Seclusion across Mental Health and Disability

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There is a young man who we will call Gerry. He is a 23 year old man with a diagnosis of schizoaffective disorder, who has had several admissions to a mental health unit in another area and who has recently moved into a local boarding house. He uses a range of drugs on a semi-recreational basis, including amphetamines several times a week and cannabis and alcohol daily. Gerry and has been becoming more and more agitated over the past few weeks. Yesterday he visited his mother at home and assaulted her when she would not give him any money, pushing her to the ground and threatening her with his fist. He spent the night roaming around the boarding house and the streets, muttering loudly to himself, and was eventually picked up by the police and taken to the local emergency department. He was sedated, and transferred when medically stable to the mental health unit, where as the sedative wore off he has been difficult to contain.

Shouting and aggressive, he has roamed the high dependency unit, intimidating the other patients and threatening staff, and he has nearly got into several fights with another patient. On several occasions the nursing and medical staff have tried to listen to his concerns and talk him down, with no effect. He refused oral medication and threw the water at the nurse offering him the tablets. The staff members feel his behaviour is placing all of them and himself at risk. What are the options at this stage?

Where risks are significant and the person is not well known, is unpredictable and is actively aggressive, management is likely to involve some at least of these elements - restraint, compulsory medication, and seclusion. All of these have the potential to be controversial, but seclusion – which I will define later - is the primary focus of this presentation.

Young men with a history of psychosis who threaten violence to staff are the most-secluded group within the mental health system worldwide. However, the mental health system is not the only setting in which a person can be legally secluded in Victoria. What is the case in disability, or in dual diagnosis? What if Gerry had an intellectual disability in addition to his psychosis? What if his primary diagnosis was autism rather than psychosis?

Although seclusion is used widely in both mental health and disability services, most of the literature on the use of seclusion arises from the mental health sector, and little of this touches on persons with a disability, inside or outside the mental health system. Some studies tend to show that seclusion rates are higher within mental health for those with diagnoses of mental retardation, developmental disability and neurological impairment[1], and found that in mental health units, children with weak verbal skills and a high incidence of specific learning disabilities were more likely to be secluded[2].

In this context, with seclusion being increasingly seen within mental health as a failure of treatment rather than a therapeutic option, an examination of how this intervention is used in disability is overdue.

In mental health, seclusion seems to be used as an acute response to safety issues (real or perceived) and this is legislated for with varying degrees of completeness and complexity in the mental health acts of the States and Territories. Although seclusion is regulated variably in mental health across Australia, in disability it is hardly regulated at all. At the time of writing, the new Disability Act in Victoria is the first Australian legislative provision to regulate seclusion in the disability sector. The Commonwealth Disability Services Act 1986 makes no mention of seclusion, nor do the Disability Services Acts or Regulations of any of the other States of Territories. This lack of regulation leads directly to a lack of information on how often it is used, and where it is used; poor definitions across sectors have also hampered data gathering. Conversely the new legislation in Victoria is expected to result in information that will fill this void.

[1] Garrison (1984)
[2] Millstein (1990)

Definitions and Legislation

Definitions are, strangely, few and far between. Many US states do not define the terms 'seclusion' and 'restraint' in their legislation, and in a 1985 survey of US states, 19 of 36 had no statutory definition.

The UK has one standard definition in the Code of Practice of the *Mental Health Act 1983*. This also limits the use of this intervention to contain severely disturbed behaviour which is likely to cause harm to others, and each UK trust has a seclusion policy which accords with this. However, across Europe and the rest of the world there is a range of definitions and rationales.

In Australia, in the year 2000, the *Application of Rights Instrument to Australian Mental Health Legislation* by the Australian Health Ministers' Advisory Council found that most Australian states and territories were only in partial compliance with the *United Nations Principles for the Protection of and for the improvement of Mental Health Care.*

The main reason for poor compliance was the lack of appropriate criteria for seclusion, or the inclusion of additional criteria such as destruction of property. Additionally, the use of common criteria for seclusion and restraint was not always appropriate; for instance a criterion of medical treatment was felt to be understandable in the case of restraint, but not seclusion. Another problem was the use of separate registers for such procedures, without a requirement to include them in individual patient records, or at least make a cross-reference.

In the Victorian *Mental Health Act 1986*, seclusion is clearly defined and is only to be used in public mental health services, although emergency seclusion may be used in voluntary patients. Criteria include the prevention of absconding as well as immediate or imminent risk to the person or to others. Seclusion records are required to be sent to the Chief Psychiatrist.

Seclusion is not defined nor discussed in the New South Wales *Mental Health Act 1990*, although a policy directive defines seclusion and outlines a wide range of clinical reasons for its use including the disruptive effects of excessive internal stimuli and as part of a behaviour treatment program. This policy provides for the seclusion of informal patients with their advance consent. Clear directives are made regarding documentation in the patient's file as well as central reporting of all seclusion episodes.

The Queensland *Mental Health Act 2000* has a definition of seclusion with an odd exception, where 'the overnight confinement for security purposes of an involuntary patient in a high security unit' is not counted as seclusion[3]. Seclusion is only permitted for involuntary patients, and the reasons for seclusion are to protect the patient or other persons from imminent physical harm. Nothing is mentioned about documentation, and a report of seclusion is only required if the Director of Mental Health requests this.

In South Australia, the *Mental Health Act 1993* contains no reference to seclusion, and mention of seclusion was also absent from the April 2005 review of mental health legislation[4]. Despite this, the Policy EDM P6-02 *Restraint and Seclusion in Health Units (Including Mental Health Units)* from December 2002 defines seclusion but does not differentiate the criteria for seclusion from those for restraint. These include, as well as immediate or imminent risk to the person or others, the need for medical and nursing procedures, the need for medical treatment, the destruction of property and the risk of absconding. The policy is intended to apply to voluntary as well as involuntary patients. Reporting and documentation are well covered; but this policy does not have the force of legislation.

West Australia's *Mental Health Act 1996* defines seclusion and rules that seclusion is only permitted in an authorised hospital. It is not clear whether these provisions apply to voluntary as well as involuntary patients. No direction is given in the Act about reasons for the use of seclusion, and although records of each authorisation of seclusion are to be kept 'as specified in the regulations', no regulation about this could be found.

The Northern Territory *Mental Health and Related Services Act 2004* incorporates a definition of seclusion and permits its use for voluntary as well as involuntary patients; however a voluntary patient must be kept in seclusion for no more than 12 hours. The reasons for seclusion are identical to those for restraint, and include the need for medical treatment and the destruction of property as well as to prevent the person from

[3] Queensland Health *Mental Health Act 2000* Resource Guide, section 8.6.3

[4] *Paving The Way*, Review of Mental Health Legislation in South Australia, Report, April 2005

causing injury. Documentation is required to be kept in the patient's file, and to be inspected by a community visitor at least every 6 months.

The Australian Capital Territory legislation *Mental Health (Treatment and Care) Act 1994* contains no definition of seclusion, however specifies reasons for its use (to prevent harm to the patient or to others) and requires documentation in the patient's file, notification of the community advocate and maintenance of a register. Seclusion is only to be used under this legislation if the person is involuntary. Unusually, the administrative document *Psychiatric Services Unit Policy S:1* provides for the use of seclusion in a community care facility.

Tasmanian legislation allows the use of seclusion in the *Mental Health Act 1996*, specifying that this may be used 'for the protection of the patient or other persons with whom the patient would otherwise be in contact.' It defines seclusion and restricts its use to involuntary patients, in approved hospitals. Documentation is not specifically covered, however all incidences of seclusion are to be reported to the Mental Health Tribunal.

Reasons for seclusion:
In addition to the lack of consistency around definition, it is commonly reported that rates, duration and methods of seclusion vary significantly, as do reasons for seclusion (Busch *et al.,* 2000), and the associations between seclusion and other interventions such as chemical or mechanical restraint, one-on-one nursing or locked wards. The Pennsylvania Office of Mental Health and Substance Abuse, in its report on seclusions based on data collected from 1985 to 1990, found that almost half of the justifications for seclusion had nothing to do with behaviour posing an imminent threat of danger to the patient or others, rather reflecting the attitudes of the hospital culture. This contention is also supported by Fisher (1994).

The most common reason given for the decision to seclude was:

- Prevention or management of actual or imminent violence (also the only reason endorsed by the *United Nations Principles).*

Others included:

- Reduction of environmental stimuli, avoiding exacerbation of agitation or frustration,.
- Reinforcement of coping skills,
- Aid to cognitive processes secondary to a low-stimulus environment,
- Reinforcement of need for compliance and conformity (can be viewed as punitive),
- Protection of the therapeutic milieu.

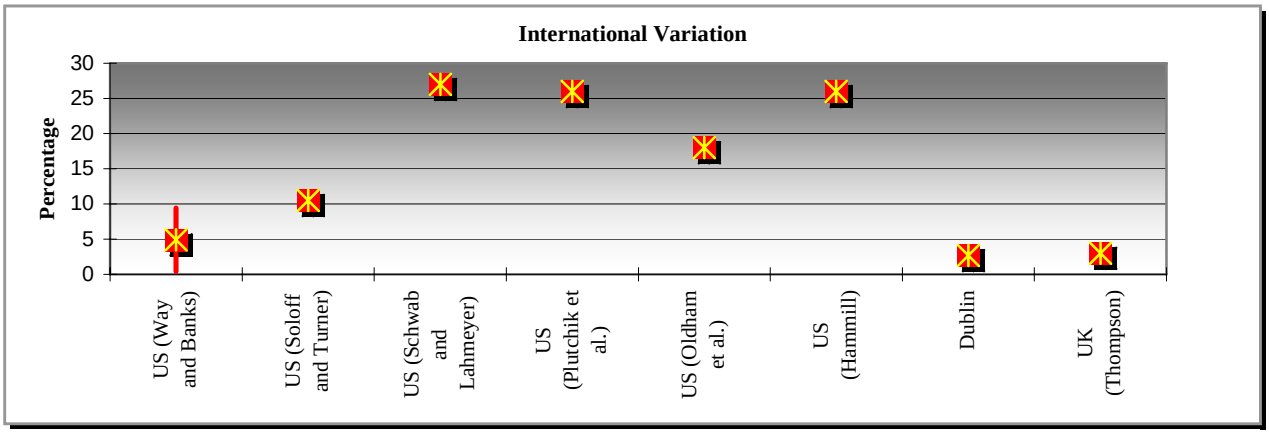
Many studies examined variations in seclusion use with particular characteristics of the individual patient (age, gender, country of birth, length of stay and diagnosis), and these have frequently yielded contradictory results. External factors such as the nature and staffing of a service, the physical environment and the ward culture are thought to also play a role, as are temporal variables. Robust findings associated with an increased incidence of seclusion include a younger age of the person, male gender, severity of illness, psychosis (schizophrenia and BPAD), dual diagnosis, involuntary status, staff attitudes, level of staff training and numbers, forensic settings, and the early phase of admission.

Outcomes:
There is some evidence that the use of seclusion may reduce both violence and injury to patients and staff, and that in some situations there are no other effective interventions available. However negative physical outcomes can be serious or fatal.
The more positive views on the psychological outcomes of seclusion were found in theoretical papers or from staff interview studies, whereas data gained from patient interview sources tends to emphasise the traumatic effects of seclusion. These studies raise the issues of whether seclusion re-traumatises the patient at their most vulnerable, whether this damages the therapeutic alliance, and, if so, whether this can be justified.

Incidence and Duration:
The Australian Council on Healthcare Standards (ACHS) collects data submitted voluntarily by health care organisations (HCOs). Victoria, had an overall seclusion rate of 14.85% of admissions in 1999, and an overall seclusion rate of 14.4% of admissions in 2000. Australia secludes 9.93% of patients admitted to public hospitals and 1.68% of admissions to private hospitals. The *Report on Seclusion to the Chief Psychiatrist's Quality Assurance Committee* (Harte, 2002), found that 13.1% of admissions into public mental health services in Victoria in 1999-2000 included a seclusion episode at some stage. It is possible that rates

for the other states may be under-represented in the ACHS figures as data collection was more complete within Victoria, and a higher rate of Victorian hospitals submitted voluntary data.

There are relatively few studies of seclusion rates, and these come mostly from the United States and from Britain. Evidence suggests that seclusion is less used in European countries, including the United Kingdom, than in North America (Bogaert, 1980).



Duration of Seclusion

The modal duration of seclusion was reported by Oldham *et al.* as 1.25 hours (1983), by Hammill *et al.* (1989) as 1.0 hours, and by Soloff and Turner (1982) as 10.8 hours. Plutchik *et al.,* found on chart review that the modal seclusion duration was 4.1 hours. Thompson (1986) gave the median duration of seclusion in Newcastle as 4.3 hours.

The Quality Assurance Committee report (Harte, 2002) noted the modal seclusion duration in Victoria for the year 1999-2000 to be 4.8 hours.

Dual Disability

Individuals with dual disability may be at high risk for seclusion and restraint in mental health settings because these settings generally are designed for persons with greater cognitive and verbal abilities and communication problems may trigger or exacerbate problem behaviours. Such patients may also have relatively high rates of self-injurious behaviour (e.g., biting, pinching, head banging) that could prompt a decision to seclude.

For a person with an intellectual disability, the unfamiliar environment of the inpatient unit may be stressful. Add to this the experience of being looked after by unfamiliar staff members who may not be trained in communication skills, a lack of access to their usual communication tools, and possibly having their ability to communicate impaired by mental illness. Behaviour may be the only real means of communication for this person.

Seclusion in disability settings however, may have less in common with seclusion in mental health than might be thought.

The use of seclusion in disability services tends to be more predictable, and to occur as an explicit part of a plan. The need for seclusion in mental health is often short-term; the need for seclusion in disability may be in the longer term.

The physical frailty of many persons with a disability also needs to be borne in mind in the seclusion process, the amount and type of medication they are on considered, and their vulnerability to injury and choking borne in mind. Exclusion of delirium or pain as a cause of the problematic behaviour is vital as seclusion will exacerbate rather than relieve the problem.

Problematic behaviour in this setting where possible should be assessed for meaning before making decisions to use seclusion and restraint. Where agitated or violent behaviour is a new phenomenon the person should be carefully assessed for an underlying medical condition.

Sensory Impaired
Seclusion and restraint may be more traumatic and potentially more dangerous for those who may be unable to understand what is happening or unable to communicate their questions or concerns. The US National Association of State Mental Health Program Directors in their publication *Reducing the Use of Seclusion and Restraint Part III (Lessons from the Deaf and Hard of Hearing Communities)* noted that communication problems may lead to unnecessary interventions, and special care must be taken to achieve effective communication, firstly to avert the use of seclusion and restraint if possible, and secondarily to minimise the trauma of the intervention to the patient.

History of Trauma
Many persons with a disability have a history of abuse, which is also known to predispose to the development of a psychiatric disorder. A history of abuse also appears in to predispose to seclusion and restraint in the mental health system (Beck and van der Kolk, 1987). Where a person has a history of abuse, seclusion and restraint can trigger responses to traumatic previous experiences. Responses may be extreme, and may include symptoms such as flashbacks (hallucinations), dissociation, aggression, self-injury and depression.

Seclusion in Victoria; a brief comparison of the current legislation.

	Mental Health	Disability
Where?	Designated seclusion rooms within public mental health system inpatient units,	Disability Service Providers approved by the Secretary (includes appointment of an Authorised Program Officer)
When?	Any time	Any time
Who can be secluded?	Persons with a mental illness; usually involuntary	Persons with a disability
Who can authorise seclusion?	Authorised Psychiatrist may authorise. In an emergency, the senior Registered Nurse on duty may authorise and must without delay inform a medical practitioner, and the authorised psychiatrist informed as soon as practicable.	Authorised Program Officer may authorise. The seclusion must be explicitly part of a written Behaviour Management Plan. In an emergency, an approved Disability Service Provider may authorise seclusion and inform the Authorised Program Officer without delay, and include this episode in the monthly report to the Senior Practitioner.
How Long?	Modal duration 4.8h	Not known
Reviews?	Registered Nurse at least every 15 minutes Registered Medical Officer at least every 4 hours	Not specified
Reporting?	A Register is to be kept by the Authorised Psychiatrist of all seclusions in the service and sent monthly to the Chief Psychiatrist. All seclusions are to be reported whether patient voluntary or involuntary.	Only seclusion of persons eligible for service under the Intellectually Disabled Persons Services Act are required to be reported. However, seclusion of eligible persons in NGO facilities is required to be reported. The inclusion of seclusion in a Behaviour Management Plan must be reported to the Senior Practitioner. Behaviour Management Plans must be reviewed at least every 12 months. Monthly seclusion returns are to be sent by the Authorised Program Officer to the Senior Practitioner.
Reason for seclusion?	Immediate/imminent risk to health or safety of self or others Absconding	Prevention of physical harm to self or others, prevention of property destruction where this would include a risk of harm to self or others.

Conclusion

Although mental health and disability services both use seclusion, this practise has been studied far more in mental health, and is the subject of a growing movement to minimise its use. Disability services have recently reformed legislation to reflect similar concerns, and are in the relatively early stages of the vast and difficult process of finding out what is happening with seclusion in disability, how and where this is appropriate, and what action to take when this intervention is not supported by the evidence. This is a timely attention to a potentially controversial intervention used in a population that is at times both particularly challenging, and highly vulnerable to the potential adverse outcomes of seclusion.

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