| **Seclusion Policy Practice Guidance Note**<br>**Use of music in seclusion - V02** | | |
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## 1 Introduction

1.1 "Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others." (Department of Health (2015), Mental Health Act 1983; Code of Practice, paragraph 26.103). The room is designed to be as vandal proof as possible in order to provide a safe space in which to contain someone who is severely disturbed. By its nature and design the area is low stimulus; it is usually located in a quiet area of the ward and has plain walls. Natural light is available but windows are often too high to provide a view.

1.2 Individuals have preferred sensorimotor experiences which help them function optimally within their usual environments. A low stimulus environment can be helpful when using de-escalation techniques as sometimes extra visual/tactile/auditory input can be distracting and overwhelming to some individuals. Others can struggle with reduced input and appear to have difficulty calming when in seclusion. In these instances the clinical team could consider adding some auditory input such as music or relaxing sounds. It is important to draw on knowledge of the individual and their optimal sensory input rather than make assumptions that what is calming for one person is calming for all (Brown and Dunn, 2002, Champagne and Stromberg, 2004, Champagne, 2011, Tschacher, 1995).

1.3 Listening to music of your own choice is a commonly used strategy for relaxation, managing voices and keeping arousal levels to the optimum levels. Research suggests it can have a positive effect on patients' mental state (McCaffrey, Edwards and Fannon, 2011; Smith and Jones, 2014). In turn this could lead to a quicker termination of seclusion and reintegration onto the ward.

1.4 Some seclusion suites have been installed with a sound system that can link into various music devices and is controlled by the observing member of staff. These guidelines should inform when and how this facility is used.

1.5 In seclusion suites where a sound system is not present there may be an option to play music through an appropriate intercom. Use of the intercom in this way should also be informed by this guidance note.

## 2 Procedure / Process / Guidelines

2.1 In the first instance seclusion should be used as a low stimulus environment as per usual practice. Use of music should be considered when:

- the service user remains acutely disturbed and it appears that low stimulus is having no effect or a negative effect
- the service user is engaging in unhelpful or antisocial behaviours as an apparent result of lack of stimulus
- use of music has previously been found to be a useful method to promote de-escalation with that service user
- it is part of their individual advanced plan or current care plan

2.2 The care team should give consideration to the use of music in the above instances, drawing on knowledge gained from assessments and existing care plans. Care needs to be taken when working with individuals with sensory processing issues. Where there are identified or possible sensory issues then the clinical discussion should include a clinician with training to Sensory Integration module 1 or above.

2.3 If it is decided that music should be introduced then a care plan should be written to support this if one is not already in place.

2.4 The music played should be the choice of the service user. If they are not able to articulate a choice at that time then staff should use their prior knowledge of the service user's preferences or carers/family members could be contacted to find out what music the service user likes to listen to and, in particular, what they find relaxing. If the service user's choice of music is not readily available then a list of what is available to choose from should be communicated in an appropriate manner. If the music choice is not felt to be appropriate by the clinical team (e.g. not age appropriate, or offensive lyrics) then alternative choices can be offered.

2.5 A phone would not normally be used as the music device. This could lead to interruptions from calls, messages or alerts.

2.6 The service user should be asked if they want the music on at that time using communication methods appropriate to their needs. If they are unable to answer then close attention must be paid to their response to the music to determine if they are finding it helpful or invasive.

2.7 If the service user becomes over stimulated in response to the music, it should be changed or switched off as appropriate.

2.8 When music is used it should be included in the seclusion record of observation along with the description of the service user's presentation at that time. This can be reviewed by the clinical team to evaluate the effectiveness of the intervention to inform future care.

2.9 Music should normally be switched off during seclusion reviews to allow the service user and staff to concentrate on the discussion. There may be exceptional circumstances where this is thought to be counter therapeutic in which case the decision lies with the clinician leading the review.

2.10 Offers of music should not be used as incentives or removed as punishment. The use of the music is to meet the optimum level of sensory stimulation for the service user in seclusion and should only be offered or withdrawn based on its therapeutic value at that time.

2.11 Once seclusion is terminated, the service user should be asked for feedback on the intervention. Where use of music has been helpful, there should be the opportunity to build it into part of an advanced plan for de-escalation to help avoid further use of seclusion.

## 3 References

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