Trends in Seclusion Practice in the Newcastle Area

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The use of seclusion in psychiatric hospitals has been declining over the last century due to the development of other methods of managing disturbed behaviour and more successful treatment of illnesses predisposing to disturbed behaviour. Pressure from society has come in the form of the 'open door' movement and legislation such as the Mental Health Acts of 1959 and 1983 and may also have promoted less restrictive management of patients or simply produced a shift of the site of management from hospitals to prisons.[1] Guidelines from the Mental Health Act Commission have recently been formulated and may continue this process.

In recent years, seclusion, as used in Newcastle upon Tyne, has continued to decline and in this paper information is given on the use of seclusion and the factors related to the decline in its usage. The study looked retrospectively at all seclusions in 1981 to 1985 in the psychiatric units of the Newcastle Area, excluding those for mental subnormality and long-stay wards. The general adult psychiatric admissions in the year 1981 were used as a control group. Information was obtained from case-notes, admission documents, nursing notes and seclusion records.

Of 1695 admissions in 1985, 31 patients were secluded 86 times; 11 men and 20 women. The 18 patients secluded/1000 admissions in 1985 shows a continuation of the decline in the use of seclusion reported elsewhere.[2] The median duration of seclusion was 4.0 hours and again most patients (17) were secluded only once; eight patients secluded two to three times and six patients secluded four or more times. The decline occurred in all groups but most consistently among males.

Men were secluded more often than women (113:82) and certain diagnoses were associated with seclusion (Table I). There has been a decline in the numbers of all the major diagnostic groups involved but the psychotically ill remain the largest group.

Previous seclusion was associated with subsequent seclusion. Only about 2.3% of patients are secluded; of those who have been secluded once 43% are secluded again, of those secluded twice before 64% are again secluded and of those secluded three times 81% will again be secluded. Compulsory admission was associated with subsequent seclusion. During the period studied some 909 (10%) patient admissions were formal and of these 103 (11%) resulted in seclusion compared with 144 (1.8%) of informal patient admissions. Most seclusions (57%) occurred during the daytime and the three mealtime hours accounted for 24% of seclusions.

The type of behaviour resulting in seclusion is shown in Table II. Males were secluded more often than females for incidents involving self-harm (2.4:1) and threatened violence (4.5:1), and there have been changes in the type of behaviour resulting in seclusion (Table III).

While there has been a trend towards fewer admissions in the study period this does not seem to account wholly for the fall in the use of seclusion. One would expect the most disturbed patients to continue to be admitted despite any increase in community care of less disturbed patients. It may be that a small number of disturbed patients have been admitted to secure units and special hospitals but this is unlikely to be the full explanation. The use of other forms of situational restraint, such as locked wards, has not changed in the Newcastle area over the study period so it would seem that there has been a real fall in the use of seclusion

TABLE I

The numbers of the various diagnostic categories of general psychiatric patients secluded in 1981–5

Diagnosis	*Number of admissions in 1981*	*Number of patients secluded in*					
		1981	*1982*	*1983*	*1984*	*1985*	*1981–5*
Organic psychoses	72	3	1	3	3	0	7
Endogenous depression	278	3	1	2	2	3	11
Bipolar affective disorder	249	23	22	11	18	12	65**
Schizophrenia/paranoid psychoses	382	22	25	22	20	13	82**
Neuroses	531	2	3	0	1	2	6
Personality disorder	126	7	4	3	2	1	15
Alcohol & drug dependence	355	3	0	1	3	0	6
Mental retardation	14	3	0	0	0	0	3

** = $P < 0.001$, Chi-squared test (Yate's correction factor) & Fisher's exact test.

https://doi.org/10.1192/S0140078900024457 Published online by Cambridge University Press

TABLE II
Nature of incidents, resulting in seclusion, associated with the various diagnostic groups in 1981–5

		Type of behaviour (% incidents)				
			Violence to:		*Non-violent:*	
Diagnosis	*N*	*Self*	*Staff*	*Other*	*Threat*	*General*
Schizophrenia & paranoid psychosis	204	5	37	16	13	29
Bipolar affective (hypomania)	254	0	36	14	7	43
Other psychoses	116	21	25	22	10	22
All non-psychotic disorders	96	18	44	12	6	20
All incidents	674	9	35	15	9	32

TABLE III
Changes in the nature of incidents resulting in seclusion during 1981–5

		Type of behaviour									
				Violence to:				*Non-violent:*			
		Self		*Staff*		*Others*		*Threat*		*General*	
Year	*N*	*No.*	*(%)*	*No.*	*(%)*	*No*	*(%)*	*No.*	*(%)*	*No.*	*(%)*
1981	234	34	(15)	75	(32)	35	(15)	38	(16)	50	(22)
1982	130	5	(4)	35	(27)	19	(15)	10	(8)	61	(47)
1983	108	8	(7)	41	(38)	11	(10)	4	(4)	43	(40)
1984	111	4	(4)	43	(39)	21	(19)	2	(2)	41	(37)
1985	91	1	(1)	53	(58)	17	(19)	8	(9)	12	(13)

during 1981–1985. The procedure during seclusion has not changed over the five years and the median duration of seclusion changes little from year to year.

There has been a particular decline in the use of seclusion for the management of incidents involving self-harm, threatened violence and general disturbance. These changes have resulted in fewer seclusions of male patients with organic psychoses and female patients with personality disorders or alcohol and drug dependence, the groups most involved in self-harm.

It appears that staff tolerate threats of violence differently resulting in a decrease in the number of male schizophrenic patients being secluded, the group previously secluded most frequently for threats. Patients with personality disorder have been secluded less often for violent acts but there has been an increasing number of female hypomanic patients secluded for actual violence. Interestingly, there has been an equivalent fall in seclusion of female hypomanic patients for general disturbance. It might be argued that seclusion as a response by staff to disturbance is decreasing for all behaviour but that by not secluding patients with hypomania when they are generally disturbed an increasing number may progress to actual violence and then be secluded.

Previous seclusion is probably important as it seems that in any episode of illness the disturbance of an individual is of similar degree until treatment takes effect. This may take several weeks to occur and some patients remain treatment resistant. Some patients seem, whenever ill, to be disturbed to the same degree, even if episodes are years apart; unfortunately, some patients acquire a reputation for violence which is responded to by staff in a way which, in itself, may promote incidents which result in seclusion. Also, if a patient has been secluded once in any episode of illness this may diminish the reluctance of staff to use seclusion again for that patient, particularly if s/he is again disturbed shortly after removal from seclusion.

However, it seems that there is no demographic or diagnostic difference between the chronic and repeatedly secluded patients, so it is likely that there is a spectrum of disturbance due to mental illness, rather than there being a discrete group of repeatedly disturbed patients.[3]

There has been a decline in the percentage of compulsory patients secluded while the percentage of voluntary patients who are later secluded has fallen less. Formally admitted patients, however, are still about six times more likely to be secluded than informal patients. This does not seem to be

due to the introduction of the Mental Health Act 1983, as the number and type of sections have altered little, but may be due to use of alternative managements on admission of formal patients. Mealtimes, however, remain a high risk period for seclusion.

Seclusion is being used less in Newcastle and will probably continue to decline as alternative management procedures are developed and used. While this is generally desirable it may be that not secluding certain patients leads to worse disturbance. The Mental Health Act 1983 does not seem to have had any direct effect upon the practice of seclusion but it is likely that it will indirectly modify attitudes and encourage further change. It seems likely that the decline is due mainly to a change in staff attitudes and thus response to disturbance, particularly non-violent acts, rather than any change in the patient population. However, it may be that the trends outlined are indications that disturbed patients are continuing to find their way into prisons rather than hospitals.

References

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Jobs and Computers

Information technology training for long-term day hospital patients

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This is a report on a project which offers long-term day hospital patients a training which will lead to paid employment on the open market. Lack of work compounds the low self-esteem of chronic psychiatric patients. They experience multiple disadvantages, including loss of status, purpose, personal identity, social contacts outside the family, and a time structure to the day. Many of these disadvantages are known to be experienced by unemployed people in the general population.[1] In most surveys, a fifth of the unemployed report a deterioration in their mental health since being unemployed, with an increased frequency of deterioration proportional to length of time without work.[2] Work enhances self-esteem by decreasing the degree of dependency and by allowing identification with non-patients and may influence perceived locus of control. Work provides social participation and is 'a visible measure of normality' for former patients.[3]

Long-term mental illness may itself involve loss of self-esteem and also deprive the patient of social roles in which he is valued by others. These disadvantages may be compounded by a socially-learned tendency to attribute control to external factors in the environment rather than the individual's own action.[4] It has also been suggested that the reinforcing quality of an event is dependent on how responsible the individual feels for it, with externally attributed events being of lower value. Such an external locus of control would seem to be quite closely related to learned helplessness[5] and it is possible that it can be modified by cognitive therapy,[6] although little work has been done on this. Locus of control theory might then provide a useful framework for considering the extent to which psychiatric patients perceive their circumstances as immutable, regardless of whether this is objectively the case.

The therapeutic value of work for chronic psychiatric patients was well recognised 30 years ago with, for example, the setting up of the first experimental workshop in Britain in Banstead. Simple repetitive work provides retraining and basic skills in 'work habituation', and in both health authority day hospitals and local authority social services department day centres, work has consisted of packing, sorting, labelling, or work with non-powered hand tools (such as staplers, hammers, needles) or domestic work, such as cleaning or sweeping. In occupational therapy, which involves craft work, a patient may be doing something purely for his own satisfaction, to meet his own expectations and to provide his own reward.[7] This is an ability without a social role.

Since the 1960s jobs have become progressively less available. Day hospitals seem to have become more involved in 'humanistic growth games' and craft work, and less concerned with preparation for productive activity. Traditionally, factory type work in an industrial workshop has provided the first stage of rehabilitation towards work on a production line, while some units have offered clerical work. With the decline in the availability of factory work, and with the spread of information technology, neither the traditional industrial nor the clerical approach seem adequate. Bennett[8] has pointed out that the nature of the tasks often provided for schizophrenic patients underestimates their capacities. He refers to the difficulties in securing more complex work and adequately supervising it by nurses and occupational therapists: "It is quite possible, given