providing care plans which meet their needs.

The Safewards initiative has been rolled out across the country in the United Kingdom as a practice model (Safewards, 2015). Preliminary research on the impact of the initiative notes that simple interventions aiming to improve staff relationships with patients can reduce the frequency of both conflict (by 15%)

and containment (by 26.4%) incidents, relative to the control condition (Bowers et al., 2015). Australian mental health policy has taken this important practice model under consideration when implementing similar reforms.

Seclusion use in Australia

In Australia, there has been research in support of changing the care of people in acute inpatient units. The most recent figures of seclusion according to the Australian Institute of Health and Welfare are as follows:

> *Nationally, there were 8.0 seclusion events per 1,000 bed days in 2013–14. The national rate of seclusion has gradually decreased over time. In 2009–10 there were 13.5 seclusion events per 1,000 bed days and the rate of seclusion has steadily decreased over the last 5 years to 8.0 in 2013–14. This represents an average annual reduction of 12.2% over the 5 year period.*
>
> (Australian Institute of Health and Welfare, 2015)

Significant changes within the mental health sector in Australia have reduced rates of seclusion; however, there are still areas that can be improved (Ross et al., 2014).

When is seclusion used in the Australian context?

Broadly, seclusion is used when people are a threat to themselves or others, as a restrictive measure, to calm them down. There has been Australian research to look at typical situations where seclusion occurs. Findings show that seclusion occurs more commonly in the first 2 days after admission, on weekdays more than weekends, and between the hours of 9:00 am and midnight (Happell & Gaskin, 2011). This finding is quite a broad time frame which illustrates the need for greater research in the area and also illustrates the complex nature of measuring seclusion rates.

National policy

Australian mental health policies come under the National Mental Health Strategy, formed in 1992, and updated regularly since to "improve the lives of people with a mental illness" [Department of Health (DoH) 2014]. Since prior to 2005, there were gaps in legislation pertaining to reducing harm to patients; the "National Safety Priorities in Mental Health: A National Plan for Reducing Harm" policy was introduced (National Health Working Group, 2005).

Reducing harm (2005)

This document is the first Federal Government Plan aiming to protect and improve the safety of people within mental health care (Sherbon & Barraclough, 2005):

> *The National Mental Health Working Group seeks to use the plan to provide leadership in the four national priority areas where stakeholders agree collectively we can prevent adverse events, do less harm, and make mental health services safer. The plan also provides a blueprint and access to tools that are important in identifying, measuring and developing system changes that can reduce harm in all areas of need in the sector.*
>
> (Sherbon & Barraclough, 2005)

The plan utilizes the aforementioned UN's Principles and uses them for change:

> *The goal of the Plan is to reduce the use of these interventions, and the adverse events that accompany them. However, it is acknowledged that there are situations where it is appropriate to use interventions such as restraint and/or seclusion but only as a safety measure of last resort. It is clear that restraint and seclusion are not a substitute for inadequate resources and are not to be used as a method of punishment, and if used in either of these ways is a serious contravention of consumer rights…*
>
> (National Health Working Group, 2005).

The plan proposes to put in place national standards for use of restrictive practices, as well as develop consistent monitoring systems in order to measure whether or not newly implemented actions are working. Staff education is also raised as an important point which needs reform: to focus on the alternatives to restrictive interventions (DoH, 2005).

National Mental Health Policy (2008)

The National Mental Health Policy is a key document to ensure that everyone in need has access to appropriate mental health care (DoH, 2008). This policy recognizes the impact that community mental health services have been put under since the shift from institutions to community-based care. This document reiterates the rights of consumers and calls for care to be provided in the "least restricted environment" (DoH, 2008, p. 8).

State-based policy

There are two key Victorian policies pertaining to the rights and safety of those in acute care. There has been a push federally from the national reducing harm policy (National Health Working Group, 2005).

Creating safety: Addressing restraint and seclusion practices project report

In 2009, the Department of Health commissioned a quantitative study into the seclusion and restraint records of six inpatient units across Victoria. Dr. Ruth Vine, Chief Psychiatrist, reported that:

> *The aim of the Creating Safety project was to learn how to reduce and, wherever possible, eliminate the use of restraint and seclusion in order to strengthen and support safety in adult acute mental health inpatient units. A significant finding of the project is the need to involve staff of all disciplines and at all levels, including senior health services management. This is critical if restraint and seclusion use are to be appropriately addressed and significantly reduced.*
>
> (Department of Health, 2009, p. 1)

Despite significant limitations in extrapolating the data due to a small sample size, this report found that examination of the seclusion and mechanical restraint statistics can provide a better understanding of the situation in order to improve it.

Reducing restrictive interventions

In 2013, the Victorian Government released a new policy aimed at reducing restrictive practices in mental health: "Providing a Safe Environment for all: Framework for reducing restrictive interventions" (Department of Health and Human Services (2013). This policy was heavily influenced by the UK's Safewards program.

Within the document, there are four elements: principles, capabilities, care approaches, and enablers which combine to create a "how to" for reducing restrictive interventions. The principles are the key underlining theories and values that need to be present for genuine and positive therapeutic interventions. Restrictive interventions are not therapeutic interventions; they are a reaction to risk (DHHS, 2013). Examples of principles utilized are preserving dignity, recovery-orientated practice and utilizing the lived experience of consumers.

The policy states that being aware of trauma that consumers have been through, and attempting not to re-traumatize through care, having recovery-orientated practice, and supported decision-making are key care approaches that will help reduce restrictive practices. This approach incorporates conducting risk assessments, anticipating needs, and having a healthy and active review process. By looking at each capability and practicing the "enablers" (in terms of tasks to improve in each area), the policy aims to reduce restrictive practices and "create an environment of safety" (DHHS, 2013).

Reducing seclusion rates has been a focus for quality improvement and research in a Melbourne acute inpatient service (AIS) (Hamilton & Love, 2010). Distress and trauma were reported as a great concern, as well as demoralization of staff, as these were impacts of the use of seclusion (Hamilton & Love, 2010).

The emergency department as a flashpoint

Many people arrive at mental health wards requiring seclusion (Trauer, Hamilton, Rogers, & Castle, 2010). It is appropriate to look at how people are entering wards, and many are via the emergency department, which can often be a very stressful environment. The DoH has recognized this as a "known problem area" and priority in terms of combating seclusion (DoH, 2005; Hamilton & Love, 2010). It is also recognized that despite mental health staff adequately trained in seclusion in the wards themselves, those working in emergency departments often do not have the same training and experience (DoH, 2005).

Summary of implications from the literature

Seclusion as a method of managing risk has been a contentious issue within mental health for some time (Trauer et al., 2010). There have been significant developments in reducing the rates of seclusion from both policy and practices (Hamilton & Love, 2010). Seclusion does not fit comfortably within the UN Principles for the Protections of Persons with Mental Illness nor does it have a large place within Australia's contemporary policies in mental health. Therefore, challenges to seclusion and other restrictive interventions are taking place through training packages and other reforms throughout Australian mental health wards. In order for changes to occur, there must be an understanding of who experiences it, when seclusion occurs, as well as the nature and context of the events.

Aims of the current study

To investigate demographics of those experiencing seclusion, the length, duration, and admission route of seclusion episodes, to determine the psychosocial factors of the most distressed vulnerable patients with mental health problems presenting to an acute inner city tertiary referral hospital.

Research question

In public hospital acute inpatient mental health services, who was secluded and for how long?

Method

Study design

A descriptive study design was chosen, in order to illustrate who were being most affected by seclusion and the nature of these seclusion events. As the introduction section has shown, there was limited information in the

international literature regarding the demographics of who gets secluded in a given local context. Quantitative data were useful to discover who was secluded and for how long and how frequently they were secluded (Babbie, 2012). The data collected were secondary data, collected originally within the inpatient mental health unit setting for service delivery in terms of patient treatment and care. It was used here for the separate yet related purpose of service quality assurance and potential enhancement. The data were drawn from patients admitted to one inner city inpatient unit during one full calendar year (2013).

Service context

The current study is to locate within a comprehensive adult area mental health service for people aged between 16–64 years who live in an inner urban area of Melbourne. The AIS has 44 beds, providing short-term inpatient treatment to people during the acute phase of mental illness, and includes a 6 bed Extra Care Unit and seclusion for people with more intensive care needs. Within the wards, there are activity and quiet spaces, an activities kitchen, women's-only spaces, and a courtyard. Both voluntary and involuntary patients are treated. Staff are a multidisciplinary team: nurses, psychiatrists, social workers, occupational therapists, psychologists, and peer workers.

Data analysis

Frequency distributions were utilized to describe demographics such as age, gender, country of birth, employment status, housing status, and marital status. Service use data examined point of admission, number of admissions; duration of hospitalizations, length, and frequencies of seclusion episodes, including multiple admissions and seclusions, and case management status.

The mean and range of patient age were calculated. In order to describe the events, the length of seclusion was studied via the use of a box and whisker plot, and calculations regarding the mean, median, and mode times for the seclusion events, as well as establishing outliers, were conducted.

Ethical considerations

The hospital Human Research and Ethics Committee has approved this research under the "Recovery-Oriented Practice and Peer Workforce Development" project.

All information was de-identified to adhere to patient confidentiality principles. Data were accessed by the Service Development Manager and passed on de-identified as secondary data; therefore, consent was not required (National Health and Medical Research Council et al., 2007) since researching the data were to improve service delivery (Office of the Health Services Commissioner,

2001). This study did not infringe on a person's right to service as patients were de-identified and the researcher had no role in service delivery (Babbie, 2012).

Results

There were 655 admissions in the 2013 calendar year (354 admissions occurring via the Emergency Department). Of the 655 acute psychiatric crisis admissions in the year 2013, 91 (14%) included some period of seclusion (Figure 1). There were 79 individuals who experienced seclusion that year (91 admissions: 12 people had been admitted twice) (Table 1). These 79 people as a group had a total of 200 seclusion events.

Admission pathways into the AIS

Overall, 53% of admissions into the inpatient unit occurred via the Emergency Department. Just under half of admissions involving a seclusion episode were admitted via the Emergency Department (41/91). Of those who experienced seclusion coming via the Emergency Department, approximately half experienced seclusion within the first 4 h of admission into the inpatient unit. Key times for admission were in the afternoon Tuesdays–Fridays.

Investigating seclusion events

Of the 200 seclusion events, 96 cases (45%) were within the currently clinically and legally acceptable 4 h duration. One-third of the 200 sample experienced seclusion once. The most frequently occurring time was 4 h (the mode), and this was also the median.

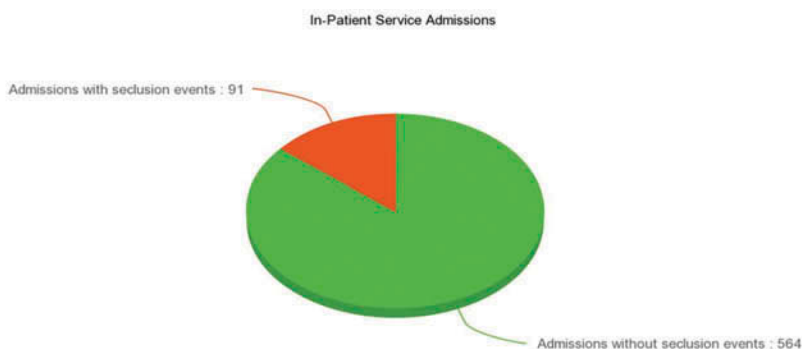

Figure 1. Proportion of psychiatric crisis admissions that included psychiatric crisis admissions seclusion.

Table 1. Admission pathway and volume data.

Significant data point	Number
In-patient admissions	655
Admissions via ED	334
Patients experiencing seclusion	79
Admissions with seclusion episode	91 (12 people were admitted twice)
Seclusion events	200
Seclusion events for ED transfers	41
Seclusion events for ED transfers within 4 h	16

Demographic data of those who experienced seclusion

Of the 79 individuals who experienced seclusion, the age range was 17–74 years. The mean age was 36, with two-thirds of people within the age bracket 18–39 (Table 2). Approximately, two-thirds were male. Nearly half-identified housing status as "unknown" and 27% lived independently. 75% of those secluded had never been married. Four people were found to be in employment at the time of their admission. The majority (62 of 79) were born in Australia.

There were two distinct groups of people who became secluded: those who were secluded for short periods of time irregularly and those who experienced lengthier seclusion events and/or those experiencing multiple seclusion events during their inpatient stay.

Multiple seclusion events

There were 30 people who had one seclusion event and no further events, leaving 49 people experiencing multiple seclusion events. Focusing on these 49 people, only 2 were married and only 2 employed (and they were not the same people). They were largely unemployed, on a pension, and/or students. These risk factors are shown to be even greater than compared to the larger group researched. In other areas, they were similar to the larger cohort including gender (which reflected the greater population's ratio of 2:1 male to female).

Summary

The longer the seclusion events are, or the more seclusion events are experienced, the more particular demographics were highlighted, that is, male gender, homelessness, never married, and being unemployed.

Discussion

Of concern to the hospital, in meeting its mission and vision to provide excellent and compassionate health, and of concern to the researchers, was the proportionately small group experiencing longer seclusions. The subjective distress such

Table 2. Characteristics of those who experienced seclusion.

Characteristic	Description	Number	Percentage
Age*	<18	1	1
	18–29	29	37
	30–39	24	30
	40–49	11	14
	50–59	8	10
	60–69	3	4
	>69	3	4
Gender	Male	53	67
	Female	26	33
Housing status	House/Flat	21	27
	Homeless/Unknown	39	49
	Residential service	19	24
Marital status	Married/*De facto*	4	5
	Separated/Divorced	10	13
	Never married	59	75
	Not stated	6	8
Preferred language	English	73	92
	Other**	6	8
Country of birth	Australasia (Australia and New Zealand)	62	79
	Asia (Philippines, North Korea, Lao, China,	5	6
	Sri Lanka)	3	4
	Middle East (Lebanon, Afghanistan, and	4	5
	Iran)	4	5
	Europe (Romania, Greece, and England)	1	1
	Africa (Sudan, South Africa, Somalia, and		
	Liberia)		
	America (USA)		
Case managed	Yes	25	32
	No	50	63
	Changed after first admission	4	5
Employment	Employed	4	5
	Student	11	14
	Unemployed/Pensioner	44	56
	Unknown	20	25
Seclusion events (per person)	1	29	38
	2–4	39	49
	5–8	8	10
	>8	3	4
Inpatient use (length of stay per admission/91)	<1 week	10	11
	1–2 weeks	27	30
	3–4 weeks	18	20
	5–8 weeks	19	21
	>8 weeks	17	19
Inpatient use (length of admission per patient/79)	<1 week	9	11
	1–2 weeks	21	27
	3–4 weeks	13	16
	5–8 weeks	17	22
	>8 weeks	19	24
Inpatient use (admissions)	1 Admission	67	85
	2 Admissions	12	15

*Age groups as defined by St Vincent's patient records. Anyone experiencing two admissions was grouped according to the older age. All other data defined by seclusion records.
**(Arabic: 1; Somali: 1; Mandarin: 1; Korean: 1; Greek: 1; Urdu: 1).
N = 79.

events can entail for the individuals, and the potential for the experience of trauma, has been noted (Holmes et al., 2004).

Male gender

Whether it is for multiple or extended seclusion events, men are over represented in the data. There may be many reasons for this, and further research is needed to find anything conclusive; however, the socialization of men in Australia (and most Western cultures) could be playing a role. The way men are often socialized in Western cultures, including Australia, can be called "hegemonic masculinity" (Ricciardelli, Mellor, & McCabe, 2012). This refers to a process of socialization involving encouraging and normalizing traits such as aggression, fearlessness, independence, and emotional strength (Gough, 2007; Ricciardelli et al., 2012).

According to a recent Beyond Blue study *Men's Social Connectedness*, once men turn 30, their social networks go into decline and that only half of all men talk about serious issues with their friends (Beyond Blue, 2014).

Seclusion is often a reaction by staff toward patient aggression (Ross, Campbell & Dyer). The socialization of men, resulting in issues expressing their concerns appropriately, could be a factor of why men are showing up over twice as much as women in this cohort.

Potential social isolation indicated by few social relationships and lack of employment

Social inclusion has strong links to mental health and life satisfaction (Ricciardelli et al., 2012). Those who are experiencing a mental health issue as serious as requiring inpatient treatment often show a history of mental health issues, and where there are mental health issues, there are often issues with socialization (Kawachi & Berkman, 2001). Social isolation is heavily correlated with the advent of poor social skills and poor communication skills in individuals, with the relationship appearing to be bidirectional (each a cause and consequence).

Many people who experienced seclusion had never been married, and being single and alone could be an indicator of social isolation. Lack of financial resources or choice can limit the options people experience with regards to be able to socialize and forge friendships. As Table 2 indicates, only 19% of the sample were engaged in employment or education. So, it appears that over 80% might be facing social challenges.

Research suggests a link between mental health issues and social isolation, and in many cases, social isolation may exacerbate present concerns (Kawachi & Berkman, 2001). Difficulties in connecting and communicating with others could have an effect on the ability people possess to emotionally regulate within an inpatient setting.

Limitations

Limitations include that this was a single service and single time period study. The data may not be representative of all seclusion experiences at the inpatient unit studied across time or in the broader sector. This piece of descriptive research was designed to be a modest scoping study in order to acquire a baseline for further comparisons. The team intends to collect additional data, including diagnosis, medication levels, and use of admission scales, in the years to come. Further research is warranted to collect qualitative data describing the seclusion events from the perspective of those who experienced them.

Conclusions

Research into seclusion events across a 12-month period at one inpatient unit has highlighted the demographics of male gender, relationship status as single, and low income and unstable housing as factors in seclusion events overall and also seclusion events of increased frequency and duration. This research suggests a relationship between these patient demographics and the likelihood to experience seclusion. Further research is needed to explore the nature of this relationship and to develop strategies to decrease seclusion rates within inpatient settings.

Complexity and the social work role

Social work has been termed the "complexity profession" which "seeks to take account of and respond to the complexities and ambiguities that people face in real life" (Adams, Dominelli & Payne, 2009, p. 7). Having explored markers of difference, and their relevance to inpatient seclusions, could potentially enable more targeted advocacy and engagement in acute settings, paving the way for further reducing of seclusion.

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