Does seclusion result in a calmer patient?

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Introduction
This critically appraised topic focuses on seclusion as an intervention for acutely mentally unwell patients. Seclusion is defined as ‘the placing of a person, at any time and for any duration, alone in an area where he/she cannot freely exit’ (Ministry of Health, 2001, p. 43). Seclusion can be legally implemented under the Mental Health (Compulsory Assessment and Treatment) Act 1992 when ‘other methods of clinical management cannot safely be used, or have been used without success’ (p. 34). Despite the common use of seclusion as an intervention, it is suggested that many patients feel that seclusion does not have a calming effect.

The following is an example of how seclusion is explored against evidence-based practice. A scenario, search question and terms are identified. A literature search was undertaken and Greenhalgh (2001) was utilised to assess methodological quality. The most relevant research article that would assist in answering the search question was identified and is critically appraised as follows.

Clinical scenario
Tom is 18 years old when he is admitted to an acute mental health unit. He is displaying signs of psychosis and refuses to have antipsychotic medication. Tom becomes increasingly aggressive, requiring restraint and seclusion to calm him. As the registered nurse working in the psychiatric intensive care unit that day you wonder whether the treatment outcome – of a calmer patient – would have been achieved without seclusion. You are aware of the increasing amount of literature and discussion raising concerns about seclusion and wonder if the use of seclusion is evidence-based.

Research approach
In order to search the literature effectively, the following question was devised utilising Sackett, Straus, Richardson, Rosenberg and Haynes (2000). The question usually has four components: a description of the patient, the intervention, a comparison intervention and the clinical outcome. The question I have formulated is as follows: In acutely mentally unwell people, does seclusion result in a calmer patient?

A comparison intervention was not included, as seclusion should be used as a last resort in the clinical management of acutely mentally unwell people. The clinical outcome of a ‘calmer patient’ is characterised by the patient being less anxious, agitated or disruptive. From formulating a question, keywords are identified and the topic is narrowed to search specifically for relevant articles.
I searched for the use of the word ‘seclusion’ in journals through ProQuest, Science Direct and EBSCO (limited to English language and 1998–2004). Alternative words used in the texts were ‘isolation’ and ‘solitary confinement’ but I did not search these terms as ‘seclusion’ is the term recognised in mental health, and results from searching the other words would not have brought up the required literature.

My search brought up numerous articles; from this, six articles were identified as being useful to answer my search question. These articles were assessed on their methodological quality and from this assessment I chose the Meehan, Burgen and Fjeldsoe (2004) article to critically appraise. Meehan et al. is a quantitative descriptive study and even though the sample size was small it was the most relevant and highest form of research in relation to topic, sample and design that was available to answer my question and, due to the location of the research, the most applicable to New Zealand mental health.

Research study
This critical appraisal utilises Brown’s (1999) non-experimental descriptive design appraisal questions. The issue studied in Meehan et al. was views of nursing staff and patients with regard to reasons for seclusion, effects of seclusion, patients’ feelings during seclusion and possible changes to seclusion practice.

The study was conducted at two acute in-patient psychiatric units and a medium secure unit. Nurses and patients were approached to participate in the study by a research assistant. The patients approached had experienced seclusion within the 12 months prior to the study commencing, but were not invited to participate until 14 days had elapsed from the time of their most recent seclusion. Sixty percent of those approached participated in the study. Of the nurses approached, 88 per cent participated; 90 per cent were registered nurses; 10 per cent were enrolled nurses; 53 per cent were male. The participants consisted of 29 patients who had experienced seclusion and 60 nurses with psychiatric nursing experience.

Method
Data were collected with the use of a cross-sectional survey using standardised questionnaires. The instrument used to collect data from patients and nurses was the Attitudes to Seclusion Survey (Heyman, 1987). Meehan et al. state ‘staff and patient versions of the questionnaires were similar in structure and content’ (p. 35). A three-point scale of ‘never’, ‘sometimes’ and ‘often’ was used. Staff only were asked to rate the practice of seclusion, in terms of it being ‘therapeutic’, ‘punitive’ and ‘necessary for safety’ on a scale of 1 to 10.
Data were analysed using Statistical Package for Social Sciences (version 10) and chi-square tests were used to compare differences in the response profiles of both patients and staff, and the ‘sometimes’ and ‘often’ responses were combined for this purpose.

Main findings
(1) There were differences in the views of the benefits of seclusion to the patient: 4 per cent of patients believed the procedure to be often beneficial compared to 60 per cent of nurses.
(2) Significant differences between nurses and patients’ perceptions of the reasons for seclusion were evident. The study found that 100 per cent of the nurses believed that seclusion had a calming and positive effect, where 50 per cent of the patients agreed that it allowed them to escape the excitement of the ward. It is clear that from a patient perspective seclusion is not seen as a therapeutic experience. This is not unexpected, as seclusion usually involves physical restraint and loss of freedom (Meehan et al.).
(3) One-third of patients believed that seclusion did not calm them and two-thirds believed it did not make them feel any better.

Credibility profile
(1) Each variable was reasonably examined, apart from ‘the patients’ feelings during seclusion’ which were not documented in the article.
(2) Both staff and patients were approached by a research assistant, who was a registered nurse; it is not clear whether this person was involved with the mental health units participating in the research and what effect this had on the sample population and findings.
(3) The use of chi-square tests tended to make the results ‘black and white’ by combining the ‘sometimes’ and ‘often’ answers. This distorts the results of an intervention that is embedded in feelings, opinions and views from different participants.
(4) There is limited evidence that the sample population of patients was representative of the target population. A sample of 29 patients is small in comparison to the sample of nurses. The study did not identify the patients’ demographic data in regard to diagnosis, gender, age or race. The sample of nurses probably represented the target population but, once again, age and race were not identified and level of experience in psychiatric nursing was very broad.
(5) The Attitudes to Seclusion Survey (Heyman, 1987) was utilised for this study. From the review of current literature this particular instrument is not widely utilised in seclusion research.
Conclusions
The findings are consistent with other studies in this field (Griffiths, 2001; Hoekstra, Lendemeijer & Jansen, 2004) and, from a clinical perspective, they are what you would expect. The findings of Meehan et al. show a significant difference in patient and nursing staff perceptions in relation to whether seclusion calms patients or not and it becomes clear that seclusion is far from a therapeutic experience. The benefit of this study is that it increases awareness of patients’ perceptions of seclusion and will encourage nurses to consider their own behaviour and intentions when initiating seclusion.

The findings of Meehan et al. need to be taken into consideration in clinical practice settings and more research is required into the reasons for seclusion. Is calming the patient the main goal of seclusion or is seclusion utilised for the safety of the patient and the environment? The Meehan et al. study is only ‘one piece of the puzzle’; other influencing factors, such as clinical settings, knowledge and individual patients’ situations, must all be taken into consideration before changes can be made in practice.

Commentary
These findings can be used in the New Zealand context to support both mental health consumers and nurses by reducing the use of seclusion. The Mental Health Commission (2004) identifies in its report Seclusion in New Zealand Mental Health Services the factors that have an impact on the use of seclusion, for example, systematic constraints, resource limitations and staffing and management processes. This research, along with current and future research, will further challenge the use of seclusion and alternative strategies will need to be developed to significantly reduce the use of seclusion in the mental health services over the next 10 years.

Does seclusion result in a calmer patient? From the evidence available it is difficult to say whether seclusion does or does not calm patients. What we do know from Meehan et al. is that 100 per cent of nurses believe that seclusion has a calming effect, while 65 per cent of patients in this study stated that seclusion never made them feel any better. It is acknowledged that Meehan et al., a quantitative descriptive study, is considered weak in comparison to controlled studies. However, no controlled studies exist that evaluate the value of seclusion for people with acute mental illness (Sailas & Fenton, 1999), most likely due to the ethical considerations of controlled studies. Reviewing the literature and appraising the most valid article has not answered the question but has given greater awareness of nurses’ and patients’ perceptions of seclusion and the effect that seclusion has on patients.
References


Griffiths, L. (2001). Does seclusion have a role to play in modern mental health nursing? British Journal of Nursing, 10 (10), 656–661.


