EDITORIAL

Seclusion: What’s in a name?

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It was a comfort to walk into the Unit office within which the air conditioning unit was pumping instant relief from the blazing sunshine that had to be negotiated to reach the Psychiatric Intensive Care Unit (PICU).

The staff who greeted me seemed remarkably upbeat, unaffected by the Unit’s troubles and the fact that just outside the walls of PICU, there was an exceptionally inviting, warm and lazy summer afternoon. There was no need for me to explain my purpose in attending the Unit. Everyone already knew I was there to perform the Approved Clinician Review, required by the UK Mental Health Act Code of Practice (2015) for Vincent, a patient who had been in the Unit’s Extra Care Area (ECA) for nearly two weeks.

I was told there had been an assault yesterday during which a member of staff had been kicked. An account was given of while although Vincent was accepting all his medication, he was still experiencing almost perpetual agitation within the ECA. He was also having great difficulty achieving any coherent conversation with the staff. Other concerns included difficulties in encouraging him to take adequate fluids and come into the shade from the ECA garden area within which he appeared to enjoy lying under the punishing sunshine. Overall it was a worrying, although to me not surprising, description of how life had been for Vincent over the last 24 hours in the microworld of the PICU’s ECA.

As we made progress towards the ECA, I caught myself thinking about first meeting Vincent. My thoughts travelled back to the late 1980s, he was 17, and I was 23 years old. He had just been admitted to hospital experiencing his first episode of acute mania. I pondered my first impression of him as a highly intelligent, affable, charismatic and very determined young man. Characteristics that never abandoned him despite nearly 30 years of battling the attrition of his schizoaffective illness. Over the years, I had nursed him during many admissions to hospital. In the years since our first meeting, he had spent much time in inpatient services, including medium secure units. In the past, he had also spent time locked alone in seclusion rooms into which, at times, I had taken him. Equally, during less troubled times over the years we had spent hours playing chess together and chatting about all manner of things. We had laughed together many times. I remained confident in the strength of our long relationship.

As I chatted with the nurse accompanying me down the corridor towards the ECA, I was confident that I was successful in concealing from her the feeling of apprehension which also walked with me. This apprehension arose from the concern that my presence within the ECA would upset the delicate balance of support and interaction carefully cultivated by the two members of staff who had been with Vincent over the previous hours. I sought some comfort in the fact that I knew Vincent very well. In a way, we had grown up together.

As gently as I could, I tapped on the observation window
in the door of the ECA. Apparently instantly, the familiar face of one of the PICUs Health Care Assistants appeared in the window. With a reciprocated smile, the beep of the electronic door lock signalled that I could enter.

On entering the ECA, Vincent was engaged in an attempt at conversation with the staff member sat next to him, the theme of which was persuading him to remove his track suit jacket which he had zipped up to the top, despite the very warm weather. Looking up towards me, for a moment, he seemed unaware of my presence, almost looking through me. As the presence of someone new sank in, he sat up upright in his seat on the brown leather sofa, then gestured shooting in my direction with an imaginary rifle. As if to support the perceived fire power, a stream of confused obscenities also travelled in my direction. In that moment, I seem to have appeared to him as an anonymous outsider, the intentions of whom were unknown and to be feared.

My apprehension that the delicate atmosphere the ECA was indeed disturbed by my presence was diminished by the timely intervention of the female staff member sat next to him. Reaching out a warm hand to Vincent she told him not to worry and that I had only come to ensure that he was ok. Her words seemed to be precisely timed and toned, injecting the atmosphere with reassurance and calm and, in all probability, preventing the imaginary rifle fire turning into an all too real hand or foot travelling in my direction. I felt saddened that Vincent didn’t recognise me, the fog of his acute symptoms trapping him in an inner world, within which everything outside appeared ambiguous and to be distrusted.

In my mind at least, it was becoming clear that the use of the ECA would probably need to continue. The discussions that followed confirmed that all were agreed that Vincent needed to be separated from his peers in the PICU with the constant support of the staff. The risks to others were just too high. The use of the ECA was authorised for another 24 hours. During my return to the office to write up my review, I again found my thoughts back in the 1980s. I was struck by just how differently things would have been. Back then, my review would most likely have been conducted through a reinforced window from the other side of a locked seclusion room door.

Since the 2015 revision of the UK Mental Health Act Code of Practice, the use of the ECA described above requires monitoring and review consistent with that for traditional seclusion, which unlike the ECA, would have seen Vincent locked alone in a room. Across the world today, the use of seclusion involving locking patients alone in a room remains the focus of energetic debate.

Since the late 1790s when Phillipe Pinel demonstrated he could operate his asylum, the Becetre in Paris, without profound use of shackles, handcuffs and seclusion, the debate has raged on.

In the UK, the 1880s bore witness to an exchange of letters between the two Victorian reformist pioneers John Conolly and Daniel Tuke. During the exchange, it was argued that while overly relying on the seclusion room should be condemned, the other extreme of regarding the padded room as never useful, must equally be a very questionable position to take.

Where and when will this debate end and what is required to advance practice for this debate? My account of reviewing Vincent in the ECA, who was never separated from the staff by means of a locked door, is an alternative to traditional seclusion. This may mark the significant advance in seclusion practice, which for over a century has been so elusive.

It remains to be seen whether the revision of the UK Mental Health Act Code of Practice 2015, within which the scenario of the ECA now requires regulation identical to that of traditional seclusion, will be helpful in positively affecting practice. There are those who have argued that the use of the ECA, keeping patient and staff together without locking the patient alone in a room merely provides a disguise for seclusion. When the door is locked on the person alone inside it is clear what seclusion is and when it has begun; therefore, for the sake of clarity, this is what should be done. Many would passionately argue that this would be a retrograde step and keeping patients and staff together within an ECA during the course of the disturbed episode is superior to locking a patient alone in a room, regardless of the need to employ similar reviews and monitoring.

This issue of the Journal of Psychiatric Intensive Care contains two papers on seclusion (Kaar et al. 2017; Elzubeir & Dye, 2017). Elzubeir & Dye (2017) argue that if a patient is to be locked alone in a room, then specific goals for ending seclusion should be set with the patient in advance, and this will reduce the length of time spent in seclusion. Kaar et al. (2017) provide details on what a seclusion facility should look like in terms of physical characteristics, confirming that if patients are to be locked alone in a room, then careful consideration should be given to the environmental conditions within which this takes place.

Perhaps representing a significant step forward in the debate about the nature and regulation of seclusion, NAPICU (2016) published a position statement on the use of ECAs and traditional seclusion, encouraging greater use of the former as a direct alternative to the latter. We at the JPI would strongly encourage you to carefully review all of these publications.

In many services beyond the UK, the description of my review of Vincent in the ECA would not have been considered to be seclusion. A credible argument can be advanced that unless a patient is taken to a room, left alone inside with the door fixed, seclusion has not occurred. Can...
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Having a member of staff sat with a patient in a multi-roomed ECA for the total period of time during which the resolution of disturbance takes place be counted as seclusion? This requires us to reflect on the term ‘seclusion’, and ask what truly is in a name?

While it is undeniably important that episodes of ECA use and long-term segregation are robustly monitored and reviewed, for many in the UK it is disconcerting as well as confusing that this situation now has an identical definition to that of locking a person alone in a room.

For many, proclaiming that it is all the same is both inaccurate and unhelpful for advancing practice as we progress into the twenty-first century. While the use of the ECA approach requires similar regulation and review as traditional seclusion, it is not, and should not be, considered the same as locking a patient alone in a room.

Front line staff, patients, regulators and managers should unify in encouraging the locking of fewer people in seclusion rooms, with promotion of the use of the ECA as a direct alternative; even if the regulation framework is the same. The endless preoccupation with the word ‘seclusion’ driving some practitioners and regulators to overlook the advantages of keeping staff and patients together during the management of disturbance, needs to be re-dressed. I would contend that it is not the same, and in fact the use of the ECA presents a significant positive step forward. At the same time however, there should be an enthusiastic embracing of the need for more robust monitoring and regulation of the use of ECAs.

While the seclusion debate rages on, advancing practice can only be achieved with the input and enthusiasm of the clinical community joining with patients, in particularly those who have experienced seclusion and the ECA. If it were possible to reach back through the ages and invite Pinel, Conolly and Tuke to join us in today’s debate, it is surely our duty, to have something new to tell them.

The JPI and NAPICU are working hard to advance the debate and develop practice. If you have any comments or ideas we would be very pleased to hear from you.

Note

The case description in this paper is factual, names and some details have been changed for the purposes of anonymity.

References

