SECLUSION

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This paper deals with the issue and the practice of "**Seclusion**", and its alternatives in our dealings and treatment of the severely disturbed and violent psychiatric patient. The terminology of seclusion at Mt Carmel Hospital is Single Room. This refers to the purposely built rooms for solitary confinement as still considered necessary today in various male and female wards.

Incidentally we still meet people today who ask us if we still use the rubber rooms. It is interesting to note that the one on the male side received a direct hit in the 2nd World War and was never built again. The female one has been out of use for about 25 years, was dismantled about 15 years ago and its door is the Mount Carmel Hospital Museum.

The United Kingdom Department of Health (1) defines seclusion as "The supervised confinement of a patient alone in a room which may be locked for the protection of others from significant harm". Some additions, though, can be put to this definition.

First is that it is the **Temporary** supervised confinement and

Second is that it is also used for the protection of **self** from significant harm. Such as when the patient is threatening to smash himself through glass or when the patient asks for it himself in order to decrease sensory input, overstimulation and interactions.

Third point is that seclusion is also used to protect **property**, such as when a patient is threatening to break the television, water taps etc.

So the best definition of seclusion, in our opinion is that:

"SECLUSION IS THE SUPERVISED TEMPORARY CONFINEMENT IN A ROOM WHICH MAY BE LOCKED FOR THE PROTECTION OF SELF AND OTHERS FROM SIGNIFICANT HARM AND TO AVOID DESTRUCTION OF PROPERTY".

Although the practice of seclusion in prisons is considered justified by the law and the general public, it horrifies some lay and professional people when informed of its use. The reason, we believe, is that a clear cut, black or white distinction is made between people living outside and people living inside the hospital. This believe is that all people outside the hospital are fully responsible of their actions and act with intent, while all the people inside the hospital are totally unaware and cannot take responsibility of their actions. As we all know reality is that there are various shades to this colour picture and some patients can actually act also out of malice.

Some background to seclusion

In the U.K. the Lunatic Asylum Act of 1842 tried to transform the madhouse into a hospital. It was felt, on medical grounds, that restraint provoked the very condition it sought to control and aggravated and stimulated disruptive behaviour.

Studies by Hill and Conolly, two prominent psychiatric reformers of the 19th century, noted the improvement in behaviours of patients when a policy of non-restraint was implemented. Conolly asserted that the successful implementation of the 'moral treatment' required the total abolition of physical restraint (2). He also condemned the use of instrumental restraint, such as restraining chairs and chains as treatment. The proponents of non-restraint did not, however, altogether abandon security in the name of 'moral treatment'. They transformed their solitary confinement cells into modern seclusion rooms and emergency treatment units for disruptive behaviour.

In Scotland, the Commissioners' report of 1988 described the virtual disappearance of seclusion from mental illness hospitals, with the exception of secure hospitals (3). Regional secure units in England now deal with the small percentage of National Health Service patients who present with difficult and challenging behaviour.

In 1992, the U.K. Department of Health published the Report of the Committee of Inquiry into Complaints about the Ashworth Hospital. It recommended the phasing-out and the ultimate ending of seclusion at Ashworth Hospital. The response by the Special Hospital Service Authority (SHSA) was that, although it intends to reduce the use of seclusion to a minimum, it was unable to support its total abolition (4).

What constitutes a behaviour problem?

Professionals should recognise that behaviour which may seem odd or irrational at a given time needs to be seen in the context of events over a longer period of time. Behaviour should therefore not be categorized as disturbed without taking into acount the circumstances surrounding it. The type of behaviour which is likely to cause problems professionally on the wards includes:

- (a) prolonged verbal abuse and threatening behaviour towards other patients or staff,
- (b) destructive behaviour on property,
- (c) self-injurious behaviour and
- (d) physical attacks on others

Possible causes of disturbed behaviour

Professionals should also be aware that disturbed behaviour is often a characteristic of discontent or conflict with social, environmental or psychological circumstances and is rarely driven by malice alone. There may be a number of reasons for disturbed behaviour. These may be due to problems created by the staff, the environment or the patient himself.

Due to Staff:

- not involving the patient in treatment planning
- lack of information or wrong or lack of communication with the patient
- abuse of authority by the staff involved or ignoring patients rights
- lack of responsibility, accountability and knowledge and skills by the staff involved
- negative or wrong attitudes of staff. E.g. patients not tolerated
- shortage of staff
- inexperienced and untrained staff
- wrong or insufficient usage of medication
- not generally meeting the patient's reasonable needs for food, clothing and comfort

Due to Environment:

- Overcrowding, lack of privacy and quiet places
- too much stimulation, noise and general disruption
- an unsuitable mix of patients
- antagonism and aggression on the part of others
- boredom and lack of environmental stimulation

Due to the patient himself:

- when medication is contraindicated as in the Neuroleptic Malignant Syndrome
- mental illness, personality disorder and mental impairment
- inappropriately expressed needs for attention by the patient

How can Seclusion be prevented?

Adequate staffing levels, training in the management of disturbed behaviour and ensuring individual patient care plans will go a long way to preventing behaviour problems. Staff will be able to anticipate potential difficulties much more easily if they are involved with the patient at the earliest opportunity, preferably prior to admission. Only by getting to know and understand patients and gaining their confidence will staff be able to improve their own professional knowledge and competence. In fact the latest trend in psychiatric nursing care in the U.K. is to have the community psychiatric nurses based on the wards where they also work with the same patients they see in the community.

General preventive measures include keeping the patients fully informed of what is happening and why, recognising their individual rights and ensuring that patients' suggestions or complaints are dealt with fairly and promptly. Each patient should be given a defined personal space with a convenient secure place for the safekeeping of his possessions. The care environment should include quiet rooms, recreation and visiting rooms. Patients should be given individual activities according to need as well as structured activities with suitable trained staff. The staff should be trained in the prevention and management of disturbed behaviour. The mixture of the types of patients put together should be constantly monitored and also all the individual programmes. Enough fresh air, open space, comfort and access to some use of the telephone should be provided.

Some facts and trends of seclusion

Most of the studies on seclusion published indicate that its use is ineffective. In one hospital alone, the Bedford Veterans Administration Hospital, in 1952, seclusion hours were reduced from 2,900 hours in February down to 28 hours in November (Chalk). And this was long before the widespread use of psychotropic drugs(5) Staff numbers and the level of experience of the nurse in charge(6), the absence of clear policies of some units(7) and low medication policies(8) have all been linked with higher seclusion rates. The duration of seclusion also appears to vary from one study to another, but there appears to be broad agreement about the type of patient most likely to be secluded. This is the young psychotic male patient(7, 9, 10, 11, 12). Violence and disruptive behaviour appears to be the most common reason for secluding patients.

Conditions of seclusion

The European Commission on Human Rights states that the room must have adequate heating (and in our case in Malta, coolness in Summer), lightening, ventilation and seating,. Seclusion should take place in a safe room, where the patient cannot harm her/himself accidentally or intentionally. It is a matter of judgement what the patient is allowed to take into the room, but he or she must always be clothed. The room must offer complete observation from outside, whilst ensuring privacy from other patients. There should be no flying insects like mosquitoes and flies or crawling insects like bugs and cockroaches.

At night the room should be quiet and dim enough to encourage sleep and yet allow full observation by staff. Personal hygiene and toilet facilities should be offered together with a fresh change of clean clothing. The time spent inside the room should be the minimum possible and if patient's condition allow, short walks in the corridor to stretch his or her legs should be considered, also in view of testing his/her condition.

The door of the room should open outwards and from the outside, only in such a way that it can be opened quickly in case of need. Food and drinks should be offered frequently. Magazines and playing cards should also be allowed if requested. The patient is talked to and given his due importance while doing continuous evaluation of his condition. If patient soils the room, it should be changed for a clean one. When the patient improves, he should be let out in stages and bargaining may be considered.

Helpful advise as to what he should avoid is given to create boundaries of behaviour. The patient is encouraged to control himself as much as possible and make the right decisions, informing him/her of what is happening and why.

The Procedure of Seclusion

After the nurse in charge checks the room for safety (such as any electric outlets) and the correct temperature. This is in view of the administration of neuroleptic drugs. The person may be offered personal reading material to offer an alternative for destructive or disorganized behaviour. Extra staff may be readily available if the patient is considered dangerous. In this case the number of nurses available on the ward should not be less than eight. Two of these will need to take care of the other patients. The medical records of the patient are consulted to assure that the patient is certified and that all forms are filled correctly. The duty doctor and Senior Nursing Officer (SNO) may be called to the scene. Any pescribed intramuscular medication may also be prepared now.

The nurse in charge briefs the staff generally on what is to be done. This preparation is done away from the clinical area so that the nursing team is united and decisive when it is time to act. The team is informed about who the patient is, who the ward staff are and who has been brought in to help and the risks are also explained. The staff is invited to remove personal jewellery, badges and pens to prevent injury to the patient and to themselves.

The nurse in charge assigns to four of the nurses the task of immobilizing the patient by taking control of his or her limbs in case the patient does not consent to seclusion. Each nurse should know which limb he is to immobilize beforehand. Some equipment may be needed such as a mattress in case the patient has a knife, blankets to immobilize him and pillows to protect the patient if he is on the floor. Which room is to be used and the whereabouts of the patient are given. Any other information about possible dangers such as an HIV infected patient is given.

The other patients should be protected from any harm and the nurse in charge explains what words he will say when the order to hold the patient is given. The patient is asked to desist from any dangerous or violent behaviour and he is offered a last chance to take control of his/her behaviour.

If the patient refuses to consent to seclusion, the nurse in charge gives the prearranged command and the team moves quickly to either side and immobilizes the patient as planned. Depending where the patient is, this might be on the floor, in a chair or on a bed. This in order to prevent further violence or injury to the patient which would result from a prolonged struggle.

The patient is then carried to the room in a secure manner and if an injection is to be given he should be partially undressed and searched at the same time for any dangerous objects. The staff may need to keep holding the patient down for some time until he calms down enough and will be considered safe to let go. Psychotic patients are especially vulnerable to being suddenly released after being immobilized and may become violent again. One nurse may be scheduled to hold the patient's hands from outside the room's window in order to allow the staff to leave the room safely.

Afterwards a brief evaluation should be carried out. Any valuables found will also need to be entered into the hospital safe through the normal procedures.

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