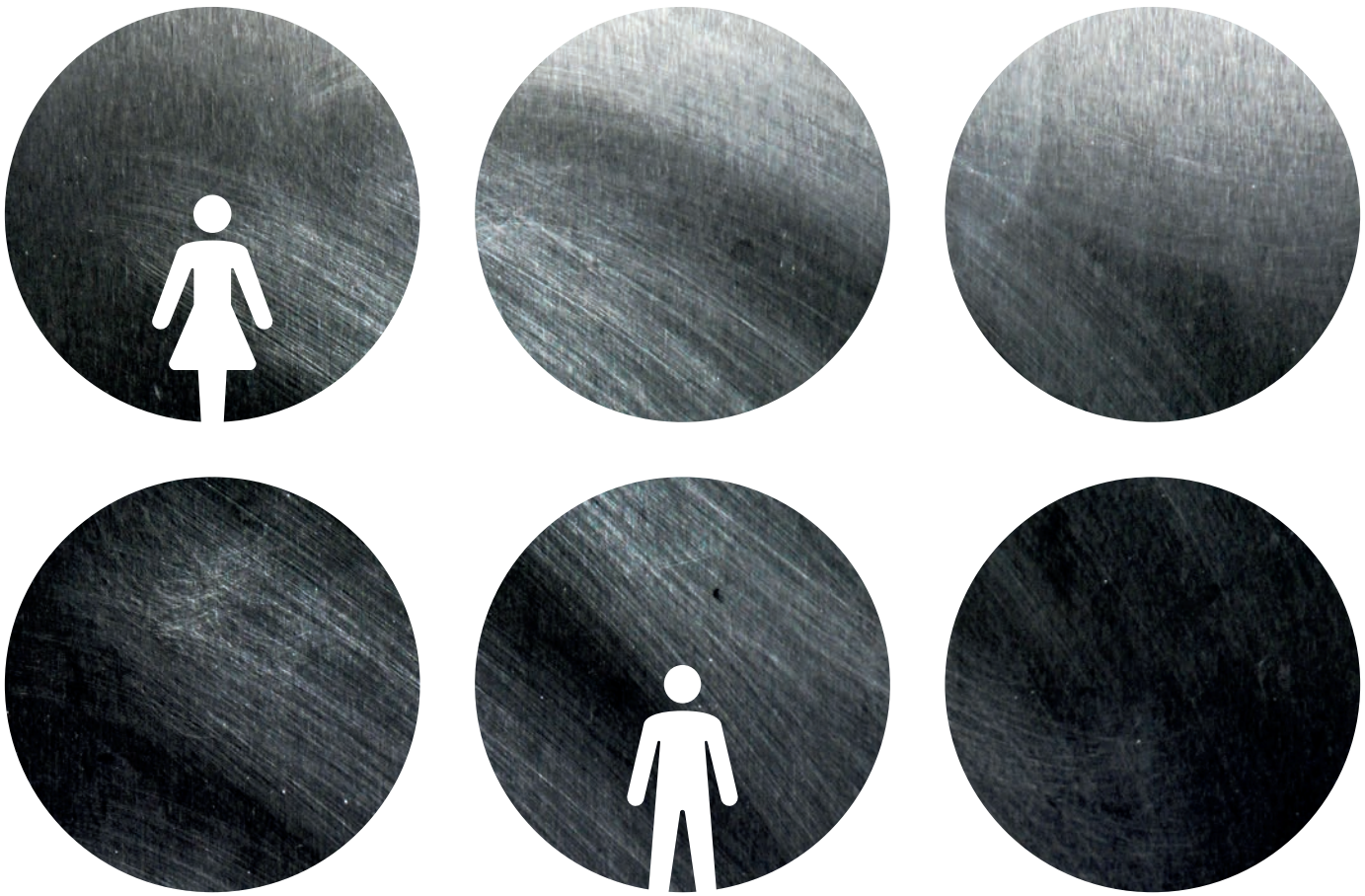
# Design With People in Mind

# The Seclusion Issue



Design in Mental Health Network
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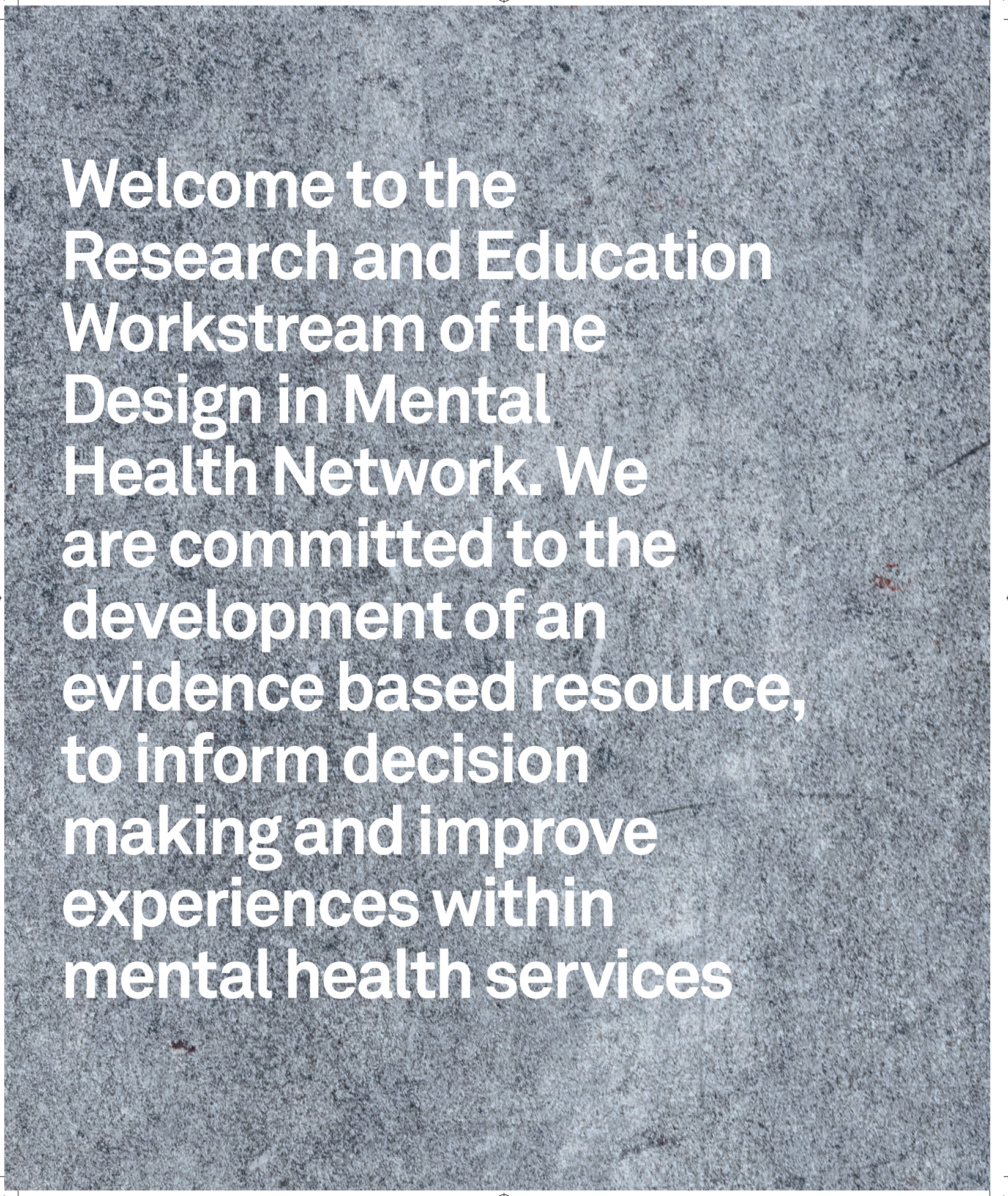


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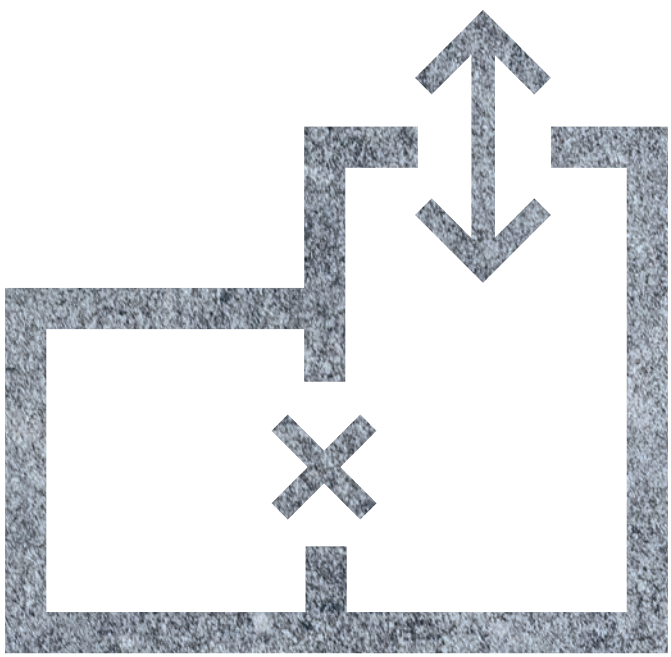
# Contents







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# Design with seclusion in mind

This publication is the eighth in the Design with People in Mind booklet series and we are delighted this year to present an evidence review on the topic of seclusion. Creating spaces for privacy and observation, whilst retaining dignity and reducing risk is central to good design in mental health care facilities yet seclusion spaces present a very specific challenge in maintaining this balance. There is nothing inherently wrong with spaces for individuals to retreat to in times of extreme distress; spaces that can foster a sense of safety, calm, solitude and support. However, current seclusion practices and spaces do not often fulfil this function, appearing instead to contain rather than support patients in their time of intense need. Research shows how patients on the whole dislike current seclusion spaces and practices and can even feel traumatised by their experiences, especially if seclusion involves lengthy periods of time without human contact in a sterile space. Staff also report a dislike of the practice, even though they recognise the need for isolation and privacy for the highly distressed and agitated.

Alternatives to seclusion have emerged in different mental health settings, but in the main, its use has remained stable over time despite representing a significant challenge to patient centred modes of care delivery. In this publication, we tackle the topic of seclusion from architectural, design as well from psychological, clinical and social perspectives. At its heart, this transdisciplinary perspective focusses on people and how design might better collaborate with people in their time of intense need.

This edition reviews the available literature relating to several topics around seclusion. In addition, we have interviewed people who use mental health services, as well as clinicians. The aim was to draw on the expertise of those living and working under challenging conditions, where seclusion is deemed necessary. The use of restrictive practices and seclusion can cause intense stress and even ignite memories of previous trauma. It is well known that a considerable proportion of individuals leave hospital with post-traumatic stress responses and seclusion use may contribute to this.

And yet, we do not fully understand why and how seclusion is used and the effects it has on patients and staff. Here we examine examples of how patients experience the stress of seclusion and make sense of it in terms of recovery, as well as the impact on relationships with staff and other patients. We also explore how trauma informed care perspectives might help navigate alternative routes through the design and delivery of seclusion. In thinking closely about the kinds of life experiences that people bring with them on their entry into hospital and how we can work more sensitively to acknowledge past traumas that people still hold in body and mind, we can better learn how design can ameliorate or compound these difficult histories.

We also explore the design of seclusion spaces, to assess whether there is good evidence for existing seclusion designs. The traditional white walls, bare room and overall lack of stimuli are scrutinised to reveal a lack of evidence supporting current design practices, raising questions about how psychologically suitable they are in their existing form. And alternatives to seclusion, such as sensory rooms, now adopted in several facilities across the world, are examined in terms of their viability for individuals needing to be placed in a safe yet isolated space. Finally, we explore whether there is capacity to introduce an element of patient choice into seclusion design; an installation of adjustable music, lighting and access to outside space and whether this might contribute to well-being.

In keeping with all other editions in this series, we wish to emphasise the importance of the relationship between environments and people; that treatments and interventions are shaped and emerge from the spaces they operate within. Our vision, as always, is for the evidence we present to be put to good use and to benefit those who live and work in mental health care environments, both in formal services and in the wider community.

Professor Paula Reavey
Professor Steven D. Brown
Isobel Thomas



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# Seclusion and quiet rooms as container spaces

If seclusion literally means to be away from other people, there is perhaps nothing inherently wrong with the practice. However, the reality of seclusion in mental health settings can involve an involuntary containment in a space that might be less than ideal, leading to longer recovery rates, increased aggression and lower satisfaction levels for patients and staff. A Europe wide study found that patients who had been secluded stayed an average of 25 days longer in hospital, despite being no less 'well' than fellow patients who had not been secluded (McLaughlin et al., 2016). Despite the existence of milder sensory or quiet room alternatives, seclusion spaces involving a locked room with little or no furnishings are widely used within psychiatric settings as a containment measure for distressed or disruptive inpatients.

NICE [the National Institute for Health and Care Excellence] guidelines state that services using seclusion should have a designated room that:

- allows staff to clearly observe and communicate with the service user
- is well insulated and ventilated with temperature controls outside the room
- has access to toilet and washing facilities
- has furniture, windows and doors
- ideally can withstand damage

However, the guidelines do not provide any further information relating to seclusion use, staff conduct or patient wellbeing.

## Design considerations

Primarily used to protect the patient and others from harm, the seclusion environment is designed to be non-stimulating (Van der Merwe et al., 2013), with robust infrastructure and a lack of furnishing (Ching et al., 2010). Usual features include heavy-duty doors, bare walls, recessed light fittings and minimal furniture to ensure patients, staff and the structural environment cannot be easily damaged during times of heightened emotional distress (Bowers et al., 2017; Gutheil & Daly, 1980).



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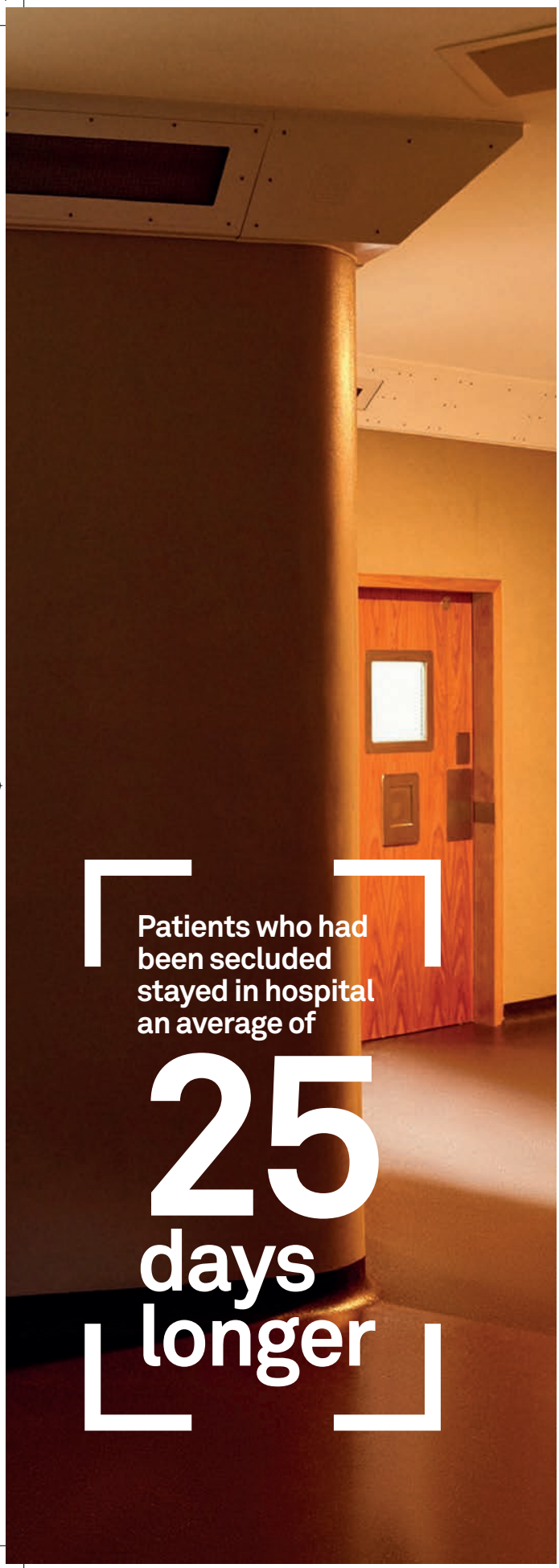


Limited research exists into the 'optimal' seclusion room design (Harrison: Ministry of Health, 2012; Hertfordshire University Trust, 2019). There are, however, national standards and specifications for seclusion rooms, such as staff being able to observe the entire seclusion area, fixtures limiting risk, and furnishings designed to be robust and resist impact (Department of Health, 2021; Gutheil & Daly, 1980). Furthermore, staff should be able to control heating, cooling and water from outside the room (Department of Health, 2021). Despite this, there is no core guidance on design schemes, beyond recommendations such as the use of calming colour schemes in seclusion design, which often results in the adoption of a white colour pallet (Harrison: Ministry of Health, 2012).

Central to seclusion room design is creating a single-function space with low-levels of stimulus, placing the safety of the service user at the forefront (Department of Health, 2021). Ensuring staff can readily observe the seclusion area involves the adoption of bright artificial lighting, reported to disrupt service users' sleep and exacerbating levels of distress (Holmes et al., 2015; Karlen et al., 2017). El-Badri and Mellsop (2008) found that 85% of staff and 95% of patients thought seclusion rooms had to change. Both staff and patients recommended changing the colour of the walls, giving patients control over the temperature and lighting, and allowing fresh air, entertainment, and distraction. When interviewing forensic psychiatric inpatients, almost all felt the seclusion room to be too cold, noting that patients were often required to remove socks for safety reasons. Other patient studies have recommended seclusion environments focus on therapeutic activity, representing cosy peaceful spaces lined with soft furnishings, TVs, books and other meaningful activity (Konito et al., 2012).

It is also important to consider the impact of the broader ward environment as well as seclusion itself. Van der Schaff (2013) found fourteen design features that were statistically associated with levels of seclusion, with the presence of 'special safety measures' including delayed alarms on door locking mechanisms, door position monitoring and violence-proof finishes associated with a higher risk of seclusion, and more private spaces and higher comfort levels associated with lowered risk.

**Given a lack of rigorous research examining the psychological effectiveness of seclusion, a Cochrane systematic review concluded that there is no evidence to suggest that seclusion be the best way to support an individual in distress, especially in its current format (Sailas & Fenton, 2012). However, it is important to be mindful of the benefits of quiet spaces that enable reflection and harness a sense of privacy and psychological safety.**



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# Staff and patient experiences of seclusion

Studies which have focused on staff and patient experiences find that seclusion is mostly associated with negative affect (Askew et al., 2018; Chieze et al., 2019). Many patients feel coerced, angry and experience a loss of autonomy at being secluded (Holmes et al., 2004). However, some patients and staff report the importance of seclusion in enabling them to feel safe and secure on the wards (Stowers et al., 2002; El-Badri & Mellsop, 2008; Hoekestra et al., 2004).

Examinations of patient and staff experiences of seclusion often find there is tension between a perceived lack of patient welfare with a recognised need for patient and ward safety (Laukkanen, et al., 2019). A literature review by Van Der Merwe and colleagues (2013) highlighted the negative and difficult experiences that seclusion can evoke for patients such as feeling scared and abandoned, lonely, upset, worthless, and humiliated.

In recurrent themes across studies, patients reported experiencing seclusion rooms as humiliating and wholly punitive (El-Badri & Mellsop, 2008; Hoekestra et al., 2004). However, staff report that seclusion is effective, therapeutic and necessary for the safety of the unit. Through habituation, staff who use seclusion more often, viewed it more positively and as a legitimate and acceptable practice (Van Doeselaar et al., 2008). However, staff who do not have access to seclusion facilities tend to view the practice less favourably (Bowers et al., 2017). This suggests that the presence of seclusion facilities may increase the acceptability of seclusion amongst staff above other potential restrictive practices.

Despite some staff holding positive attitudes towards seclusion, the picture is complex. Seclusion can create dilemmas for nurses, as well as initiating emotional distress through experiences of anxiety, fear and guilt in the aftermath (Laukkanen et al., 2019). In an interview with psychiatric staff in Ireland, Moran and colleagues (2009) found nurses viewed seclusion as a last resort and were distressed when they had to engage with it. Although some studies have found staff to have troubling experiences with seclusion, this is often paired with feelings that patient dignity and ward safety was maintained via its use (El-Badri & Mellsop., 2008; Van Der Merwe et al., 2013). Some patients have also reported that seclusion can actually create feelings of safety, protection and an opportunity to de-escalate (Holmes et al., 2015; Stowers et al., 2002). Exploring patients' lived experience of seclusion within a forensic psychiatric setting, Holmes and colleagues (2015) found that some patients even requested to be secluded if they felt it was in their best interest.

However, studies have also discovered a recurrent theme of loneliness emerging from seclusion use. Patients can view seclusion as a punitive measure, experiencing isolation and abandonment and a breakdown of trust (Holmes, 2004). Lack of contact with nurses and staff when in seclusion has been found to contribute to some patients acting aggressively within the seclusion room; as a method of being heard and noticed, for example banging on the door to catch nurses' attention (Holmes, 2004; Kuosmanen et al., 2015).

Holmes and colleagues (2015) found that patients felt they received less attention from nursing staff when in the seclusion room, due to difficulties due to communication barriers. Such a lack of communication and attention can become distressing to patients, who may feel they are being ignored or their needs neglected. Communication and contact between staff and patients before, during and after seclusion has been found to be critical (Van der Merwe et al., 2013).



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> *"I've been involved in the building of seclusion rooms and seclusion spaces, and NHS England has a list of things they have to adhere to in terms of, you know, door design, lock design. But actually there's no list of things that they have to adhere to in terms of therapeutic design."*
>
> Professor of Mental Health Nursing



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Echoing feelings of loneliness, Konito and colleagues (2012) found patients reported that a lack of meaningful activity and stimulation was a contributory factor in their negative experience of seclusion. Whilst Hoekestra and colleagues (2004) found patients experiencing loneliness and a lack of autonomy when in seclusion, they also described needing more information on why seclusion had taken place and some distraction techniques to help manage the experience.

## Design considerations

Though seclusion potentially holds a valuable place as a means to support the safety of patients and staff (Van Der Merwe et al., 2013; Stowers et al., 2002), it is important for design principles to establish a sense of safety, validation and robust protection – physically and emotionally. Whilst difficult experiences may arise due to the nature of emotional distress, the design of the seclusion room should avoid triggering further feelings of humiliation, powerlessness or punishment (El-Badri & Mellsop, 2008). Beginning with the interior design of the seclusion room, the literature suggests that a peaceful environment with calming-coloured walls may support patients to feel more relaxed, valued, with the environment appearing less clinical (e.g. Konito et al., 2012; Harrison: Ministry of Health, 2012). Kuosmanen and colleagues (2015) encourage stakeholders to establish comfortable, safely furnished seclusion rooms with easily cleaned materials and beds at a normal height, suggesting this would positively improve the atmosphere of the room. Too often beds are substituted with floor level crash mats, which are less than optimal and further communicate a sense of punishment and powerlessness.



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> *"One of the principles that we really stick to is that seclusion or segregation must never be a form of punishment… it must be a protective measure and a therapeutic measure in its own way."*
>
> Consultant Forensic Psychiatrist – High Secure Mental Health Unit

Focussing on the identified lack of communication when in seclusion (e.g. Holmes et al., 2015; Holmes, 2004; Kuosmanen et al., 2015), design principles should foster a space for optimal staff-patient interaction. Psychologists have argued it is essential to increase caring elements of seclusion such as increasing communication (Kuosmanen et al., 2015).

Perhaps creating a window within the seclusion room that connects to a staff observation point may enable a patient to be seen by staff when seeking conversation or installing a 'buzzer' system for patients to alert staff if they wish to talk, may be effective methods for enhancing communication. However, it is recognised that both methods are open to misuse and may infringe on patient privacy, such that a robust feasibility trial is crucial in providing an evidence base for this proposal.



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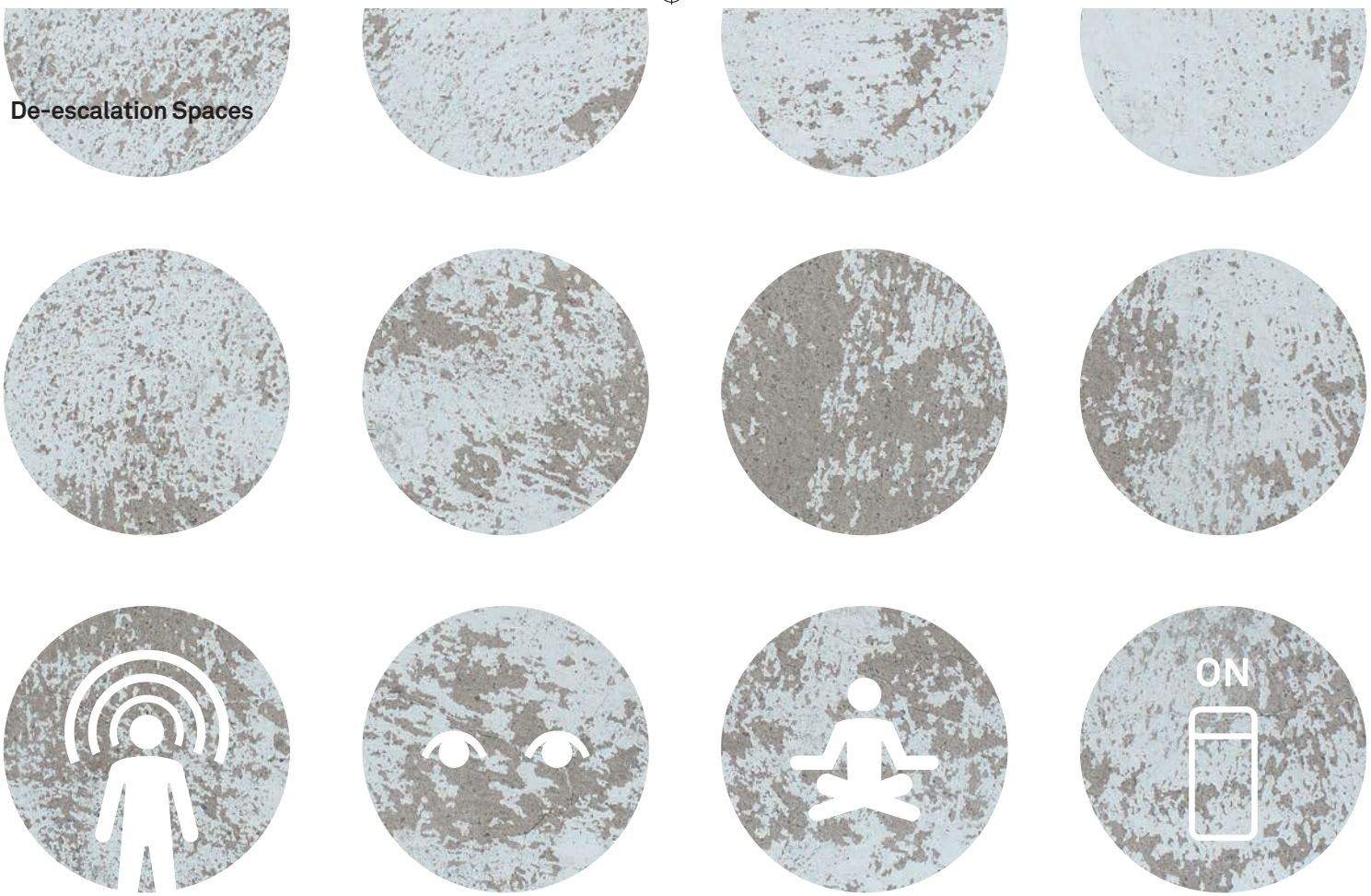


# De-escalation spaces: the move towards sensory rooms

The terms 'Comfort / Sensory' rooms are used interchangeably to describe therapeutic spaces designed to relax or stimulate the senses and promote patients' self-induced emotional regulation (Davies et al., 2019). Although sensory rooms are not designed to serve as an alternative to seclusion (Bowers et al, 2019), they are spaces that may operate as a therapeutic de-escalation tool prior to seclusion (e.g. Smith & Jones, 2014). Such spaces provide the opportunity for 'time out' in a safe space to reduce aggression (Smith & Jones, 2014), contributing to the reduction of restraint and seclusion in psychiatric units (Champagne and Stromberg, 2004).

Sensory rooms can help settle patients experiencing elevated levels of disturbance and thus, rendering less restrictive practices necessary (Lloyd et al., 2014). Most research has focussed on the implementation of sensory rooms within general psychiatric inpatient wards, CAMHS and PICU units, however, there is some exploration of its use within secure forensic services, signalling positive results overall (e.g. Hedlund Lindberg et al., 2019; Wigglesworth & Farmworth., 2016).

Lloyd and colleagues (2014) evaluated the introduction of a sensory room in an acute mental health unit in Australia. Using another unit as a control condition, they found patients reported a reduction in disturbance level after using the sensory room and a reduction in the frequency of seclusion use. Reductions in aggression and patient levels of distress after using the sensory room have also been found by other studies (Björkdahl et al., 2016; Champagne & Sayer, 2003;



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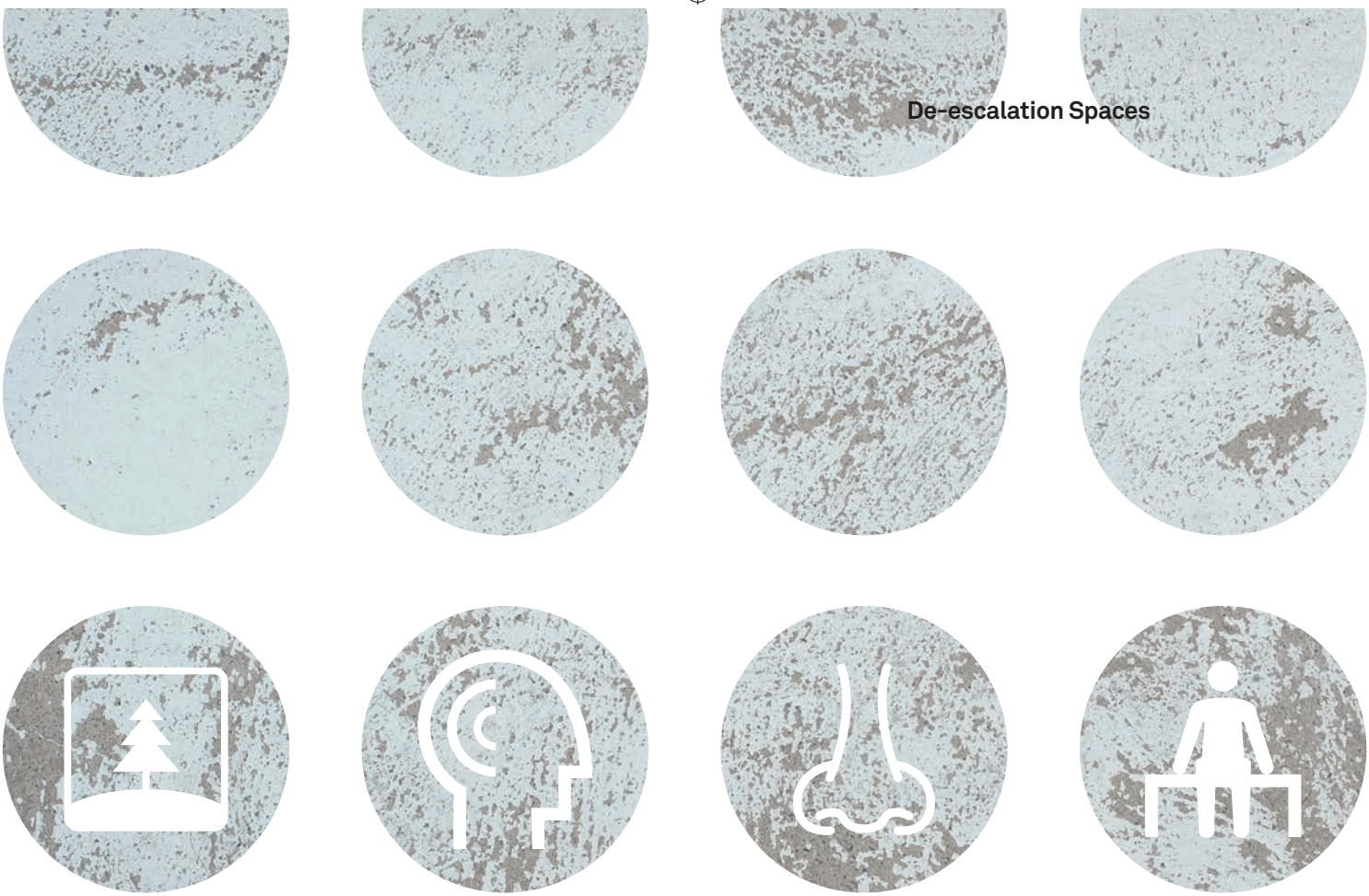

Hedlund Lindberg et al., 2019). Other studies have found little or no reduction in seclusion use (Smith and Jones, 2014).

Whilst seclusion levels do not necessarily reduce with sensory rooms, there can be a reduction in reported distress and disturbed behaviours, suggesting sensory rooms may be useful in helping patients self-soothe, though staff training in their use is essential.

The implementation of sensory rooms has not only been found to result in distress reduction amongst patients, but staff have also reported emotional benefits from using the space after critical incidents (Forsyth & Tevarrow., 2018). Thus, sensory rooms can be offered as an alternative tool for de-escalation and positive mood enhancement for both patients and staff (Dorn et al., 2020).

Björkdahl and colleagues (2016) explored staff experiences of sensory rooms in Swedish psychiatric inpatient settings. Staff expressed hope that the rooms would serve as an exciting new option in daily care, reducing coercive measures. They reported feeling the sensory rooms has helped them become better at preventing emotional distress and noticed patients had used the room both as a tool for emotional dysregulation when they are distressed, and as a preventative strategy. This has been echoed by service-users, who hoped sensory rooms would become an alternative to current restrictive practices (Barbic et al., 2019).

Whilst some studies have found staff members to express concerns regarding patients being alone left in sensory rooms (Björkdahl et al.,2016), sensory rooms have been found to help build trust and rapport between patients and staff (Sutton & Nicholson, 2011). Hedlund Lindberg and colleagues (2019) found patients reported enhanced well-being, reduced anxiety, increased self-management, and enhanced self-esteem after using sensory rooms.

## Design considerations:

Sensory rooms offer helpful design features that could be applied directly to seclusion rooms. Creating an environment to enhance patients' self-regulation (Davies et al., 2019; Smith & Jones, 2014) may help to reduce punitive experiences resulting from seclusion rooms. If a room is large enough, staff may be able to place various (safety vetted) stimuli into the room such as magazines, bubble tubes and weighted blankets etc. for patients to self-soothe. It may be beneficial to consider the structure of the room design to allow for large objects (such as a television) to pass through the door frames, should the use of the room include sensory or other meaningful activity, personalised for each individual. Comfort/sensory rooms should complement the senses: weighted blankets, bubble tubes and magazines may assist individuals in relaxation and 'self-soothing' routines are found to be particularly soothing, as is adjustable lighting and access to calming sounds and visuals.



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# Trauma informed environments: what should we consider for seclusion?

Research has consistently found there to be a high prevalence of past trauma amongst people using inpatient mental health services (Champagne and Stromberg, 2004; Kessler et al., 2010). Inpatient mental health settings may be highly distressing for those with trauma histories (Crucsak et al., 2018), especially if there is an absence of a perceived safe, soothing and supportive environment (Clark et al., 2008; Elliott et al., 2005; Muskett., 2013). To meet the needs of individuals accessing mental health services, Elliot and colleagues (2005) suggest best practice should include universal 'trauma precautions' by incorporating welcoming design with comfort and privacy.

Trauma informed services are those that address the impact trauma may have on a person, biopsychosocially (Champagne and Stromberg, 2004) and are aware of how services can serve to re-traumatise individuals through coercive practices and punitive, containing environments (Hodas, 2006). Procedures and practices such as seclusion can be re-traumatising for patients if perceived and experienced as disempowering and psychologically unsafe (Muskett., 2013; Sweeney et al., 2018). Notably, when exploring trauma-informed practise in prison design, Jewels and colleagues (2019) recognised the physical environment as potentially distressing and traumatic due to the use of sterile spaces, unnatural lighting and unexpected noise – descriptions commonly found in studies exploring inpatient perceptions of seclusion in psychiatric settings (see also El-Badri & Mellsop., 2008).

Some evidence suggests service users frequently experience traumatic events in inpatient settings, involving a loss of autonomy (Muskett., 2013). Freuh and colleagues (2005) interviewed 142 patients with a history of psychiatric admissions, finding high rates of reported lifetime trauma had occurred within psychiatric settings including the witnessing of traumatic events and reports of seclusion and restraint.

Staff can vicariously experience service users' trauma and may be affected by observing or delivering practices such as seclusion (Sweeney et al., 2018). Sequeria and Halstead (2004) found several female staff members to report emotional distress after the restraint of patients, particularly those who acknowledged how traumatising this may be for patients with a history of abuse. It is argued that trauma un-informed services may result in clinicians learning to rely on their power using coercive practices, rather than adopting relational approaches to manage distress collaboratively (Sweeney et al., 2018). Trauma informed practices use strength-based approaches and empowerment for those who have experienced a lack of power and control (Butler et al, 2011).

## Design considerations

Jewels et al. (2019) suggest trauma informed design involves institutions being sensitive to the trauma informed practices that will occur within it, whilst building an environment that fosters a sense of autonomy, empowerment and validation. Muskett's (2013) literature review identified several studies highlighting the importance of the physical environment when adopting trauma-informed care. There appears to be an underlying shared goal within trauma-informed design of creating an environment with soothing colour schemes and domestic feel (e.g., Jewels et al., 2019). Additionally, in line with sensory rooms, trauma sensory approaches →



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> *"We talk a lot about trauma informed care, but I don't think people have made the link between the trauma that seclusion can cause… And then the impact seclusion has on people's mental health. Even simple things like you've talked about lighting, but often there's no access to clocks. So people get disorientated in terms of time and day. There's really poor communication. So it's hard to talk to staff that are sat outside. You know, it's even harder to talk to family members, there's a lack of activity, so there's a lack of stimulation."*
>
> Professor of Mental Health Nursing



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are argued to strengthen the therapeutic relationship and encourage recovery (Champagne and Stromberg, 2004). Individuals have different sensory requirements which help them to self-soothe and self-organise their emotions and hence potentially prevent crisis. Thus, various sensory equipment should be made available.

> *"I would like to see patients having more of a connection with nature, because generally speaking nature is a soothing environment… a view of something nice, like a tree or being able to be near the landscape."*
>
> Consultant Forensic Psychiatrist – High Secure Mental Health Unit

Sleep is also key to self-soothing techniques. The lights in seclusion rooms are often left on, disrupting a patient's ability to sleep. Often, night lighting is required by medical personnel to access a patient and check on them, interfering with biological/circadian rhythms (Aulsenbrook et al., 2018; Cellappa et al., 2011). Disturbance to circadian rhythms and a lack of sleep can be a source of distress for patients, and be potentially traumatising (El-Khoury et al., 2021).

Karlen and colleagues (2017) note the benefits of using layered lighting when designing psychiatric spaces, allowing different light levels for day and night. Whilst lights may be bright during the daytime to encourage a sense of activity, these lights can then be dimmed at night to foster a comfortable environment for both staff and patients. Low level lights at night can permit nurses to check on patients, but also not interfere with patient sleep. If needed, lights can be brightened for examination during the night. The importance of sleep when in the seclusion environment is further displayed by Kuosmanen and colleagues (2015) who secluded two mental health nurses voluntarily for a 24-hour period, with the nurses describing sleep (within this period) serving as an escape from reality, helping to pass the time.

HMP Inverclyde focussed on 'softening' the environment through designing curved, rather than long and straight corridors, with good sightline that prevented traumatised individuals from being surprised when someone suddenly appeared around a corner (Jewels et al., 2019). Bedrooms were described to be designed ligature free, conforming to national legal requirements whilst creating a de-institutionalised, trauma reducing environment that focussed on the provision of privacy and safety alongside autonomy, reflection, and empowerment.

Incorporating layered lighting into seclusion room design may begin to serve as a solution to patient experiences of sleep deprivation (Karlen et al., 2017). This could be incorporated into the previously discussed design consideration of a temperature and lighting panel being inside the seclusion room itself to enhance patient's personal choice (El-Badri & Mellsop., 2008). The lights may be set around day and night 'standard' timed settings, with patients able to adapt the lighting within these boundaries. Learning can be taken from HMP Iverclyde in architecturally 'softening' the seclusion environment to reduce the possibility of traumatised individuals being surprised when someone suddenly appears (around corridors) (Jewels et al., 2019).

Whilst seclusion may not contain corridors, ensuring patients have a good sight line or prior knowledge of incoming staff may be of use. For example, a sign that lights up when a staff member presses a button from outside of the room – letting patients know someone will be entering. Arguably, this may serve as a 'doorbell,' although the patient has reduced agency over allowing this individual to come in, which in turn may reinforce trauma. Thus, application of this design may need further consideration.

**Finally, it may be beneficial to allow patients access to a garden area when in seclusion, which may serve as a healing space (Connellan et al., 2013; Jewels et al., 2019; Reavey & Harding, 2019). The restorative environment may enable patients to self-soothe and use nature to calm themselves.**



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# Autonomy and choice: what next?

Patient levels of personal control, autonomy and privacy can be affected by coercive practices and via the restrictive properties of the built environment (Evans, 2003; Hoekestra et al., 2004). In general, being able to regulate one's social interactions and physical spatial relationships through the influence of design-based features has been found to result in patient and staff satisfaction and in a reduction of aggression within psychiatric units (Ulrich et al., 2018; Van der Schaaf 2013; Jenkins et al 2022).

Seclusion might be viewed as the ultimate removal of autonomy and choice and yet the picture can be complex (Hoekestra et al., 2004; Newton-howes, 2013). Certain authors have argued that less restrictive approaches should only be used in treatment to enhance recovery (Davidson, 2005). However, others note that seclusion is 'beneficial' to patients at times, especially when it is voluntary' or is listed in a prior agreed care plan with the patient (Van Dorp et al., 2021; Vrunwink et al., 2022). Nonetheless, promoting greater autonomy within seclusion spaces and in consultation with patients is possible, benefitting patients and staff alike.

## Design considerations

Jenkins and colleagues (2014) investigated multiple design improvements on levels of aggression within an NHS psychiatric intensive care unit, citing the importance of increasing patient space and social autonomy. Within the unit, they found increasing privacy and providing greater access to alternative communal rooms reduced levels of aggression.

When focussing on improving seclusion, Hertfordshire University Trust (2019) identified a lack of national standards, guidance, and evidence for the design of seclusion within the UK, and certain NHS trusts have started to assemble a standard design of seclusion that would be robust, therapeutic and safe in the long-term. Accounting for the safety and utility of the room, attention was given to the robustness of furniture such as heavy doors, reinforced windows, and stainable walls – factors considered to be within the normal design of seclusion. However, additional consideration was given to the social autonomy of the patient, with access to fenced seclusion garden space, a lounge area, bedroom and a choice of activities.

Cornella and colleagues (2021) explored patient experiences of seclusion in an 'enriched' seclusion room versus a regular seclusion room. The enriched seclusion room contained audio visual facilities, self-service to adjust lights etc., with the distractive element appreciated. Unfortunately, seclusion was still described by both groups as a very negative experience, rendering further investigation necessary.

> *"I surveyed the white walls, the single simple mattress, the lack of any stimuli whatsoever and quickly decided it was horrific. Anyone with a mad choking dark brain would have no distractions from their splintering mind."*
>
> David Parkin - author, theatre maker, musician and installation artist

**Patient experiences of seclusion may be enriched through increasing autonomy, enabling navigation between spaces, albeit limited, and an engagement in meaningful activity (Konito et al., 2012). The design of seclusion requires navigation away from the idea of the 'room' towards the concept of multiple but limited 'zones/spaces' when in seclusion. Additional thought may need to be provided as to the observational points of multiple spaces. However, if a patient was able to move into a garden area or sensory space within seclusion, this may enhance a sense of autonomy and a capacity to self-soothe and emotionally regulate in empowering and autonomous ways.**



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**Design in Mental Health Network**
www.dimhn.org
Paula Reavey, Steven Brown, Isobel Thomas, 2023

Published by the Design in Mental Health Network, May 2023

Printed by London South Bank University

Design and illustration by Lex Johan
Set in 8/10pt Akkurat

**Picture credits**
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**For citations**
Reavey, P., Brown, S. D., Thomas, I. (2023).
*Design with People in Mind: the Seclusion Issue*,
Design in Mental Health Network.



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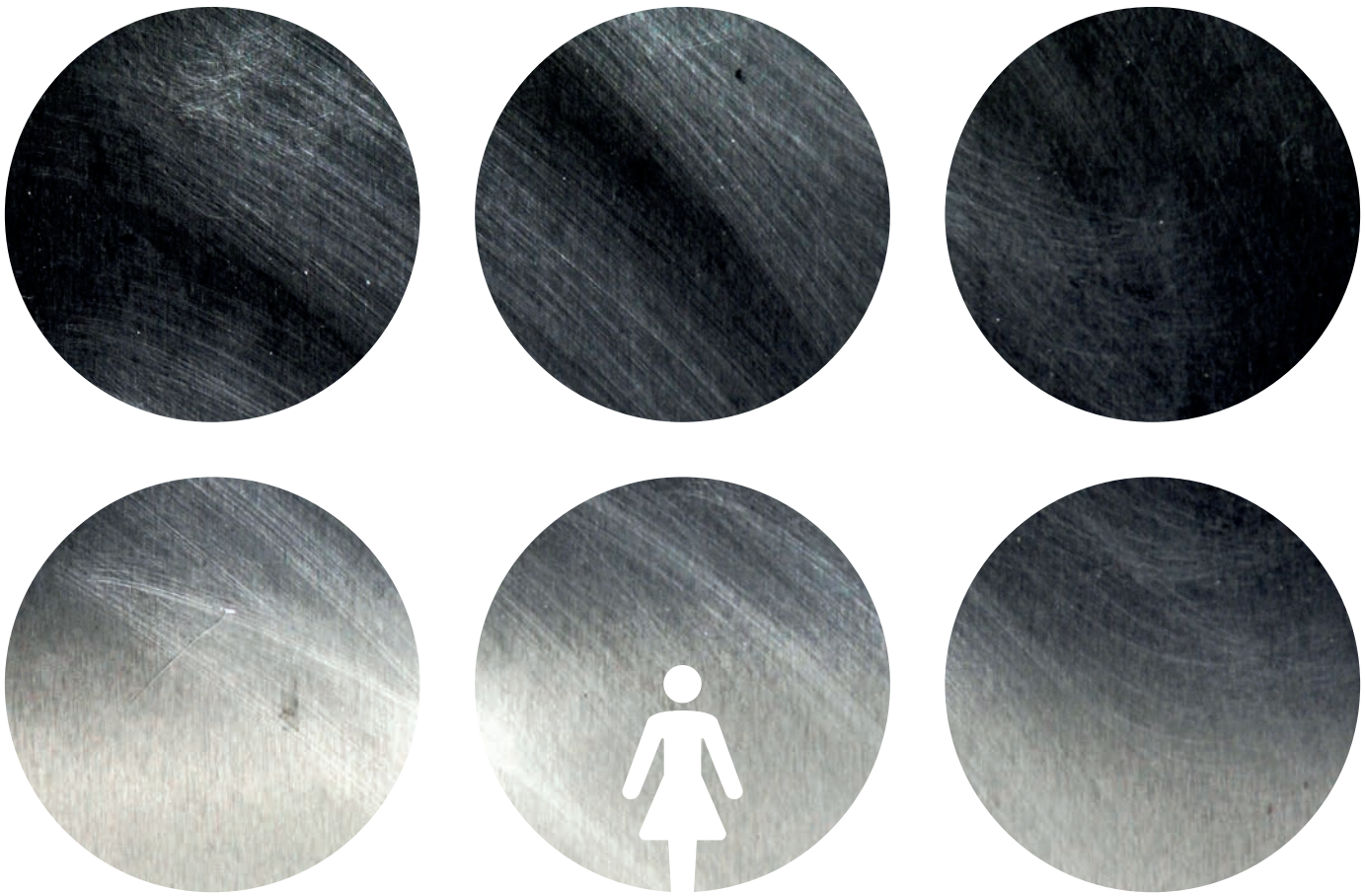

08 No 8 in a series of booklets, published by the Design in Mental Health Network, 2023

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