POSITION STATEMENT PAPER ON SECLUSION USAGE AMONG AGGRESSIVE PATIENTS

Qusai Mohammed Harahsheh

Correspondence:
Qusai Mohammed Harahsheh
School of Nursing
The Hashemite University
Email: Qusaimohad@yahoo.com

Abstract

Every challenge in this world should be managed by appropriate ways to maintain the balance of life. These ways should be prioritized according to the nature of the challenge; medication and therapy used to treat mentally ill patients, and at the same time seclusion is the last choice to control the aggressive behaviours among those patients. But if seclusion is chosen, the health care providers should follow special rules before, during and after implementation.

Key words: **Seclusion, Aggressive, patient**

Introduction

In our world there are many problems, diseases, and tragedies. There are wars, stressors, difficulties, responsibilities and tasks, all of them may result in mental disorders within people, as a circle of destructive behaviours images.

On the other hand, there are many solutions, medications, methods, techniques and good people which help in maintaining the balance in this life.

In general, mental illnesses are inability to cope with different stressors which are developed by the environment, both internally or externally. This failure of coping is reflected as incongruent feelings, thoughts and behaviours against norms which are used locally or culturally. At the same time this maladaption interferes with people's function socially, physically and occupationally (Townsend, 2006).

Moreover there are many methods used to control the destructive behaviours. One of the most important methods is seclusion. Seclusion is defined as involuntary or voluntary isolation of patients in a specific room. This room is called a seclusion room. It has many characteristics focusing on a non-stimulating place, It must be locked, supervised via a window and contain safety measurements as a whole (Health Care Commission 2008).

Furthermore seclusion is considered as one of the most important measurements used in close units for mental health patients as a result of aggressive behaviours which may affect health care providers, other patients in the unit and the patient themself. (Happell & Harrow, 2010).

The number of seclusion episodes varied from 3.7 - 110/1000 in patient/days in the USA and the Netherlands and 1.3 - 1517/1000 patient/days in Australia, Belgium (Janssen et al., 2008).

The Mental Health Commission defined seclusion as a place that has a locked door designed in a way which prevented patients from going outside; this person was to stay in this room alone and all the time.

In 1839 the British psychiatrist John Connolly advocated to eliminate seclusion from treatment (Colonize, 2005).

Many centuries previously, seclusion was used as an essential element of treating the acute mentally ill patient. It was used in 1950 when psychotropic agents failed to control aggressive behaviours of patients (Guthrie, 1978).

Furthermore the position statement defined it as a critical issue, with highly commitment to it according to the judgment of professionals and it resulted in best and safe practice. At the same time it described the important conditions, how staff worked with these conditions, which procedures must be used and how staff must apply procedures by specific strategies to implement it in the correct and safe way (Vollmer et al., 2011).

The purpose of this position statement paper is to clarify use of seclusion for mentally ill patients in psychiatric settings, and identify seclusion procedures used by psychiatric nurses in daily practice.

The current author outlines this paper as following; introduction of literature review which is divided into opponent and proponent studies, summary and conclusion of literature,

followed by a position statement which concludes with specific concerns and recommendations related to seclusion and finally a summary and conclusion of the position statement followed by acknowledgment and references.

Literature Review

Introduction

This literature review will explain and clarify the usage of seclusion, effects and reasons of usage among mentally ill patients in the psychiatric settings, and describe the opponent and proponent studies. The author used many online databases such as Science direct, biomed and PubMed, and found a huge number of articles related to seclusion, most of them against seclusion and others in defence of using it among psychiatric patients.

Opponent Studies

During searching in different databases the author found that most articles against the usage of seclusion among psychiatric or mentally ill patients. Many studies concluded that using seclusion is still a large ethical dilemma because it is acting against patient autonomy (Prinsen & Van Delden, 2009); at the same time using seclusion is considered as distractive of patient rights to make personal decisions or choose the preferred way of treatment (FinLex, 2009).

Furthermore people may look at seclusion from a human and ethical dimension; on this point the International Recommendations didn't consider seclusion as a treatment or therapy, and the use of seclusion must be just as an emergency measure and the specialist must use it carefully, on the other hand some studies show that some patients considered seclusion as unnecessary, extra intervention and sometimes it may not have any benefits for them (Soininen et al, 2013).

At the same time seclusion may cause emotional trauma and distress for patients and staff (Frueh et al., 2005), moreover nursing and medical ethics working together must respect the dignity and the autonomy of the patient by providing choices, not by paternalistic practice (Holmes et al., 2004), and staff in the psychiatric field must not seclude any patient.

On the other hand the basic element in the therapeutic relationship between staff and psychiatric patient is trust, so how can patients trust any person who restricts them in a closed room and restricts their autonomy; from this dimension seclusion is not preferable in the psychiatric setting (Soininen et al., 2013).

Although seclusion is considered as a safety measuret which prevents trauma or injury and is an agitation reducing measure, the practice still lacks the effectiveness and safety for use in this intervention (Bergk et al., 2011). There is not enough evidence about the effectiveness of seclusion and there is no marked in decrease in the distractive or aggression behaviours by seclusion among serious mentally ill patients (Sailas E et al., 2000).

Now, to decrease seclusion use the new science focuses on the alternative measures to reduce using of seclusion in psychiatric settings, but there is insufficient implementation of these measures (Gaskin C et al., 2007) To be more focused on this point it is important to know that use of support, active listening, good communication between staff and psychiatric patient will decrease the seclusion usage to 73% among child units and 47% among adolescents in a psychiatric unit.

Furthermore (Smith et al., 2005), suggest using the psychiatric emergency response team in stressful situations and crises in psychiatric settings. This team is trained, educated, have a therapeutic way of communication and have de-escalating techniques skills. The suggestion is to involve this team to work effectively with aggressive and violent patients without use of seclusion.

Moreover, Scanlan (2009) concluded that providing training strategies during crisis situations, such as de-escalating measures and non-violent interventions are an essential element to decrease using seclusion in any psychiatric unit.

On the other hand Stewart et al, 2010 suggest that use of medication such as atypical antipsychotics play an effective role to decrease use of seclusion.

Regarding quality of life, medical science patient satisfaction and patient quality of life during and after hospitalization the new science starts to apply the concordance term in hospitals which means involve patients in the decision making process to choose the treatment method and take patient opinion before any intervention like seclusion (WHO, 2008).

Furthermore seclusion may act negatively on the caring process; there are many traumas and harmful results for both staff and patients, that have occurred during seclusion interventions (Frueh et al., 2005).

The current author obtained a policy about seclusion from King Abdullah University Hospital, developed in 2013. This policy concluded with a specific concern and recommendation for seclusion. It aimed to provide specific guidelines related to therapeutic use of seclusion for psychiatric patients in any psychiatric setting.

Proponent's Studies

During the searching process the author found a few studies affirming use of seclusion in psychiatric units These articles focused on the time, duration, and goal of using seclusion among psychiatric patients.

The international recommendation considered seclusion as an emergency measure provided to prevent any incidence of violence or injuries for staff and patient. This was from a legal dimension, but not from a humanity dimension. Seclusion may not affect any patient quality of life, but the negative mode is it may decrease the patient's quality of life (Soininen et al., 2013).

(Schreiner et al., 2004) conclude that to keep patients and staff safe at the psychiatric unit, seclusion must be used, and this use depends on empirical knowledge; at the same time if the decision is taken to put any patient in seclusion room it's must depend on objective behaviours.

It is important to know that 33% - 62% of seclusion incidences occurred as a result of actual threatening violence (El-Badri &Mellsop, 2002). For this reason seclusion is used just in an emergency situation (Tardiff & Lion, 2008). Furthermore many countries use seclusion for management of disruptive, aggressive, violent behaviours enacted by psychiatric patients, and this management is considered as the last choice and aimed to protect patient, staff, and other workers' safety (Hoyer G et al., 2002).

Many studies focused on the reason for using seclusion. Some of them concluded that seclusion may be use when a patient developed disorientation or aggression without violent signs or threatening others as a prophylactic measure among psychiatric or mentally ill patients (Kaltia et al., 2003).

Moreover the use of seclusion is accepted when a patient developed aggressive behaviours (Poulsen H et al., 2002).

At the same time, the (MHC, 2011) suggests using seclusion became the cause of 20% psychiatric nurse loss in many areas within the last year as a result of aggressive behaviours and shortage of staff.

On the other hand (O'Hagen et al., 2007) shows agreement with seclusion intervention for an immediate debriefing technique but it must be followed by formal incident of debriefing intervention.

Summary and Conclusion

On review of the literature studies the highest number of studies in this literature were against use of seclusion among psychiatric patients. A few studies defended use seclusion because of safety for patient and staff; in general seclusion usage is still an ethical dilemma.

On one hand patients have right of autonomy, safety, and self-determining. Seclusion contravenes all of their rights. Studies have shown that seclusion cannot solve the problem completely and health care providers can use other measurements such as medication, communication skills, and decreasing this technique. This measurement is to protect patient rights and enhance patient quality of life.

On the other hand, a few studies defend the use of seclusion because of it protects staff and patients from aggressive behaviours and violence which are developed by psychiatric patients who have disorientation and aggression signs.

Finally the new science is focused on providing training and courses for staff who are working in the psychiatric field to enhance their ability to use other measurements with psychiatric patients, especially with aggressive and violent patients, to decrease seclusion usage in psychiatric settings.

Position Statement

The current author strongly agrees with using seclusion procedure for psychiatric patients just in highly stressful situations to protect patients and staff and the medical global message is to enhance patient quality of life and prevent harm during and after hospitalization especially when in the psychiatric field we have many other choices rather than seclusion, such as medication, communication skills, verbal-de-escalating technique and many other methods.

The author has developed this position statement with policy developed by King Abdullah University Hospital. This position statement summarizes specific concerns and recommendations for seclusion usage, that must be applied by all health care providers and especially in psychiatric settings.

The following list of major concerns and recommendations:

- Try restrictive practice (Seclusion) as a last choice for safety precaution and to prevent harm.
- Educate all health care providers especially psychiatric nurses about communication skills and de-escalating technique.
- Provide pharmacological courses for psychiatric patients focused on atypical antipsychotic medication to use it for patients rather than seclusion.
- Educate staff on how to develop a trusting relationship with psychiatric patients.
- Develop a special team in every psychiatric setting such as psychiatric emergency response team characterized by the ability to communicate on therapeutic ways and effectively with aggressive patients. Manage the stressful situations without any physical activity, highly trained in verbal de-escalating technique, Ability to work effectively with aggressive and violent patients.
- Start applying the concordance term in psychiatric settings.
- Solve the shortage of staff in psychiatric settings by enhancing the job satisfaction for them, especially salary and working hours issues.
- Provide courses related to signs of agitation and aggressive behaviours of patients to take the correct precautions from the health care providers.
- Human being rights and patient dignity should be protected by nurses all the time, especially during seclusion.
- The seclusion room should be used after an assessment of the needs of the patient and staff.
- Acceptable reasons for seclusion :

(1) To prevent physical injury.

(2) To decrease stimulation for the patient.

(3) To prevent major damage to the unit.

- Nursing note must be written every two hours, date, time of violence and any destructive behaviours from patient and any order taken from the doctor.
- Continuous monitoring and observation should be done by staff after any violent behaviour.
- Medication meals, fluids must be given to patient carefully.
- Maintain personal hygiene twice daily and clothing if needed, toileting every two hours during day time and four hours during night time, if patient uncooperative use a bedpan.
- Educate nurses, unqualified personnel and family caregivers on the appropriate use of seclusion, and on the alternatives to these restrictive interventions.
- Assess patient status pre seclusion usage, talking with patient, going to other calm area, explore the problem and try to solve it before using seclusion.
- Ethical consideration to clarify when, where and how patients are to be secluded and monitored during seclusion.
- Seclusion needs doctor assessment before applying, then doctor order and charted in medical record date and time of seclusion
- If seclusion order obtained, charge nurse and nursing supervisor must be informed.
- If seclusion applied, family and care giver should be informed as soon as possible.
- Seclusion should be applied by a qualified staff nurse.
- Seclusion ends when a doctor orders it after assessing patient behaviour status and decide there is no dangerous behaviours toward self or others.

Summary and Conclusion

The purpose of this position statement paper was to clarify using of seclusion for mentally ill patient among the psychiatric settings, and identify seclusion procedures used by psychiatric nurses in daily practice.

Seclusion is considered as a last choice to control aggressive behaviour, to maintain a safe environment and prevent harm for patient themself, staff, and others, and other interventions must be used first; if medication and other techniques are not effective then seclusion can be used.

If seclusion is ordered for use, psychiatric nurses must implement the concerns and special considerations mentioned previously.

Despite seclusion affecting patient autonomy and contravening human rights, the main goal in the psychiatric setting as a priority is to enhance safety precautions and prevent harm of self and others and enhance quality of life.

As reviewed, literature studies found that most studies are against using seclusion and to reduce this practice and enhance patient quality of life by using another proper way to reduce and avoid seclusion.

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