Commentary: Seclusion Practice in a Canadian Forensic Hospital

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J Am Acad Psychiatry Law 29:310–2, 2001

The article, "Seclusion Practice in a Canadian Forensic Hospital," by A. G. Ahmed and M. Lepnurm[1] evokes further questions about the use of seclusion and restraint in psychiatric hospitals. This subject remains at the heart of intense debate within psychiatric and consumer groups, and recently there have been legislative interventions that have intensified the discussion. Although most of the debate and research have focused on the civil psychiatric hospital, there is comparatively little information available about the practice of seclusion and restraint in forensic hospitals or in those facilities that provide psychiatric care to prison inmates, as in this example.

Guttheil and Applebaum[2] provide a brief review of some of the benefits of seclusion, which they compare with a prescription of space, that may be helpful in providing external controls to disturbed patients who have poor internal controls. They note a number of potential advantages, including containment for the out-of-control patient, isolation from distressing interpersonal relationships, and diminished sensory input. They caution, however, that seclusion and/or restraint can be easily misused, in particular if it serves a punitive function, is a substitute for staff time or attention, or is a mechanism for the acting out of countertransference reactions.

In contrast to certain clinicians' views that seclusion may be therapeutically beneficial, others view it invariably as an assault on patients and in particular recommend the abolition of mechanical restraint, especially when dealing with children and adolescents.[3,4] This is also the view of patient advocate groups,[5] who cite anecdotal stories of members who were seriously emotionally traumatized by either mechanical restraint or seclusion. Many clinicians view the imposition of seclusion and/or restraint as countertherapeutic, in that it destroys the potential therapeutic alliance and changes the physician-patient relationship from mutual collaboration to an authoritarian structure.

The intensity of this long-standing debate was heightened in the fall of 1998 when the *Hartford Courant*[6] ran a story about the misuse of seclusion and restraint and cited 142 deaths that had occurred since 1988. This set in motion legislative responses and public hearings by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as well as the Health Care Financing Administration (HCFA). A number of professional groups presented briefs to both organizations regarding their views on the use and limitations of both seclusion and restraint.[7–10] Although the story published by the *Courant* identified the majority of serious injuries and deaths as occurring through the use of mechanical restraint, seclusion practices were also included, given that they, too, are a form of restraint.

The professional organizations agreed on many points, including the need for qualified persons to authorize, monitor, and implement seclusion and/or restraints, the establishment of hospital policies to define the reasons for restraints, careful monitoring of patients during seclusion and/or restraint, and training of staff in applying seclusion and restraint safely. They also acknowledged the need for documentation and for the reporting of serious injuries to oversight organizations. There was, however, significant divergence of opinion in certain key areas. The American Nursing Association[8] affirmed that restraint should be used only as a last resort and indicated its intent to reduce the use of physical restraint.

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Likewise, the National Association for State Mental Hospital Program Directors[10] indicated their commitment to the goal of reducing and eventually eliminating the use of seclusion and restraint.

Other groups, including the American Psychiatric Association (APA),[7] raised key concerns about this pending legislation. In particular, they grew concerned regarding the "one-hour rule" mandating a psychiatrist to perform a face-to-face evaluation of a patient within one hour of ordered seclusion or restraint. The regulation was described as an "inappropriate attempt to practice medicine" and "an ineffective substitute for the individual clinical judgment of the physician." As well, the APA raised legitimate concerns regarding the increased costs of such measures, given the limitation of resources available in mental health services. They also questioned the policy of restricting the use of seclusion and restraint to emergency situations in which there is a clear threat to the patient or others and considered other indications, including risk to the staff.

The literature on the use of seclusion and restraint was well summarized by Fisher in 1994,[11] and some of the conclusions were summarized further by Ahmed and Lepnurm.[1] At that time, Fisher's conclusions lent some support to the APA position, but also raised other objections. Fisher concluded that seclusion and restraint were efficacious in preventing injuries and decreasing agitation, and he considered it nearly impossible to operate a treatment program for severely agitated or ill patients without some form of seclusion or physical restraint. However, he documented that demographic and clinical factors have limited influence on the actual prevalence or rates of restraint and seclusion, indicating that it was simply a greater issue than a clinical matter or a medical matter. He documented that nonclinical factors at a local level, including cultural bias, staff role perceptions, and the general attitude and expectations of hospital administration and staff, had greater influence on the rates of seclusion and restraint than did clinical need.

Further, the literature shows marked differences in the rates of seclusion and restraint that could not be reasonably accounted for by patient variables alone. Notably, rates of seclusion and restraint vary from 15 to 51 percent in state hospitals, an average of 26 percent in municipal hospitals, but only 3.6 percent in military hospitals and in British hospitals. These data argue strongly for regulatory oversight, with the goal of reducing the use of seclusion and restraint to the absolute minimum.

Other countries engage in a similar debate over the use of seclusion and restraint and deal with regulatory oversight through different mechanisms such as ombudsman functions or legislation. Australia has had advanced legislation in this area for some years, as evidenced by the Mental Health Act of 1986.[12] This legislation governs the admission of voluntary and involuntary patients to hospitals in the state of Victoria. By law, seclusion is allowed only for immediate or imminent risk to the safety of the patient or others or to prevent absconding in involuntary patients. A face-to-face medical examination is required within four hours and repeatedly every four hours thereafter. Compliance with detailed monitoring and reporting is mandatory and data are subsequently forwarded to enable the facility and others to monitor and compare the level and standards of seclusion within the facility. The Act also limits the use of seclusion to public hospitals and prohibits it from being used in private hospitals or in supported residential service programs. Information programs for patients outlining their rights and abilities to challenge seclusion and/or restraint behavior are readily accessible. The Act and its guidelines indicate that the data produced regarding the reasons for seclusion, the frequency and length of time of seclusion episodes, and the implementation of interventions to reduce restrictive measures are all forwarded for quality assurance purposes to monitor and hopefully reduce the frequency of seclusion use.

The monitoring of seclusion as a quality assurance measure has distinct advantages. For some time, the Commonwealth of Pennsylvania has been closely monitoring the use of seclusion in Pennsylvania state hospitals. Chengappa and colleagues[13] recently published a study of 74 patients in which data were gathered on the frequency of seclusion episodes for a period before instituting risperidone therapy and monitoring any change in the frequency of seclusion in the following three months. They noted significant decline in the use of seclusion hours in the same patients after inception of risperidone therapy. Other treatment interventions can be similarly compared if sufficiently detailed information on use of and reasons for seclusion are maintained.

Although it is clear that there are major changes under way in the use of seclusion and restraint in civil psychiatry populations, it is unclear whether such

changes would be of benefit to patients in forensic hospitals or in prison psychiatric units. There are significant differences in these populations that must be considered that are outlined in part by the article by Ahmed and Lepnurm.[1] By nature, prison populations have a higher base rate of violent behavior than civil psychiatry populations and in addition have high rates of personality disorder diagnoses and, in particular, antisocial personality traits that are also noted by Ahmed and Lepnurm. Further, prison psychiatric patients emerge from a milieu in which there are severe restrictions on liberties and privacy and in which anti-authoritarian behavior is common in the inmates. Further, this population has a higher rate of predatory violent acts compared with reactive violent behaviors. There is substantial question about whether one could recruit and retain nursing and psychiatric staff to assess and treat such individuals, unless the staff had assurances of their own protection and could use seclusion and/or restraint.

Ahmed and Lepnurm[1] outline some of the rather distinct differences between a forensic or prison psychiatric population and a civil forensic psychiatric population. Notably, in the prison setting the majority of patients were not under civil commitment but were there on a voluntary basis. Although some of this is simply administrative convenience, it is also due to patient preference to be in a psychiatric facility instead of the prison. This is perhaps most dramatically demonstrated by the fact that many patients had to be secluded when told they were to be repatriated to the prison from which they had come. Presumably, this notification precipitated an acute aggressive reaction.

The authors compared the rates of seclusion in their prison psychiatric hospital population with those in a like facility in Britain and found similarities. Although there were some differences, probably related to administrative definitions, the overall rates were similar. There are no standards by which it can be determined whether the rates themselves are appropriate. However, it is evident, as in the Pennsylvania study,[13] that careful monitoring of the rates of seclusion may well serve as an ongoing measure by which the institution can compare itself with other similar facilities, as well as an internal review over the course of time with the intent of effecting an improved practice to reduce seclusion rates. Further studies comparing rates of seclusion in different patient populations and, in particular, using measurements of risk of violence will perhaps offer better comparisons between facilities and provide better data for use in internal audit.

Although the goals described by many professional groups to JCAHO and HCFA hearings regarding the need for eventual elimination of use of seclusion and restraint are laudable, it would seem unlikely that such a goal would be appropriate or achievable for patients in forensic psychiatric facilities or in prison psychiatric hospitals. Nonetheless, forensic facilities and prison psychiatric units would be well served to establish procedures for careful monitoring of rates of seclusion, reasons for seclusion, and institutional responses to minimize use of seclusion and restraint as described in Ahmed and Lepnurm.[1] The use of such data for quality assurance and for research in the development of improved clinical practice is clearly established and data regarding use of seclusion and restraint should be monitored in all forensic settings.

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