The Practice of Seclusion and Time-out on English Acute Psychiatric Wards: The City-128 Study

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Background: Seclusion is widely used internationally to manage disturbed behavior by psychiatric patients, although many countries are seeking to reduce or eliminate this practice. Time-out has been little described and almost completely unstudied.

Aim and Method: To assess the relationship of seclusion and time-out to conflict behaviors, the use of containment methods, service environment, physical environment, patient routines, staff characteristics, and staff group variables. Data from a multivariate cross-sectional study of 136 acute psychiatric wards in England were used to conduct this analysis.

Results: Seclusion is used infrequently on English acute psychiatric wards (0.05 incidents per day), whereas time-out use was more frequent (0.31 incidents per day). Usage of seclusion was strongly associated with the availability of a seclusion room. Seclusion was associated with aggression, alcohol use, absconding, and medication refusal, whereas time-out was associated with these and other more minor conflict behaviors. Both were associated with the giving of as required medication, coerced intramuscular medication, and manual restraint. Relationships with exit security for the ward were also found.

Conclusions: Given its low usage rate, the scope for seclusion reduction in English acute psychiatry may be small. Seclusion reduction initiatives need to take a wider range of factors into account. Some substitution of seclusion with time-out may be possible, but a rigorous trial is required to establish this. The safety of intoxicated patients in seclusion requires more attention.

SECLUSION OF PATIENTS by isolating them in specially prepared locked rooms is a common strategy in the management of disturbed behavior among psychiatric inpatients. Seclusion seems to be used in a variety of circumstances, the most prevalent being aggression, including verbal abuse (Mason & Whitehead, 2001), property damage (Ahmed & Lepnurm, 2001), physical aggression to others (Sullivan, Wallis, & Lloyd, 2004), and self-harm (O'Brien & Cole, 2004). It is also used for the management of acute psychiatric symptoms (Morrison & Lehane, 1991), disruptive behavior (Oldham, Russakoff, & Prusnofsky, 1983), and risk of absconding (Morrison, Lehane, Palmer, & Meehan, 1997). Time-out is less well studied. Apart from the older literature on the use of

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this as a behavior therapy intervention to withdraw access to positive reinforcement (Clark, Rowbury, Baer, & Baer, 1973), little has been published, and we were unable to locate many previous empirical studies of it use as a containment method for disturbed patient behavior in psychiatric wards (Ryan & Bowers, 2006).

Variations in the use of seclusion exist between countries, with some using seclusion much more frequently than others (Bowers et al., 2007a), and additionally, surveys have shown significant variation in usage rates within countries (Crenshaw & Francis, 1995). Rates of seclusion are generally badly expressed in published work so far, with few studies providing much information of service setting, patient flows, bed numbers, and occupancy, making comparisons problematic (Bowers, 2000). Several countries are working hard to reduce their use of seclusion, including the United States (American Psychiatric Association, 2003), Australia (Australian Government, 2008), and the Netherlands (Abma, Widdershoven, & Lendermeijer, 2005; Janssen, Noorthoorn, De Vries, Hutschemaekers, Lendermeijer, 2008). There are several before-and-after studies of various interventions to reduce seclusion use, and although most are not well-described or rigorously carried out research projects, they do generally demonstrate falls in seclusion use (Mistral, Hall, & McKee, 2002; Smith et al., 2005; Sullivan et al., 2004).

Despite the many published empirical studies on seclusion, most have been conducted in single hospitals, thereby raising questions about generalizability, as well as producing a degree of heterogeneity in findings about the profile of secluded patients. For example, some studies show men are more likely to be secluded (El-Badri & Mellsop, 2002), others women (Hafner, Lammersma, Ferris, & Cameron, 1989), and yet others find no significant gender difference (Sullivan et al., 2004). Similarly contradictory findings are apparent for staffing levels, staff gender, and many other issues. In this study, we report survey data covering 6 months on 136 acute psychiatric wards in England.

AIM

In this analysis of a large dataset, we aimed to assess the relationship of seclusion (isolation of a patient in a locked room) and time-out (patient asked to stay in room or area for period, without the door being locked) to conflict behaviors, the use of containment methods, service environment, physical environment, patient routines, staff characteristics, and staff group variables.

METHODS

Design

A multivariate cross-sectional study was conducted.

Sample

The sample is composed of 136 acute mental health wards with their patients and staff in 67 hospitals in 26 NHS Trusts (organizational units with common clinical policies and investment levels) in England, in 2004–2005. Acute mental health wards were defined as those that primarily serve adults with acute mental health problems, mainly taking admissions directly from the community and not offering long-term care or accommodation. Wards that were organized on a speciality basis; that planned to change population served, location, function; or were scheduled for refurbishment during the course of the study were excluded. The 136 acute mental health wards that participated in the study represented 25% of the estimated 551 wards in England. The study was approved by the North West Multi-Centre Research Ethics Committee.

Instruments and Response Rates

The Patient–Staff Conflict Checklist (PCC-SR), an end-of-shift report by nurses on the frequency of conflict and containment events, was collected for a 6-month period on all participating wards (Bowers et al., 2005). On entry to the study, the ward nursing staff received training in this measure, and each ward was provided with a handbook giving definitions of items. At the end of each shift, nurses indicated the frequency of 19 conflict events (including aggressive behaviors, rule breaking, absconding/eloping, consumption of drugs or alcohol, regular medication refusal, PRN medication refusal, and demanding PRN medication) and 10 containment methods (including medication, seclusion, manual restraint etc.). Because wards were in the study for 6 months, each submitted several hundred PCC-SRs. In recent tests based on use with case note material, the PCC-SR has demonstrated an interrater reliability of .69 (Bowers