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Review Article

Seclusion: A Concept Analysis

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ABSTRACT

Objective: Seclusion guided by the legal bodies, has been a measure frequently used to manage distracting and violent behaviour. Nonetheless, seclusion of mentally ill patients in a psychiatric set up has proven to be a difficult practice for most nurses and psychiatric patients because the meaning of the term seclusion is not fully understood. Moreover, how, where, when to and when not to seclude patients is not meticulously followed. The aim of this paper was to clarify the meaning of seclusion.
Methods: A concept analysis of seclusion was performed utilizing the eight steps of Walker and Avant's strategic method. Initially 20 articles from 1999-2017 were reviewed. Seven articles were later dropped and thirteen articles were finally reviewed to deduce the definition of seclusion.
Results: The antecedents for seclusion were identified as physical and verbal aggression, absconding tendencies, harm to self and others. Resultant consequences were that it; calms patient agitation, controls disruptive behaviour, guarantees a safe environment, prevents patient harming self and others, but it may cause physical and psychological harm to the patient.
Conclusion: The aim of this paper was to facilitate proper interpretation of seclusion which in turn would lead to proper execution of seclusion. This will consequently reduce patient seclusion related health challenges as well as reduce the use of seclusion.

Key Words: seclusion, concept analysis, antecedents, consequences, Mental Health Act, Walker and Avant

INTRODUCTION

The management of aggression, violence and behavioural disturbance is a continuing dilemma for psychiatric services notwithstanding developments in pharmacotherapy, psychological interventi-ons for many mental disorders. In a bid to ensure patient safety and facilitate total recovery, seclusion is exercised mostly on the unstable or high risk patients as part of the inpatient care. [(1)] As an intervention strategy, seclusion provides clinicians and ward nursing staff, a means to manage disruptive behavioural disturbance and to guarantee a secure and smooth running of the psychiatric ward. [(1)] However, seclusion is a controversial issue and its value has been extensively debated in the literature. [(2)]

Seclusion is a coercive measure which involves isolating the patient in a locked room and observing at regular intervals. [(3)] Seclusion is often employed on compulsory basis and is considered to be unpleasant to some nurses and patients. [(4)] Consequently an agreement has materialized over the past decade that seclusion is a safety management strategy used as a last resort and moreover the use of this strategy can and should be substantially reduced. [(5)] Importantly, the seclusion procedure is guided by the facility standard operating procedures, legal bodies; the Mental Health Act, the 2006 United Nations Convention on the Rights of Persons with Disabilities.

Failure to observe these attracts legal predicaments. The standards imminent in the European Union recommend alternatives to traditional seclusion practice and emphasise less restrictive techniques (e.g. comfort rooms) and fundamental to policy is the reductive approach of seclusion in the United Kingdom, Australia and New Zealand. [28]

Significance and uses of the concept

A concept analysis is a process that strives to come up with concrete attributes of a given concept by putting in place a distinct and practical definition that will guide operation for the intention of enriching interaction through effective communication among health workers as they render their caring roles. [6] This analysis will facilitate proper interpretation of seclusion in conjunction with the observance of the legal bodies. Moreover the appreciation of seclusion will reduce inappropriate seclusion episodes. The aim of this paper is therefore to clarify the meaning of seclusion. This will enhance an understanding of what proper seclusion is and how best seclusion can be deliberated and its use reduced.

METHODS

Walker and Avant strategic eight step method of concept analysis was used in analysing the concept of seclusion. These steps include concept selection, determining the purpose of analysis, clarifying and developing the operational definition and distinguishing the concept of ordinary language, identifying the uses of the concept, determining the attributes or characteristics of the concept, identifying the antecedents of the concept, identifying the consequences of the concept, constructing a model case, contrary case, borderline case and defining the empirical referents of the concept. The cases were narrated according to the writers' clinical experience.

Literature was sought from dictionaries and Google Scholar, PubMed and Medscape. The words seclusion and concept analysis were used to search for relevant literature. Relevant English articles from 1994 to 2017 were reviewed from the fields of Psychiatry / Mental health and legal bodies. Initially 20 articles from 1994-2017 were reviewed to deduce the definition of seclusion. Seven articles were later dropped and thirteen articles were finally reviewed because they were focusing more on restraints and discussions on elimination of seclusion rather than seclusion itself.

RESULTS

Definitions of seclusion

The term seclusion may be self-explanatory to individuals working in psychiatric settings, but it is poorly defined. Principally, it depends on who is describing seclusion, that is, whether it's the medical bodies, policy makers, researchers or legal sectors. [1] For example, from the English dictionary, seclusion is defined as a circumstance in which an individual stays separate or is kept separately from other people. [7] Seclusion is a situation of one being on their own, away from people. [8] It further explains that seclusion may mean abandonment, to be deserted or cast away.

The medical bodies have a broader outlook of seclusion adding also a rationale for its use. The Psychiatrists define seclusion as the supervised confinement of a patient intentionally placed alone in a locked room for a period at any time of the day or night so as to protect the patient, other patients and staff from injury. [9] When a patient is placed in a room, such as the seclusion room and the door is not locked, it is not considered as seclusion [10] Forensic psychiatry articulates that seclusion is an intervention for managing violent. Mentally ill patients in psychiatric units and involves confining that individual in a supervised room. This is involuntary isolation to protect others from harm. [11] The Sergen's medical dictionary (2012) defines seclusion as a supervised confinement of the patient to a separate room, to protect the patient and others from harm. It is an approach used in unstable and aggressive patients in

psychiatric units. [11] Seclusion is the placement and withholding of a patient in a bare room to control circumstances that may end up in an emergency. [12] It is also defined as a physical strategy whereby a patient with a psychiatric crisis is enclosed in a room that is either locked or from which free exit is forbidden. [13] A patient who has been enclosed and forbidden to vacate the room in the course of a psychiatric management strategy is considered to be undergoing seclusion, whether or not the intervention is implemented in a formal secure room or in any other alternatively labelled environment, including a patient's hospital bedroom. Nursing Interventions Classification (NIC) from Mosby's Medical Dictionary (2009) defines seclusion as a solitary containment in a totally protected environment with close scrutiny by nursing staff to determine safety and manage aggressive behaviour. [11] Seclusion is a coercive measure which involves isolating the patient in a locked room, observing at regular intervals and often employed on a compulsory basis. [3] Currently, seclusion is a safety management strategy used as a last resort and moreover the use of this strategy can and should be substantially reduced. [5]

Public scrutiny of seclusion is increasing and legal standards are changing, consistent with growing evidence that the use of this intervention is innately dangerous, capricious and generally avoidable. [5] In the recent years the legal definition of seclusion now carries much more weight. The European Committee for the Prevention of Torture and inhuman or Degrading Treatment of Punishment (CPT)has defined seclusion as a form of ill-treatment in some cases, because of appalling sanitary conditions, poorly ventilated seclusion premises, no means for the patient to contact the staff, unsuitable bedding, absence of window glazing. [12]

The Mandela rule 44defines seclusion as characteristically comprising three elements: social isolation and limited, if any, meaningful human contact, a monotonous physical environment where sensory stimulation is decreased and increased institutional control of entirely all aspects of the individual's daily life providing clients with restricted personal autonomy. [14]

More recently in England and Wales, following the legal changes brought about by a revision of the Mental Health Act 1983, seclusion is now defined by the Code of Practice as the supervised confinement of a patient in a room, which is locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others. [15]

In Australia the legal definition of seclusion is the involuntary solitary confinement of a person in which free exit is prohibited Mental Health Act 1996 Part 8 Section 116 (1996:57). [16] In Zimbabwe, the Mental Health Act, Part 14 Section 114 (1996:214-215) states that seclusion involves patient isolation in a locked room where they are unable to leave it voluntarily. However, it is not considered seclusion when only the lower half of the door is locked and upper half of the door is left unlocked. Patient monitoring, documentation of the seclusion procedure and psychiatrist prescribing the seclusion is emphasised. [17] The locked door, patient monitoring, documentation, psychiatrist ordering the seclusion policies from the Mental Health Act are in harmony with the mental health acts of other countries.

There is a significant discrepancy in the terminology used to describe the places in which seclusion interventions take place. [18] For example, a patient who has been enclosed and forbidden to vacate the room as psychiatric strategy is considered to be undergoing seclusion, whether or not the intervention is implemented in a formal secure room or in any other alternatively labelled environment, including a patient's hospital bedroom.

Again, time out is another intervention loosely referred to as seclusion and involves patient staying in their own room or in the seclusion room, but the door

is unlocked. [12] The patient can leave the room voluntarily hence it is not considered as seclusion. Some facilities use additional terms, including quiet room and time out room to refer to the same or essentially the same type of space of the seclusion room. However, these terms, do not describe seclusion due to the fact that they are not typical in the literature and fail to emphasize that there is only one type of highly specialized space that is acceptable for seclusion to be delivered. [18]

The definition of seclusion is further obscured by the admixture of the terms seclusion and restraint, as noted in vast policy documents and most research using both terms loosely. [1] Seclusion is the confinement of a patient at any time of the day or night alone in a room or area from which free exit is inhibited whereas restraint is the restriction of patient's freedom of movement by physical or mechanical means. [19]

Pragmatically, seclusion is best described as the isolation of a patient from others for the purpose of managing behavioural disturbances. The coalescing feature of the above definitions of seclusion is similarly the confinement of a patient, separate from others as a means to manage behavioural disturbances, to place order and protect patient from harming self and others, involving continuous patient observation and documentation, importantly, used in an emergency and as a last resort.

The Macmillan English dictionary offers the idea that seclusion is a place or situation that is private and peaceful. This could mean that this environment offers comfort and tranquility. However, the medical bodies, policy makers, researchers and legal sectors point out that the seclusion room is not therapeutic in nature rather more of a prison where a patient feels punished, deserted, cast away rather than being peaceful. [7]

Defining attributes

Defining attributes are those characteristics of a concept that are closely linked with the concept and will assist in distinguishing a particular concept from any other related concept. [6] Attributes of seclusion identified are six, and include; a locked room that the patient cannot leave, in which they can be monitored continuously and documented, characteristically a low stimulus or monotonous room, with a few loose items if any, that cannot be used in a dangerous manner by the patient. [1] Seclusion is used in an emergency and as a last resort strategy. [5] It is prescribed by the psychiatrist for example, in Zimbabwe, in Part 14 sections 114:214. [17]

Antecedents

Antecedents are events and circumstances which occur preceding the occurrence of the concept and are often associated with the occurrence of the same concept. [6] Seclusion may be initiated for a number of reasons within the confines of the law, which are aggression, absconding tendencies and harm to self and others. [20] These are distracting, chaotic and violent behaviours.

Aggression

Aggression is characterised by violence towards people and objects. The majority of studies identifies physical aggression as the immediate antecedent to the initiation of seclusion. Aggression could be physical or verbal aggression. [3] Physical aggression is the behaviour causing or threatening harm directed at others, staff, or other patients. The patient may hit, kick, bite, use weapons, break, property or other people's possessions. [21] In verbal aggression, the patient may shout, threaten or swear at others. [22]

Absconding tendencies

Absconding is leaving the ward without permission and may be catastrophic to the patient, public and relatives. There is a risk of harm to self and others, missed medication and interruption of treatment plans. [20] When a patient, threatens, attempts or absconds seclusion is used as a safety intervention.

Harm to self and others

Through aggressive acts patients may physically and psychologically harm

others, and this warrants seclusion to protect patient from harming others and self in the process. [(23)] The patient may intentionally injure self, through cutting self and head banging, hence the need for seclusion in a padded, loose objects free room. [(24)]

Consequences

Seclusion ensures control of disruptive behaviour, guarantees a safe environment, prevents patient from harming self and others, hence the safety of the patient, other patients, staff and visitors is warranted. [(1)] Confinement of the patient may also result in calming the patient's agitation.

Fig 1. Attributes of Seclusion Diagram

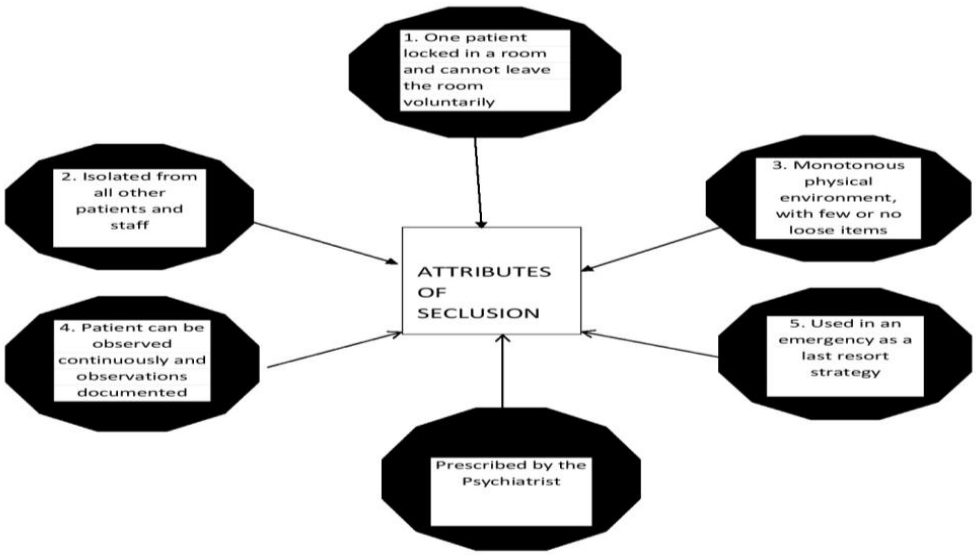

Fig1. Attributes of Seclusion Diagram

Calmspatient's agitation

Seclusion is basically effective in preventing injury and reducing agitation. [(25)]

Control of disruptive behaviour

Seclusion is a measure used to treat and manage distracting and violent behaviour. [(12)] The countries' Mental Health Act gives the mental health professionals authority to exercise professional judgement in utilizing seclusion to control violent patients, used only as a last resort, when patients exhibit destructive behaviour that may lead to violence. [(5)]

Guarantees Safe environment

Seclusion guarantees a secure and smooth running of the psychiatric ward. [(12)] The chaotic behaviour and violence that may cause disorder in the ward, fear and insecurity on staff, patients and others is prevented.

Prevents patient from harming self and others

Confinement of a patient to a separate room results in protection of the patient and others from harm. [(10)]

Physical and psychological harm to the patient

A recurring feature from the majority of researchers is that seclusion is of no proven therapeutic value. [(1)] There are significant physical and psychological risks which include death, disabling physical injuries, damage of therapeutic relationships, and a significant disturbance in the patient recovery process. [(2)]

DISCUSSION

Model case

Mr. Moyo is a 28 year old patient with a diagnosis of schizophrenia with comorbid substance use disorder. He is verbally and physically aggressive (banging the phone, yelling to others and attacked a staff member). Initially, the staff members

employ other less-restrictive measures, like counselling and communicating with a patient in a therapeutic calm manner but this fails. They then, take hold of the patient, as a team and place him in the seclusion room. Prior to secluding, on their way to the seclusion, they explain to the patient why they are secluding him. Meanwhile, the other nurse immediately informs the psychiatrist over the phone about this incident, who immediately gives seclusion orders per phone, and reassures that he is on his way to examine the patient. The staff locks the door from outside, leaving the patient in the seclusion room alone. Patient monitoring via a surveillance camera begins and is continuously performed. The details of the seclusion incidence are then entered in the seclusion register and the continuous patient monitoring is documented in the observation book. In the seclusion room the patient is noted to be leaning on the padded walls of a non-furnished room. During lunch time, four hours later debriefing (time out of seclusion) is granted to the patient on the agreed contract that the aggressive behaviour will not be repeated, as failure to conform would result in patient seclusion again.

Analysis

From the above model case, all the seclusion attributes are pictured. Attributes such as a low stimulus, monotonous room without loose items that can be used in a dangerous manner by the patient occur. Seclusion was delivered according to the standards of practice, that is; documentation and reporting immediately as well as the doctor prescribing the seclusion. Outstandingly from the rules of seclusion was deliberated in an emergency as the last resort. As a matter of fact, it appears punitive and a place of containment but in the process it minimizes the harm a patient can do to themselves and others. [(1)]

Contrary case

Mrs. Lazarus, a 40 year old woman diagnosed with organic psychosis, feels agitated while in the ward. She then voluntarily enters the comfort room as a means of finding peace and gaining self-control, without staff enforcement. While in the room, she makes use of yoga mats, rocking chairs, stress balls, books and aromatherapy products to relieve her agitation. When she feels calm from agitation she willingly leaves the room since the doors are not locked.

Analysis

A contrary case does not include any of the attributes of the concept. [(6)] Mrs. Lazarus goes to the comfort room voluntarily in order to cope with her own rising agitation and develops self-control. The patient leaves the room at any time, as the doors are never locked. The staffs do not enforce the use of comfort rooms rather; they support her to use the comfort room as needed in order to maintain a non-coercive and non-violent unit. [(18)] The comfort room is luxurious and therapeutic. The items in the comfort room include; yoga mats, radio, rocking chairs, low or adjustable lighting, books, aromatherapy products and stress balls. Comfort rooms are not containment or punitive spaces.

Borderline Case

The borderline case has some critical attributes of the concept. [(6)] John a 19 year old male suddenly becomes violent and begins throwing chairs at other patients in the ward. Immediately the staffs get hold of John and throw him into the seclusion room, without explaining the rationale for the seclusion. The patient is locked in a non-padded, monotonous room without loose items. Patient monitoring takes place haphazardly via the surveillance camera. The psychiatrist is not informed about the incident, moreover the seclusion register and observation book are not completed. The patient is left for the whole day in the seclusion room and is removed when the staffs feel it is now safe to do so.

Analysis

Indeed the patient was placed in seclusion for prevention of harm to self and others, but was done rather in a malicious manner and there was no explanation for seclusion. Certainly the seclusion room was

locked, a monotonous room without loose items but was non padded increasing the risk of patient injuring self. Patient monitoring was carried out, but irregularly. Contrary the psychiatrist was not informed about the incident, no four hourly debriefing sessions were employed and the seclusion register as well as the observation book was not completed. Notably, seclusion was utilized in an emergency, but not as the last resort since the other less-restrictive measures, like counselling and communicating with a patient in a therapeutic calm manner were not exercised.

Empirical referents

Empirical referents of a concept are classes or categories of actual concept that by their existence demonstrate the occurrence of the concept. Determining the empirical referents for the defining attributes is the final step of a concept analysis. [(6)] When a patient has been secluded the rules of seclusion ensue. Each incident of seclusion should be exhaustively documented and should include the following information:

- A clear account of the justification for the use of seclusion.
- A record of observation of the patient during and after seclusion.
- A record of the times in which seclusion was initiated and terminated.

Clear evidence that the patient's food, fluid, hygiene and toilet needs were addressed [(18)]

In Zimbabwe Part 14 Section 114 1996:215, states that, the patient should have portrayed behaviour enough to be away from other patients as the justification. Documentation is done in the specified seclusion register indicating name of patient, reason for seclusion, type of seclusion, time in, activities, duration spent and time out. [(17)]

Paramount physical, emotional, psychological needs and rights of the secluded patient should be taken into consideration, yet there are at times ignored. These are governed by the facility standard operating procedures, legal bodies; Mental Health Act, the 2006 United Nations Convention on the Rights of Persons with Disabilities. [(26)] These are some of the measurement instruments in existence. Article 14, titled Liberty and security of person, asserts that Parties shall ensure that persons with disabilities experience the right to liberty and security. It maintains the voice that persons should not be deprived of their liberty unlawfully or arbitrarily, also that any deprivation of liberty is in conformity with the law and the existence of a disability shall in no case defend a deprivation of freedom. [(27)]

Seclusion is commonly used to manage distracting and violent behaviour as well as guarantee ward safety. [(1)] However, seclusion poses a high degree of risk to patients and staff, and the majority researchers come to an agreement that it is of no proven therapeutic value. A seclusion episode may cause physical and psychological harm to the patient and may be demeaning to staff members. It may also increase the risk of liability substantially for facilities and staff. [(5)]

CONCLUSION

Seclusion provides a means to manage disruptive behavioural disturbance and to guarantee a secure and smooth running of the psychiatric ward, although. [(12)] The definition of seclusion provided in this article will facilitate proper interpretation of seclusion in conjunction with the observance of the legal bodies. Actually, overuse and abuse of seclusion are symptoms of poor quality care in facilities, poor state oversight and misdirected public policy. The state and federal agencies must take a greater role in assuring the safety and protection of patients who experience seclusion. The standards imminent in the European Union recommend alternatives to traditional seclusion practice and emphasise less restrictive techniques (e.g. comfort rooms) and fundamental to policy is the reductive approach of seclusion in the United Kingdom, Australia and New Zealand. [(28)]

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