A RETROSPECTIVE RECORD REVIEW OF PATIENTS SECLUDED AT A TERTIARY PSYCHIATRIC HOSPITAL

Gaveeta Chiba

Degree of Master of Medicine in Psychiatry

A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Medicine in the branch of Psychiatry.

Johannesburg, 2013

DECLARATION

Johannesburg, 2013

I, Gaveeta Chiba declare that this research report is my own work. It is being submitted for the degree of Master of Medicine in Psychiatry in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

……

This ……...day of ……..2013

DEDICATION

This work is dedicated to:

My husband, Shawn Moodley

My father, Viniachandra Chiba

My mother, Dhanwanthie Chiba

Thank you all for your support.

PUBLICATIONS AND PRESENTATIONS ARISING FROM THIS STUDY

Oral presentation

Division of Psychiatry, University of the Witwatersrand – Annual research Day 2009

ABSTRACT

This study aims to determine the number of patients secluded over a specified period, provide a profile of patients that are likely to be secluded, and to ascertain the reasons for seclusion.

Seclusion in the psychiatric context can be defined as the involuntary confinement of an agitated, unstable person alone in a contained, controlled environment. There are differing views on seclusion and consequently this has presented clinicians with an ethical dilemma. Significant morbidity and mortality have been associated with seclusion. In light of this, alternatives to seclusion have been explored. No data exists in South Africa on rates of seclusion for psychiatric purposes, and consequently neither the need for seclusion nor alternatives to seclusion have been explored.

The study is a retrospective review of patients secluded at Sterkfontein Hospital, a tertiary psychiatric hospital, over a six month period. Data was collected from clinical records at Sterkfontein Hospital.

RESULTS: 112 patients were secluded over the 6 month period. Users were secluded for a total of 59415.5 hours and on 4814 separate occasions. 84.8% of the users secluded were male. The mean age of users secluded was 29years. Just over half the users (52%) were secluded for their own safety and 40% of users were secluded for aggression (either physical or verbal). The commonest diagnosis was Schizophrenia (31.4%) followed by Cognitive Impairment (20.6%) and Bipolar Mood Disorder (13.7%). The most commonly used medication was Sodium Valproate (17%), followed by Haloperidol (11%) and Risperidone (11%).

CONCLUSION: Younger male patients with psychosis were most likely to be secluded. More research should be conducted locally to compare seclusion in terms of rates and patient profiles so that we may improve seclusion practices.

ACKNOWLEDGDEMENTS

1. Supervisor Professor U Subramaney
2. Statistician Professor E Libhaber
3. Special facilities at the University of Witwatersrand - Research courses
4. The staff at Sterkfontein Hospital for their assistance during the collection of data.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

NOMENCLATURE

Seclusion means the isolation of a user in a space, where his or her freedom of movement is restricted

The Act means the Mental Health Care Act, 2002 (Act No. 17 of 2002), abbreviated as MHCA.

Mechanical restraint means the use of any instrument or appliance whereby the movements of the body or any of the limbs of a user are restrained or impeded

State patient is a person so classified by a court directive in terms of section 77 or 78 of the Criminal Procedure Act; such persons have been found unfit to stand trial and/or not criminally responsible due to mental illness or intellectual disability.

Observation users are persons referred by court for psychiatric observation in terms of section 79 of the Criminal Procedure Act; they are referred for assessment of their competence to stand trial (current competence), and criminal responsibility during the period of offence (past competence).

Involuntary mental health care users are users admitted under section 33/34 of the MHCA. These users are incapable of making informed decisions, and there is reasonable belief that such users have a mental illness of such a nature that the user is likely to inflict serious harm to self or others and /or Care, Treatment or Rehabilitation (CTR) is necessary for protection of financial interests or reputation of patient.

CHAPTER 1: INTRODUCTION AND LITERATURE REVIEW

1.1 DEFINITION AND INDICATIONS FOR SECLUSION

Seclusion can be defined as the involuntary confinement of an agitated, unstable person alone in a contained, controlled environment (1). The use of seclusion for patients who are at a risk of harm to themselves or others has been a generally accepted medical practice for many years (2).

There are differing views on seclusion. "The seclusion of psychiatric patients is viewed by some as a violation of basic human rights, by others as a necessity for the control of violence, and by still others as a therapeutic modality"(3).

Fisher et al. in their review of restraint and seclusion from 1977 to 1994 in the USA concluded that seclusion is effective (4). Their review cited various authors who found the usefulness of seclusion. They found that seclusion prevented injury and lessened agitation by reducing sensory overload and paranoid excitation. It also served to preserve calm in the ward, conserved nursing resources and assisted in building therapeutic relationships. Their review also found studies that felt that seclusion in children as part of a therapeutic management program brought about positive behavioral outcomes.

Busch et al. in a literature review done in 2000 in the USA questioned the need to use seclusion as they found little evidence to guide clinical practice regarding the relative benefits and risks of seclusion. He also found inconsistencies in the application of seclusion (5).

Seclusion and restraint are not “benign” interventions. Significant morbidity and mortality have been associated with them (1). It is not infrequent that patients have attempted suicide or self-harmed whist in seclusion, given the acute nature of their condition. The use of restraints uses direct physical force to control freedom of movement. Physical restraint has been associated with an increased risk of “aspiration, positional asphyxia, dehydration, and restriction of circulation leading to possible pulmonary embolism.” (1). There is also a risk of bringing up old trauma in patients with a history of trauma, loss of dignity and other emotional injury (6). Seclusion and restraint also causes risk to staff such as injuries to staff applying the restraints (7), and a negative emotional impact on staff who participate in restraint episodes (8).

In light of these potential serious consequences, the State Mental Health Directors in Alexandria endorsed that seclusion and restraint should be used only when an “imminent risk of danger to the individual or others exists and no other safe and effective intervention is possible”. (Endorsed by the State Mental Health Directors, July 13, 1999) (6).

1.2 ETHICS

Worldwide, the use of seclusion has attracted much debate and controversy since the advent of modern psychiatry. Seclusion provides an ethical dilemma for clinicians. Opinion and operational definition varies as to whether seclusion is a “medical treatment, nursing intervention and management tool, or merely a form of situational restraint”, according to Muir-Cochrane et al. (9). In a paper discussing the legal issues of seclusion in Australia and New Zealand, this lack of clarity was revealed in Mental Health Acts and seclusion policies internationally (9). “The debate about the appropriateness of seclusion as a nursing practice in inpatient settings in the 21st century continues, with powerful and often emotive arguments from those who view it as an anachronistic and punitive form of ward

management, and from others who see it as a useful emergency measure to protect individuals from imminent harm." (9) (10).The ethical conflict arises when one considers balancing the patients' right to autonomy versus the paternalistic responsibility to prevent harm to self and others (11).

1.3 INTERNATIONAL LITERATURE

In 1998 the Hartford Courant, a newspaper in New York published articles on deaths related to seclusion and restraint. This followed five months of research into deaths that occurred to psychiatric or developmentally disabled patients who were restrained or secluded. Congressional hearings followed and these confirmed that restrained and secluded patients were traumatised and many died as a result of violent procedures (12). The resulting public and professional outcry pressed forward a flurry of new federal regulations and legislative initiatives setting national standards for reporting and clinical oversight (5). One such regulation was the "one hour rule," which states that within the first hour clinicians are required to perform a face-to-face evaluation of the person in seclusion or restraint (12).

Busch AB et al. revealed that rates, duration, and methods of seclusion and restraint still varied widely. They found little evidence to guide clinical practice regarding relative benefits and risks of various methods to control acute adult patient aggression; and even less evidence was found in child and adolescent populations (5). Despite the risks associated with seclusion, and the ongoing ethical debate about seclusion, there has been limited data on procedures that will lead to the decreased use of seclusion (7). Various programmatic efforts successfully reduce seclusion and restraint, at times dramatically, and can be used as examples of systematic quality improvement so "best practices" may evolve and spread throughout psychiatric inpatient settings (5).

Data on the rates of seclusion vary widely (13). This is due to a variety of factors. Firstly there are different methods of collecting and reporting data, for instance in the USA seclusion is reported as rates of seclusion per 1000 days. European and Australian data are often reflected as a percentage of admissions exposed to seclusion. Secondly seclusion occurs in various settings namely acute settings, nursing homes, homes for intellectually disabled, in both psychiatric hospitals and general hospitals and in forensic psychiatric settings. Some studies are conducted nationwide and others involve a single hospital setting. Lastly there are 2 statistical parameters used (either mean or median) to calculate the amount of time spent in seclusion. All this makes it difficult to compare data as a standardised method of comparison does not exist.

In their review of the evidence regarding the impact of programmatic changes on the use of seclusion and restraint, Busch and Shore concluded that interventions that are effective are those that focus on the reduction of the use of seclusion and restraint procedures themselves rather than focusing on substituting one form of intervention for another (5).

Gregory et al. examined the use of seclusion and mechanical restraint from 1990 to 2000 as well as the rate of staff injuries from patient assaults from 1998 to 2000 in a state hospital system in Pennsylvania. The study concluded that the rate and duration of seclusion decreased due to multiple factors. These included advocacy efforts, state policy change, improved patient-staff ratios, response teams, and the use of second generation antipsychotics (14).

Pollard et al. in the USA investigated the changes in seclusion and restraint within a secure acute mental health facility before and after instituting the Joint Commission on the

Accreditation of Healthcare Organizations (JCAHO) 2000 standards for utilization (2). These changes included formal and informal interventions implemented by leadership such as discussion on alternatives to seclusion, staff concerns on new policy and videotapes to stimulate discussion. Leadership commitment was reflected in facility policy, which includes review by leadership on of all episodes of seclusion. The conclusions were that the commitment that the facility and unit leadership had to new policies and the consistency of the leaderships message over time strongly affected organizational practices even though staff was apprehensive and resistant to change. Through continued facility and clinical leadership such changes could be sustained and a new standard of practice could be instituted.

Hellerstein et al. described a hospital-wide effort at an urban academic psychiatric hospital - New York State Psychiatric Institute, to decrease restraint and seclusion of psychiatric inpatients (12). Their hypothesis was that interventions could reduce the number of patients as well as patient hours in restraint and seclusion, without an increase in adverse outcomes (fights/assaults, staff injuries, and abscondments). Interventions included: 1) decreasing initial time in restraint or seclusion before a new order was required; 2) education of staff on how to identify patients at risk of seclusion and how to intervene early to avoid crises; and 3) use of a coping questionnaire to assess patient preferences for dealing with agitation. Results revealed the mean number of patients secluded decreased significantly and the mean hours of seclusion decreased markedly. Adverse outcomes (patients absconding and fights/assaults) also decreased significantly over the follow-up period. The study concluded that interventions were successful in decreasing use of restraint and seclusion on both clinical and research units over more than 5 years of follow-up and that such interventions could be tailored to suit other settings.

More recently (2007) Gaskin et al. concluded, after doing a peer based English language literature review on interventions that allow reduction in seclusion rates, that reducing seclusion rates is difficult and generally requires staff to implement several interventions (15). Most of these interventions have been mentioned above. Others include changing the therapeutic environment and changing the facility environment.

1.4 AFRICAN LITERATURE

In Africa, Sebit et al. from the University of Zimbabwe Medical School analysed the frequency of seclusion in psychiatric patients. The study demonstrated that seclusion was common (8, 5% of patients admitted during the study period); male patients were more likely to have been brought in by police; female patients were more likely than male patients to assault staff/other patients (16).

The rights of people with mental illness are often inadequately protected or overlooked in the laws of Ghana, Uganda and Zambia. Essential safeguards to prevent the abuse of seclusion and restraints are lacking (17). This is according to a Mental Health and Poverty Project brief developed by the Department of Mental Health and Substance Abuse, World Health Organization, Geneva. The project aims at developing effective mental health laws in Africa.

1.5 MHCA AND SECLUSION

The Mental Health Care Act (MHCA), 2002 (Act No. 17 of 2002) of South Africa defines seclusion as the isolation of a user in a space, where his or her freedom of movement is

restricted (18).

Chapter 5 section 29 of the MHCA states that:

(1). A mental health care user shall not be secluded as a punishment and seclusion may only be used to contain severely disturbed behaviour, which is likely to cause harm to others and where other treatment techniques have failed.

(2) While the mental health care user is secluded, he or she shall be subject to observation at least every 30 minutes.

(3) Whenever seclusion is utilized -

(a) a register, signed by a medical practitioner, shall be completed;

(b) the time period of seclusion and the reason for secluding such mental health care user shall be outlined in such register by such medical practitioner; and

(c) the head of the health establishment concerned shall receive a report on a daily basis indicating all incidents of seclusion.

(4) A transcript of the register referred to in sub regulation (2) shall be submitted by the health establishment concerned to the Review Board on a quarterly basis in the form of the form, MHCA 48.

In accordance with the MHCA, a mental health care user may be provided with care, treatment and rehabilitation (CTR) services without his or her consent (involuntarily) at a health establishment on an inpatient basis if at the time of making the application; there is reasonable belief that the mental health care user has a mental illness of such a nature:

a) that the user is likely to inflict serious harm to himself or herself or other;

b) for the protection of the financial interests or reputation of the user;

c) that the user is incapable of making an informed decision on the need for the CTR and is unwilling to receive the CTR required.

The Mental Health Care Act No. 17 of 2002 also called for the decentralisation of mental health care. One of the ways to do this was by introducing a 72-hour emergency referral and observation period for mental healthcare users (MHCUs) in designated regional and district general hospitals before onward referral to tertiary hospitals. However, translating the law into practice has proven to be challenging in various aspects including seclusion practices. Studies conducted after the promulgation of the Act suggest that implementation has not been optimal as described by Lund et al. in their review of Mental health service delivery in South Africa from 2000-2010 (19).

Sixty per cent of designated hospitals reported inadequate facilities, as found in a comprehensive study by Ramlal in her review of the MHCA from 2002 - 2012 (20). Amongst those were complaints of lack of seclusion rooms and staff to manage the clinical demand of disruptive patients. More than half (55.6%) of designated hospitals had no seclusion facilities. Of the remaining hospitals, if seclusion facilities were available the infrastructure or number of facilities was unsatisfactory, with five hospitals using inadequately refurbished wards or medical isolation units as ‘seclusion’ facilities (21). Similar sentiments were expressed by practitioners countrywide, who felt that amongst other factors, lack of seclusion facilities prevented them from applying the ideals detailed in the Act (20).

However Dr Tom Sutcliffe, former provincial Director-General of Health (1993 - 2002) and now chairperson of the trend-setting (Western Cape) Mental Health Review Board, paints a different picture (22). When asked by Bateman about the overall provision of mental health services in the Western Cape, Dr Sutcliffe replied that hospital staffs were “bit by bit not only

getting to understand their role in mental healthcare but are being provided with the resources (such as high and low secure areas enabling the seclusion of patients needing sedation)". This sentiment gives us hope for improving seclusion practices at a district level.

1.6 SECLUSION POLICY AT STERKFONTEIN HOSPITAL

Sterkfontein hospital's seclusion policy was last updated in 2011 (Appendix E). The seclusion policy defines seclusion, and clearly states how permission for seclusion is to be obtained and documented for short and long term seclusion that can occur during the day or at night. Permission for seclusion is obtained from a doctor and during the night the professional nurse in charge of the hospital must be notified. Long term seclusion must be prescribed by the doctor of the unit, and is valid for 1 month. Telephonic permission must be documented on the Z693 prescription chart and the doctor giving telephonic prescription must enter written confirmation within 24 hours of giving the permission. Seclusion is documented in the seclusion book (Z663). The form MHCA 48 (Appendix E) is completed. Throughout the seclusion period the SHK 338(night) and 337(day) forms are to be completed by the professional nurses. Patient care is defined in the seclusion policy and illustrates general and specific measures pertaining to seclusion. Such measures are taken to ensure the safety of the user.

The above seclusion policy is in accordance with the MHCA in South Africa. The act states that seclusion may only be used in patients with 'severely disturbed behaviour' for containment and not as punishment. Observation must be done every 30 minutes and documented in clinical notes. A register must be signed by a doctor, the time period and reason for seclusion must be documented and the head of the health establishment must be notified daily of all seclusion incidents. A transcript of the register must be submitted by the health establishment to the Review Board on a quarterly basis in the form of form MHCA 48.

1.7 POLICY TO MANAGE VIOLENCE AND AGGRESSION AT STERKFONTEIN HOSPITAL

Sterkfontein Hospital has a policy/procedure to manage violence and aggression. It is reviewed every 3 years or when necessary. It was last reviewed by the Nursing Policy Review Team in July 2012 (Appendix G).

It used various legal and other references when it was drawn up, namely the MHCA 2002, The Criminal Procedure Act 1977, the Human Rights Act 1998 (Article 3 and 8), the Occupational Health and Safety Act 1993, Seclusion Policy/Procedure No 39, Common Law and Civil Law. It is directed at all employees (casuals and trainees), management, supervisors and directors at Sterkfontein Hospital. It provides guidelines and procedures to ensure that all staff can manage violence and aggression competently. It also establishes health and safety hazards attached to specific tasks and steps that may be taken to prevent them.

The guidelines for managing an aggressive/ violent patient are as follows:

1. primary prevention: preventing violence before it happens;
2. secondary prevention: reactive response de-escalation;
3. tertiary prevention: physical interventions, the use of medication prior to seclusion, post incident reviews and debriefs.
4. the last step in the process is **seclusion**.

It describes the use of mechanical restraints (indications and procedure). It also provides a list of safety rules and guidelines for staff, patients and visitors. Some of the rules include not attending to an aggressive/ violent patient alone, to call for help when attacked, reporting of all injuries, maintain safe distance from an armed person and call for help.

It is the responsibility of managers to ensure that all newly appointed staff receive comprehensive training in the management of aggression, violence and assault, to ensure that all staff attends regular refresher training and to carry out health and safety audits.

As part of the implementation of the policy Sterkfontein Hospital carries out a regular training programme on calming and restraint for all personnel. One of the basic tenets is the use of de-escalation techniques, prior to any other modality such as chemical or mechanical restraint. All nursing staff is trained, particularly newer staff members, with refresher courses for those who have had previous training. Doctors have their own session every 6 months to accommodate all the new Registrars/Medical Officers that are rotating through. It is run by a senior nursing manager and an assistant, both of whom have had specific training. The course is run in workshop format and is very practical and hands-on.

The literature review has demonstrated that although numerous studies have been done in USA, UK, Australia and some European countries, there is no recent South African data on rates of seclusion, demographic profile of patients secluded, amount of time spent in seclusion, environmental factors affecting seclusion policies, reason for seclusion. Consequently little attention has been paid to alternatives to seclusion, or factors that could decrease rates of seclusion in South Africa. To address this issue the starting point would be to formulate a profile of patients that are likely to be secluded, reasons for seclusion and examine seclusion policies.

This research study aims to determine the number of seclusions that occur over a 6 month period in a tertiary psychiatric facility, the reasons for seclusion and the clinical profile of patients that are most likely to be secluded. It begins by reviewing the international and African literature on seclusion trends and explaining the South African legalities regarding seclusion. It follows with a description of the study methodology, presenting the results of the

study and a discussion of the findings of the study. It closes by listing the limitations of the study and concludes with recommendations for enhancing seclusion practices at the study site.

CHAPTER 2: MATERIALS AND METHODS

2.1 AIMS AND HYPOTHESIS

2.1.1 Aims

1. To measure the number of seclusions that occurred per month over a 6 month period.
2. To ascertain the demographic profile of users secluded.
3. To determine the reasons for secluding users.
4. The clinical diagnosis of users secluded.

* For the purposes of this study and in keeping with legitimate and correct nomenclature the word “users” will describe “patients” secluded as per the study title.

2.1.2 Hypothesis

Seclusion is most likely to be administered for young acutely psychotic males with aggressive behaviour.

2.2 METHODOLOGY

2.2.1 Study design

This was a retrospective cross sectional record review of users secluded at Sterkfontein hospital over a 6 month period.

2.2.2 Study site

The study was conducted at Sterkfontein Hospital. Located in Krugersdorp, Sterkfontein Hospital is the largest of the specialist hospitals associated with the University of the Witwatersrand Department of Psychiatry. It is a tertiary hospital and caters for mentally ill users requiring involuntary treatment, care and rehabilitation as well as assessment of forensic cases and care of "State President's Detainees". The Hospital has lock up facilities as well as open wards. Both adults and adolescent users may be admitted. There is an independent living unit which caters for higher functioning patients who could benefit from individual and group psychotherapy. All wards have rooms for seclusion. Sterkfontein Hospital thus provides the ideal setting for an investigation into the practice of seclusion.

All wards were included in the study.

The wards are grouped as follows:

- Involuntary users- 5 adult male and 2 adult female wards
- State users- 4 adult male and 2 adult female wards, one of each of these wards also admits adult observation users and thus some wards are categorised as ‘Adult Male Observation and State’ and ‘Adult Female Observation and State’
- Adolescent male ward with state and observation users

The user status will be derived from the ward from which the user was admitted i.e.

- Involuntary (male and female)
- State (male and female)
- Adult Male Observation and State
- Adult Female Observation and State
- Adolescent Male (state and observation users)

2.2.3 Sample Population

The study population included the records of male and female users secluded at Sterkfontein Hospital during a 6 month period in 2006.

Sterkfontein hospital has 2 female acute wards and 1 state patient female ward catering for both observations and state users. Male users are accommodated in wards which comprise 3 acute, 2 chronic and 4 state patient wards. Of the 612 usable beds at Sterkfontein Hospital, female beds comprise 74 beds.

2.2.4 Measurements

Data was collected from clinical records at Sterkfontein Hospital as well as the MHCA 48 forms (Appendix E) that are sent to the review board. The latter are compiled by nursing staff and are taken directly from the seclusion register in each ward.

Clinical records provided the age, diagnosis and discharge medication for users.

The form MHCA 48 provided the date, time, ward and reason for seclusion for users secluded.

Form MHCA 48 records whether users were either secluded (Option B) or restrained (Option A); only users who were secluded are included in the study.

When the data was collected the reasons for seclusion were recorded as per MHCA form 48 into the (6) categories as seen in figure 6. These reasons have been divided into 2 groups to look at the data in terms of those secluded as per MHCA indications i.e. ‘‘aggression/ risk of violence’ and ‘users own safety’, the latter is not an indication for seclusion as per MHCA.

2.2.5 Materials

To assist in data collection a data sheet (Appendix D) with the following was used to collate information:

- Age
- Sex
- Reason for seclusion
- Length of time spent in seclusion
- Date of admission DOA)
- Date of discharge (DOD)
- Diagnosis
- Medication

The variables that were included in the review were: age, sex, reason for seclusion, length of time spent in seclusion, diagnosis and medication.

The variables of diagnosis and medication might suggest a higher likelihood of psychopathology.

A total of 112 users were secluded and had seclusion documents, however, the clinical records of 26 users were not found.

2.2.6 Statistics

Data was captured on an Excel spreadsheet. Data was analyzed using the SAS version 9.2 statistical program (SAS, Cary, NC, USA). Results are expressed as mean and standard deviation or median [range] for non-normal distribution or frequencies and percentages for categorical variables. To assess differences by gender, user status, diagnosis and medication, and the reasons for seclusion, the Mann-Whitney Wilcoxon test for scores or

continuous non- normal distributed variables was used. Categorical variables were compared with Chi^2 or Fisher's exact tests where appropriate. Significance was assumed at a both-sided value of $p < 0.05$.

2.3 ETHICS

Permission was obtained from the CEO of the hospital to obtain access to records for data collection. (Appendix A).

The protocol was approved by the University of Witwatersrand Human Research Ethics Committee (HREC), protocol number M080505 (Appendix B).

Data was collected and stored in a confidential manner. The user's name remained anonymous and was not recorded on the data sheet. Only the researcher kept and had access to a separate register recording the users name and study number.

None of the data was disclosed to sources outside of the research process.

CHAPTER 3: RESULTS

3.1 NUMBER OF SECLUSIONS OVER 6 MONTH PERIOD

A total of 112 users were secluded over the 6 month period.

All 112 users had seclusion documents, however, the clinical records of 26 users were not found.

The number of seclusions that occurred per month in terms of the number of users who were secluded, the hours secluded and occasions secluded is summarised in Table 1 and illustrated in figures 1and 2.

The total amount of time spent by all the users who were secluded during a particular month is indicated in hours. The 'occasions' secluded refers to the number of separate episodes that users were secluded in that month.

Table 1 Total number of seclusions per month over 6 months at Sterkfontein Hospital

Seclusions	**March**	**April**	**May**	**June**	**July**	**August**	**Total**
No. of users	38	33	41	44	39	36	
Total hours	11814	8375	10621.5	10755	9526	8324	59415.5
Occasions	933	669	826	889	806	691	4814

Users were secluded for a total of 59415.5 hours and on 4814 occasions.

On average there were 802 seclusions per month and the average time spent in seclusion per month was 9902 hours. Figure 1 depicts the number of users secluded per month.

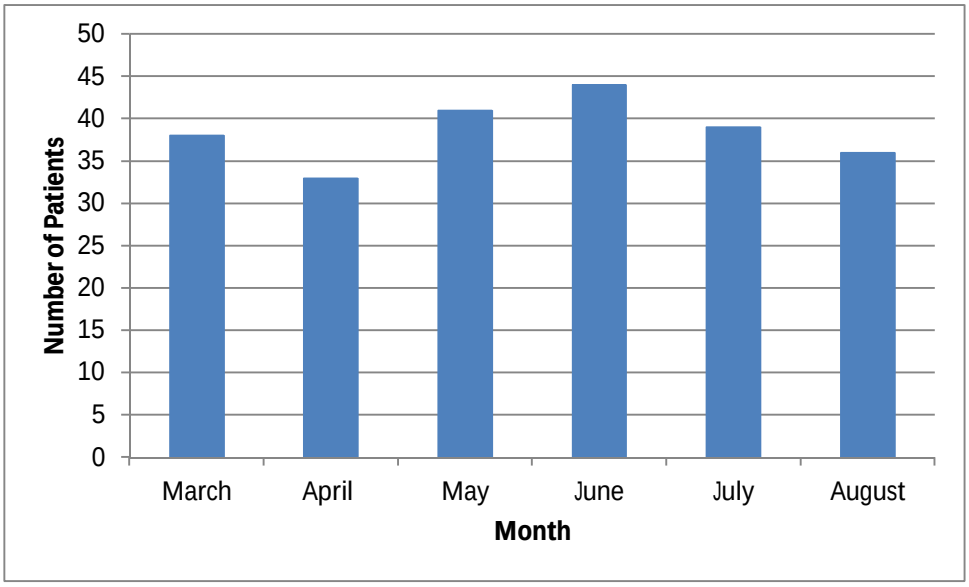

Figure 1 Number of users secluded per month during a 6 month period at Sterkfontein Hospital

Figure 2 depicts the total time spent in seclusion per month

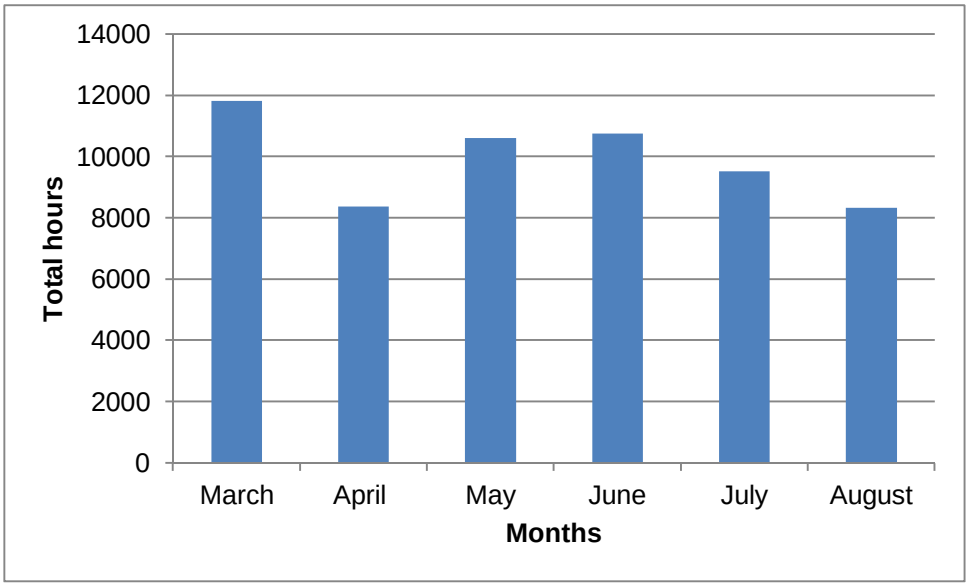

Figure 2 Total time spent in seclusion per month during a 6 month period at Sterkfontein Hospital

Table 2 depicts the following:

- The number of users that were secluded each month
- The mean number of hours that each user spent in seclusion during each month.
- The range of time that users spent in seclusion (maximum and minimum hours).
- The mean number of episodes (occasions) that each user was secluded during that month.
- The mean of each parameter over the 6 month period.

Table 2 Number of hours secluded and episodes of seclusion per user during a 6 month period at Sterkfontein Hospital

Month	**March**	**April**	**May**	**June**	**July**	**August**	**Mean**
Number of users	38	33	41	44	39	36	38.5
Hours(mean)	311	253	259	244	250	237	259
Hours (minimum)	2	2	1	2	1	1	1.5
Hours (maximum)	568	430	529	595	640	546	551
Occasions (mean)	24.5	20	20	20	20	19	20.6

The mean number of users secluded per month was 38.5.

The mean number of hours spent in seclusion every month per user was 259 hours.

The minimum amount of time that was spent in seclusion was 2 hours and the maximum amount of time that was spent in seclusion was 640 hours per month.

The mean number of episodes of seclusion per user was 20.6 per month.

The mean number of hours spent in seclusion per occasion was 12.5 hours.

3.2 DEMOGRAPHIC PROFILE

Table 3 illustrates the demographic profile of users that were secluded during the 6 month period.

Table 3 Demographic profile of users secluded during a 6 month period at Sterkfontein Hospital

Gender (%)	Male	84.82 (n=95)
	Female	15.18 (n=17)
Age (years)	Mean (SD=10.4)	29
	Youngest	13
	Oldest	67
User status (%)	Involuntary (male and female)	35.71
	State (male and female)	35.71
	Adult Male Observation and State	8.04
	Adult Female Observation and State	5.36
	Adolescent male (State and observation)	15.18

3.2.1 Gender

84.82% (n=95) of users secluded were male whilst 15.18% (n=17) of users were females as depicted in figure 3.

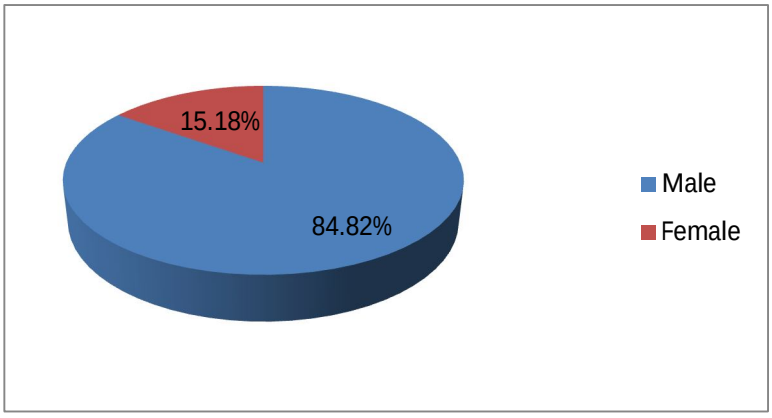

Figure 3 Gender differences in users secluded during a 6 month period at Sterkfontein Hospital

3.2.2 Age

The mean age of users secluded was 29years (SD=10.4) (95%CI), the youngest user was 13years old and the oldest was 67years old. Figure 4 depicts the percentage of the total number of users secluded, in 10 year age intervals.

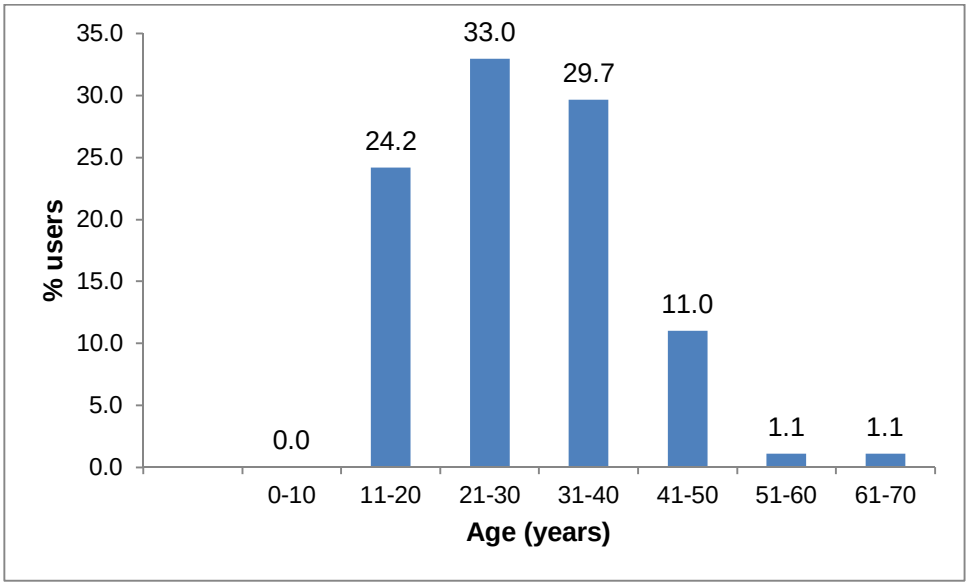

Figure 4 Age group distributions during a 6 month period at Sterkfontein Hospital

The bar graph illustrate that 33% of users secluded are in the 21-30year age group, followed by 29.7% in the 31-40year age group.

The 11-20 year old group follows with 24.2%.

3.2.3 User status

The percentage of involuntary, state and observation users is depicted on the pie chart.

35.7% (n=40) of users secluded were involuntary users, the rest were forensic users (either state or observation users).

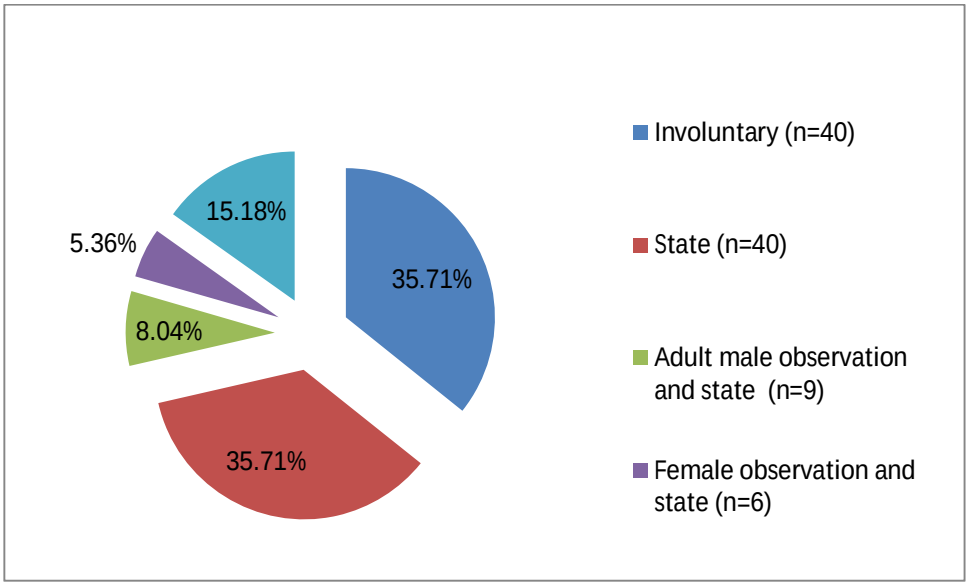

Figure 5 User admission status during a 6 month period at Sterkfontein Hospital

3.3 REASONS FOR SECLUSION

Figure 6 illustrates the reasons users were secluded as documented in the form MHCA 48.

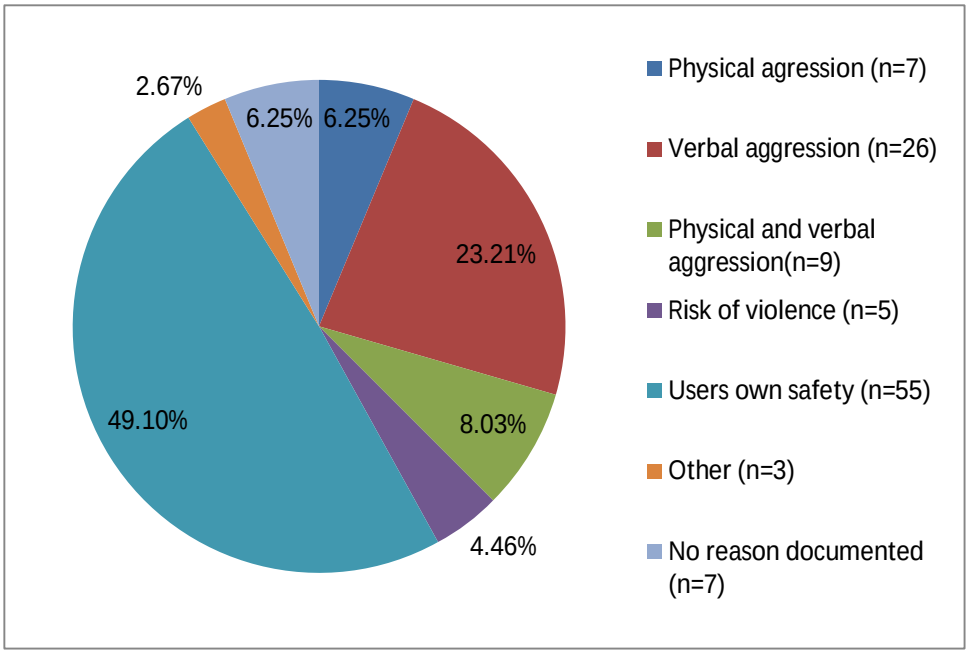

Figure 6 Reasons for seclusion during a 6 month period at Sterkfontein Hospital

Close to half of the seclusions (49.1%, n=55) were due to 'Users own safety'.

Almost a quarter (23.21%, n=26) were secluded for verbal aggression and 8.03% (n=9) were secluded for both physical and verbal aggression.

Collectively 37.40% (n=42) of users were secluded for aggression (either physical or verbal or both).

'Other' reasons for seclusion (2.86%, n=3) included attempting to abscond, self-harm attempts, previous sodomy by a fellow user and in 1 case when the user was disorientated and felt to be a danger to himself.

No reason for seclusion was documented for 7 users.

When the data was collected the reasons for seclusion were recorded as per MHCA form 48 into the categories as seen in figure 6. The division described above was made to look at the data in terms of those secluded as per MHCA indications i.e. ‘‘aggression/ risk of violence’ and ‘users own safety’, the latter is not an indication for seclusion as per MHCA.

In order to assess the data better the reason that users were secluded was divided into 2 groups: ‘users own safety’ and ‘aggression/ risk of violence’, the latter group is a combination of the remaining reasons for seclusion that were documented on the form MHCA 48 (i.e. physical aggression, verbal aggression, both physical and verbal aggression, threat of violence, other, no reason documented). Figure 7 compares how males and females differed when secluded for these 2 reasons.

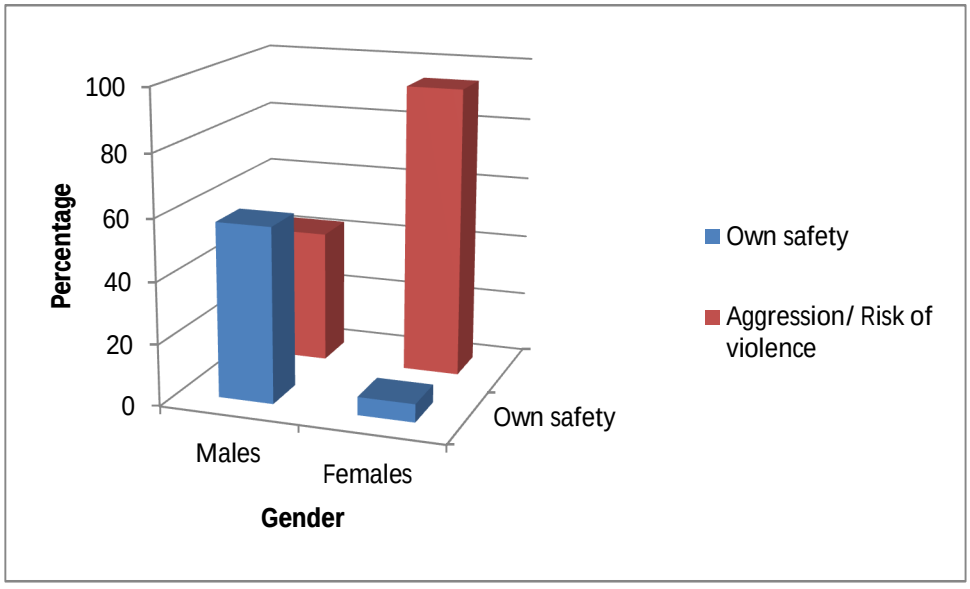

Figure 7 Comparisons of reasons for seclusion by gender during a 6 month period at Sterkfontein Hospital

Males were marginally more likely to be secluded for their own safety (56.8%, n=54) than for aggression/ risk of violence (43.2%, n=41). Females were mostly secluded for aggression/ risk of violence (94.1%, n=16) compared to being secluded for their own safety (5.88%, n=1).

Using the same division for reasons that users were secluded, as above, and condensing the status of users into involuntary users and forensic users (male and female state and observation users) Figure 8 below allows us to compare the reasons that involuntary and forensic users were secluded.

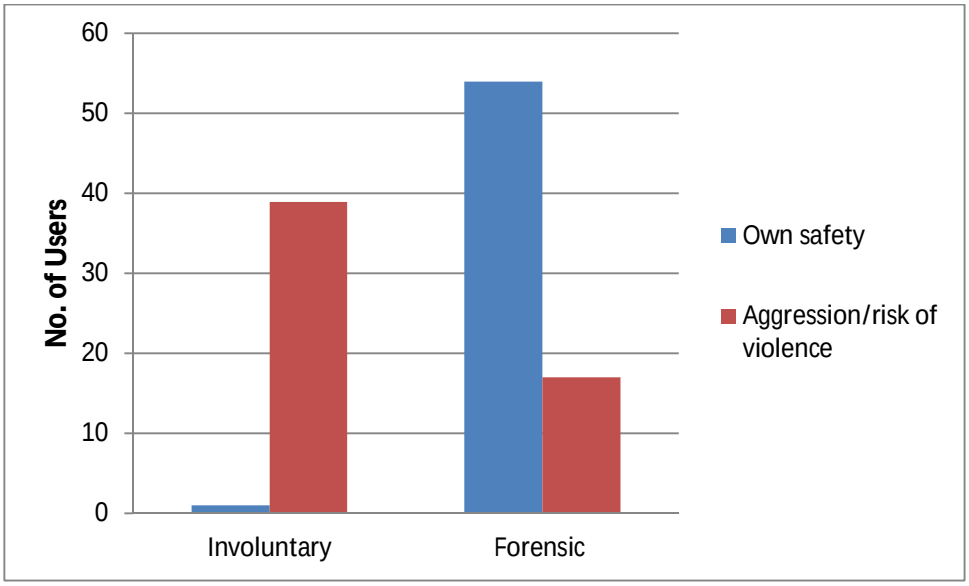

Figure 8 Comparison of user status and reasons for seclusion during a 6 month period at Sterkfontein Hospital

The figure illustrates that only 1 involuntary user was secluded for his own safety and 39 for aggression or the threat of violence. In the forensic wards close to three quarter of the users (n=54) were secluded for their own safety and 17 users were secluded for aggression or threat of violence.

3.4 CLINICAL DIAGNOSIS

The diagnostic system that applied at the time of the study and data collection is DSM IV-TR. The diagnoses recorded were those taken from the clinical records of the users.

There were 16 diagnoses found collectively. Of the 86 clinical records found, 16 users had 2 diagnoses. The total number of diagnoses adds up to 102 as the total numbers of clinical records found were 86, in addition to the 16 users who had a second diagnosis. Table 4 and Figure 9 depict the frequency (number of users) and percentage at which the diagnoses were documented

Table 4 Diagnoses of users secluded during a 6 month period at Sterkfontein Hospital

	DIAGNOSIS	**1**	**2**	**Total number of users**	**%**
1	Schizophrenia	32		32	31.4
2	Bipolar Mood disorder (BMD)	14		14	13.7
3	Cognitive Impairment (CI)	18	3	21	20.6
4	Epilepsy	2	2	4	3.9
5	Conduct Disorder	1	1	2	2.0
6	Personality disorder	1		1	1.0
7	Dementia	1	2	3	2.9
8	Substance Abuse (SA)		2	2	2.0
9	Substance induced Psychosis (SIP)	3	3	6	5.9
10	None	3		3	2.9
11	Psychotic disorder NOS	4		4	3.9
12	Schizoaffective disorder (SAD)	4	2	6	5.9
13	Frontal lobe syndrome	1		1	1.0
14	Disruptive behavioural disorder		1	1	1.0
15	Organic Brain Syndrome	1		1	1.0
16	Mood disorder secondary to HIV	1		1	1.0

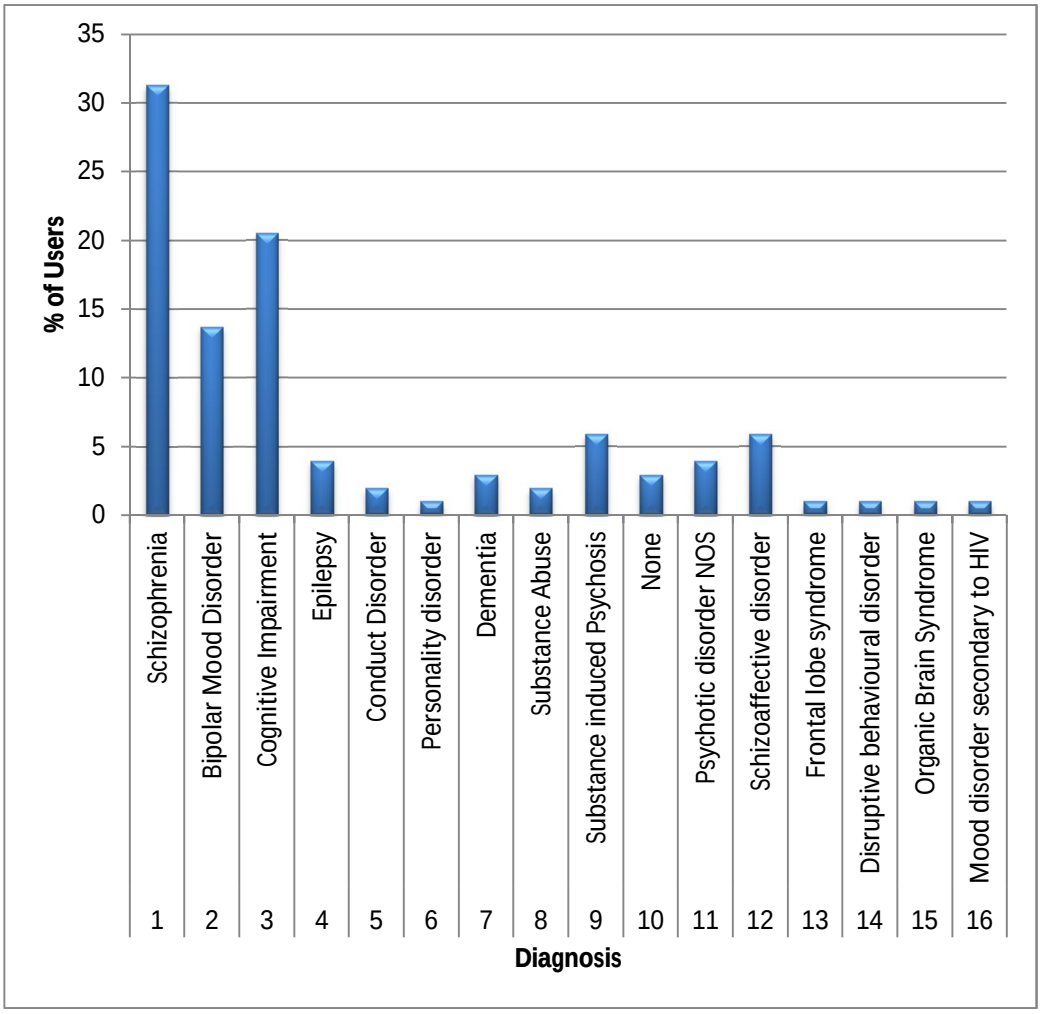

Figure 9 Diagnosis of users secluded during a 6 month period at Sterkfontein Hospital

The commonest diagnosis was Schizophrenia (n=32, 31.4%) followed by Cognitive impairment (refers to Intellectual Disability as recorded in the clinical notes,) (CI) (n=21, 20.6%) and Bipolar Mood Disorder (BMD) (n=14, 13.7%).

Of the 86 clinical records found, 16 users had a second diagnosis.

Table 5 illustrates diagnosis 1 and 2 of these 16 users, and the number of users (frequency) who had that combination of diagnoses. Diagnosis 1 is mutually exclusive to diagnosis 2.

Table 5 Frequency of second diagnosis of users secluded during a 6 month period at Sterkfontein Hospital

Diagnosis 1	Diagnosis 2	Frequency
Schizophrenia	Cognitive Impairment	3
	Epilepsy	1
	Dementia	1
	Substance abuse	2
	Substance Induced Psychosis	2
	Schizoaffective disorder	2
Cognitive Impairment (CI)	Epilepsy	1
	Conduct Disorder	1
	Substance Induced Psychosis	1
	Disruptive Behavioural Disorder	1
Epilepsy	Dementia	1

As can be seen from the table, of the 16 users 11 had Schizophrenia, 4 had Cognitive impairment and 1 had Epilepsy. Both Schizophrenia and Cognitive impairment occurred in 3 users.

Table 6 illustrates the relationship between the reason for seclusion and the commonest diagnoses. The percentages refer to the percentages of users secluded for that particular reason.

Table 6 Relationship between reason for seclusion and the commonest clinical diagnoses of users secluded during a 6 month period at Sterkfontein Hospital

Diagnosis	1	%	Number	2	%	Number
Own safety	Schizophrenia	38.0	16	CI	20.0	2
	CI	33.3	14	Dementia	20.0	2
Physical aggression	Schizophrenia	83.3	5	CI	100	1
	BMD	16.6	1			
Verbal aggression	BMD	40.0	8	Epilepsy	100.0	1
	Schizophrenia	25.0	5			
	SIP	10.0	2			
	SAD	10.0	2			
Verbal & physical aggression	Schizophrenia	50.0	3	SIP	50.0	1
				SAD	50.0	1
Risk of violence	Schizophrenia	50.0	2	SA	100.0	1
	BMD	25.0	1			
	CI	25.0	1			

When users were secluded for their own safety the commonest diagnosis was Schizophrenia, followed by Cognitive Impairment (CI). Collectively these 2 diagnoses made up 71.4% of users who were secluded for their own safety. Those with a second diagnosis who were diagnosed for their own safety had the diagnosis of Cognitive Impairment and Dementia.

Schizophrenia was the commonest diagnosis in users who had documented reports of physical aggression and both physical and verbal aggression, respectively (83.3% and 50%). 40% of users secluded for verbal aggression had Bipolar Mood Disorder (BMD). The commonest diagnosis of users who were secluded as they were at risk of violence, was Schizophrenia (50%), followed equally (25% each) by Bipolar Mood Disorder and Cognitive Impairment.

Table 7 and Figure 10 compare the 3 commonest diagnoses (which make up 74% of the diagnoses of users), with reasons for seclusion, when the reasons for seclusion are divided into aggression/risk of violence (i.e. physical aggression, verbal aggression, both physical and verbal aggression, threat of violence, other, no reason documented) and users own safety. The percentages in Table 7 refer to the percentage of users with that specific diagnosis e.g. 18.6 % of users who were secluded for their own safety had a diagnosis of Schizophrenia.

Table 7 Comparison of reasons for seclusion in the commonest diagnoses of users secluded during a 6 month period at Sterkfontein Hospital

Diagnosis	**Schizophrenia**		**Bipolar Mood Disorder**		**Cognitive Impairment**		**Remaining diagnoses**	
Reasons for seclusion	Number	%	Number	%	Number	%	Number	%
Own safety	16	18.60	1	1.16	14	16.28	11	12.79
Aggression/risk of violence	16	18.60	13	15.12	4	4.65	11	12.79
Total	32	37.20	14	16.28	18	20.93	22	25.58

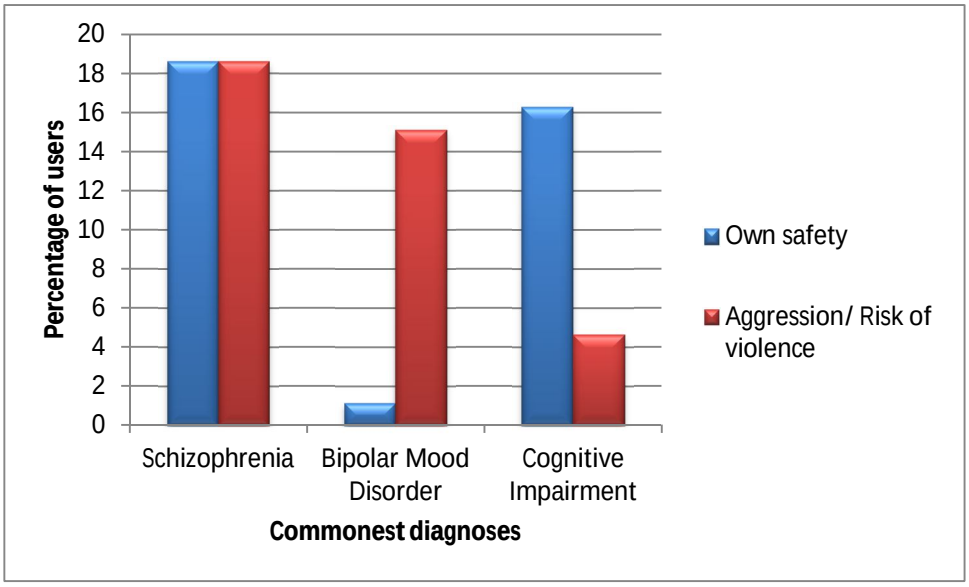

Figure 10 Comparison of reasons for seclusion by the commonest diagnoses during a 6 month period at Sterkfontein Hospital

Figure 11 and 12 look at the reasons for seclusion in a different way. The reasons for seclusion are again divided into 2 groups: aggression/risk of violence (i.e. physical aggression, verbal aggression, both physical and verbal aggression, threat of violence, other, no reason documented) and users own safety.

Each group is looked at separately and the percentages of users with the commonest diagnoses are illustrated in the figures. The remaining diagnoses have not been included in the figures. Figure 11 depicts the percentage of the commonest diagnosis of users who were secluded for their own safety.

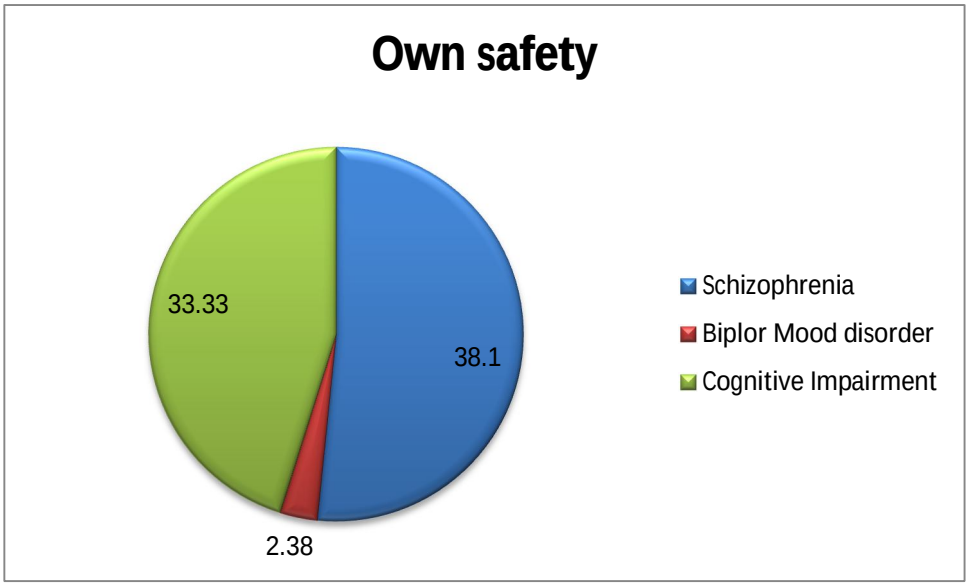

Figure 11 Percentage of the commonest diagnoses of users secluded for their own safety during a 6 month period at Sterkfontein Hospital

When users were secluded for their 'own safety' they most often had a diagnosis of Schizophrenia (n=16, 38.1%) closely followed by Cognitive Impairment (n=14, 33.33%).

Figure 12 depicts the commonest diagnoses of users who were secluded for aggression/risk of violence

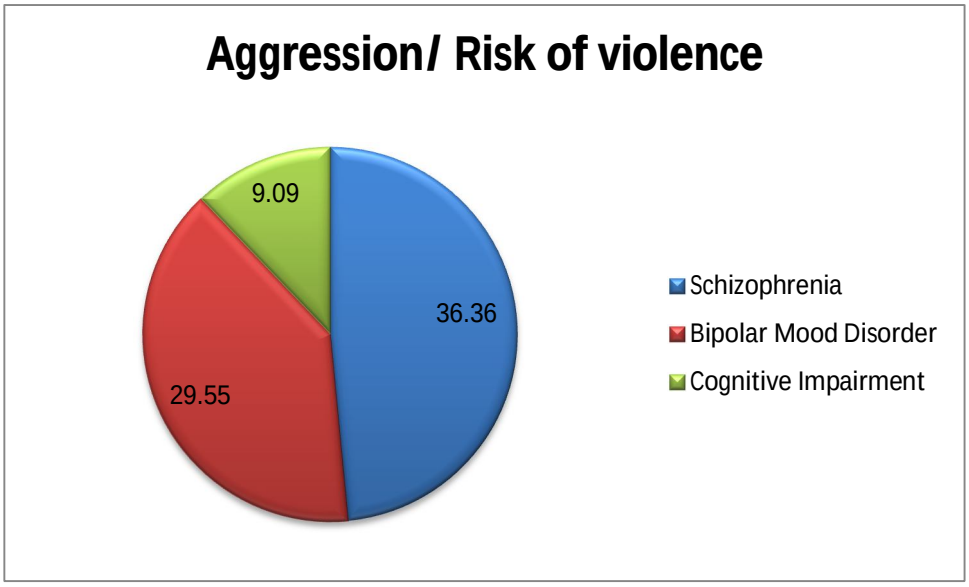

Figure 12 Percentage of the commonest diagnoses of users secluded for aggression/risk of violence during a 6 month period at Sterkfontein Hospital

In those secluded for physical/verbal aggression Schizophrenia (n=16, 36.36%) was once again the commonest diagnosis; however, Bipolar Mood Disorder came in at a close second (n= 13, 29.55%). Less than 10% (n=4) had a diagnosis of Cognitive Impairment.

Figure 13, 14 and 15 take the commonest diagnoses found and look at the reasons that users were secluded (as divided into the previous 2 groups: aggression/risk of violence and own safety. Those with a diagnosis of Schizophrenia were equally secluded for ‘own safety’ and aggression/ risk of violence as is depicted in figure 13.

Those with a diagnosis of Schizophrenia were equally secluded for ‘own safety’ and aggression/ risk of violence (n=16) as is depicted in figure 13.

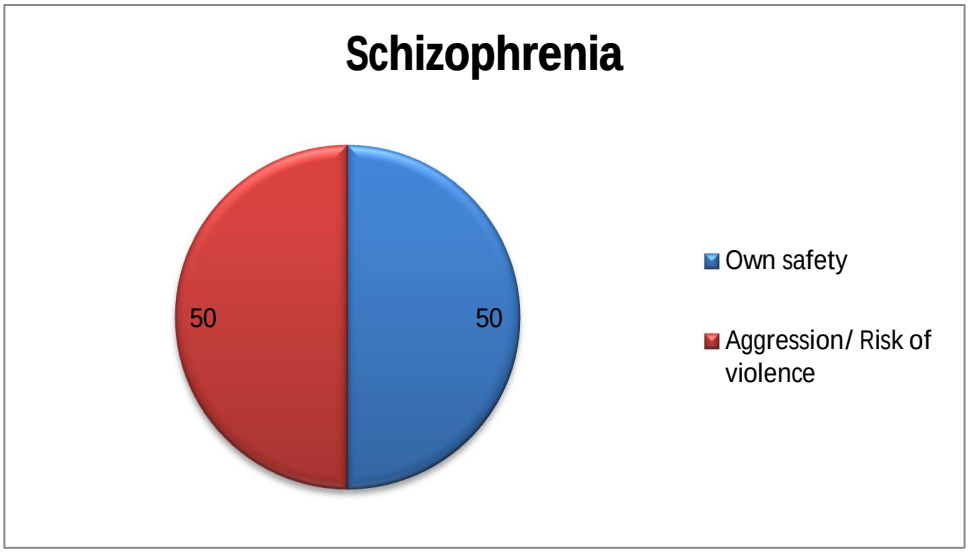

Figure 13 Reasons for seclusion in users with Schizophrenia during a 6 month period at Sterkfontein Hospital

Users with Bipolar Mood Disorder were seldom secluded for their 'own safety' (n=1, 7.1%) and mostly secluded for aggression/risk of violence (n=13, 92.9%). This is illustrated in Figure 14.

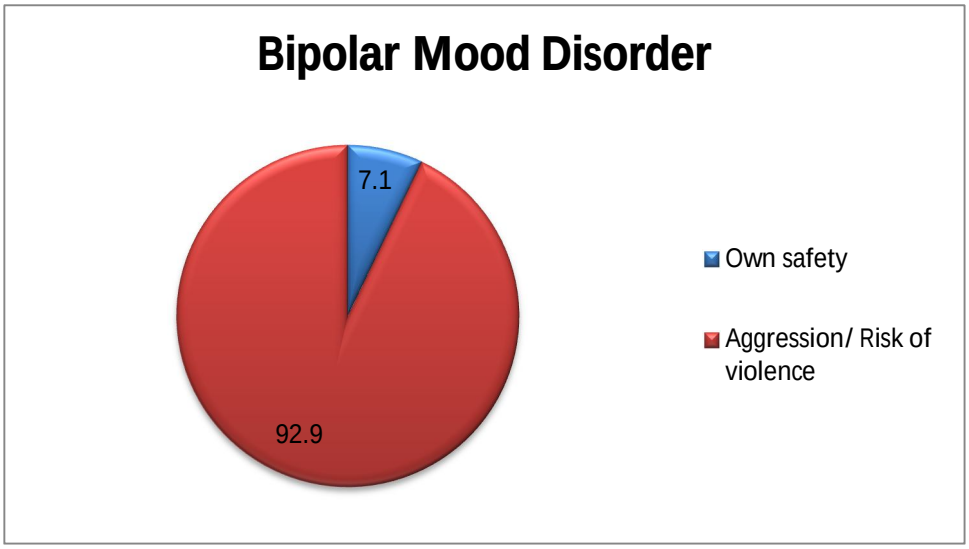

Figure 14 Reasons for seclusion in users with Bipolar Mood Disorder during a 6 month period at Sterkfontein Hospital

Figure 15 depicts that the reasons for seclusion in users with Cognitive Impairment were in over three quarter of cases for their own safely (n=14, 77.8%). The rest of the users (n=4, 22.2%) were secluded for aggression/ risk of violence.

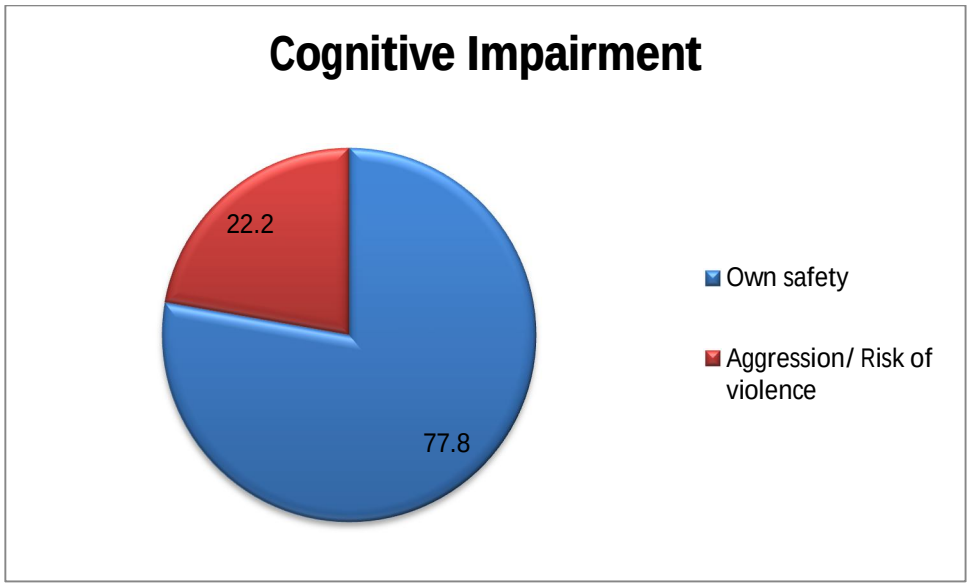

Figure 15 Reasons for seclusion in users with Cognitive Impairment during a 6 month period at Sterkfontein Hospital

3.5 MEDICATION

Table 8 illustrates medication that users were discharged on.

Table 8 Discharge medication of users secluded during a 6 month period at Sterkfontein Hospital

Medication	**%**	Frequency
Nil	6.79	11
Sodium Valproate	17.28	28
Lithium	6.79	11
Haloperidol	11.11	18
Risperidone	11.11	18
Clozapine	1.85	3
Fluanxol Depot	3.09	5
Chlorpromazine	7.41	12
Clopixol Depot	9.26	15
Androcur	3.09	5
Clonazepam	4.32	7
Orphenadrine	6.79	11
Carbamazepine	4.94	8
Galantamine	0.62	1
Sulpiride	1.23	2
Propranolol	0.62	1
Modecate	1.85	3
Trifluoperazine	1.23	2
Olanzapine	0.62	1

Figure 16 illustrates the number of users who were discharged on various medications. The most commonly used medication was Sodium Valproate (28 users), followed by Haloperidol (18 users) and Risperidone (18 users).

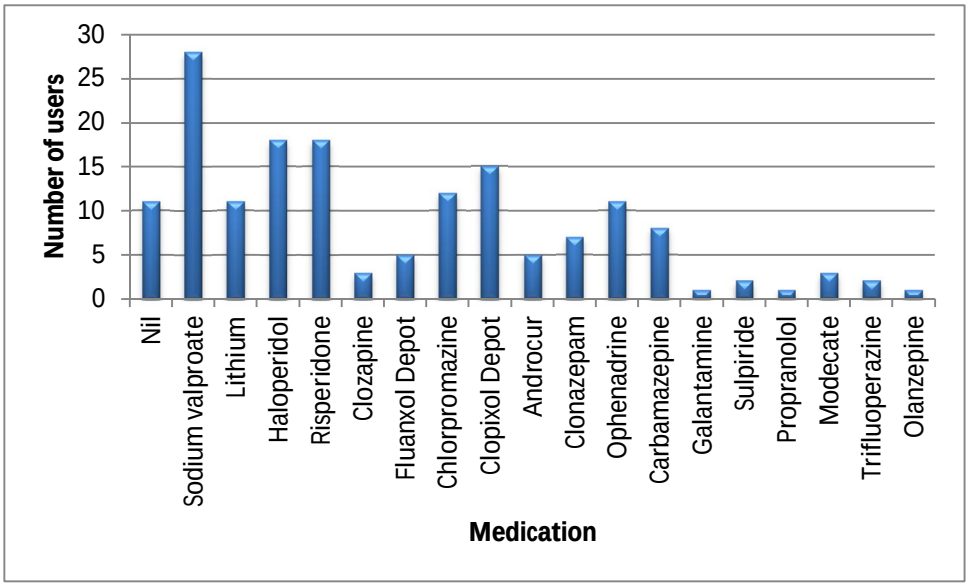

Figure 16 Number of users discharged on various medications during a 6 month period at Sterkfontein Hospital

Table 9 illustrates the number and percentage of users on various medications as divided into their medication classes.

Table 9 Medication classes of users who were secluded during a 6 month period at Sterkfontein Hospital

	Medication	Frequency	%
	Nil	11	6.79
Mood stabilisers	Na Valproate	28	17.28
	Lithium	11	6.79
	Carbamazepine	8	4.94
First generation antipsychotic	Haloperidol	18	11.11
	Chlorpromazine	12	7.41
	Trifluoperazine	2	1.23
Second Generation antipsychotic	Clozapine	3	1.85
	Risperidone	18	11.11
	Olanzapine	1	0.62
	Sulpiride	2	1.23
Depot Antipsychotic	Fluanxol Depot	5	3.09
	Clopixol Depot	15	9.26
	Modecate	3	1.85
Benzodiazepine	Clonazepam	7	4.32
Other	Androcur	5	3.09
	Orphenadrine	11	6.79
	Propranolol	1	0.62
	Galantamine	1	0.62

Figure 17 illustrates the percentage of users that were on various medications as divided into their medication categories: Mood stabilisers, Antipsychotics, Benzodiazepines and the remaining medications (Androcur, Propranolol, Galantamine and Orphenadrine).

Nearly half the users were on Antipsychotics (48, 76%) and just over a third were on a Mood Stabiliser (35.80%).

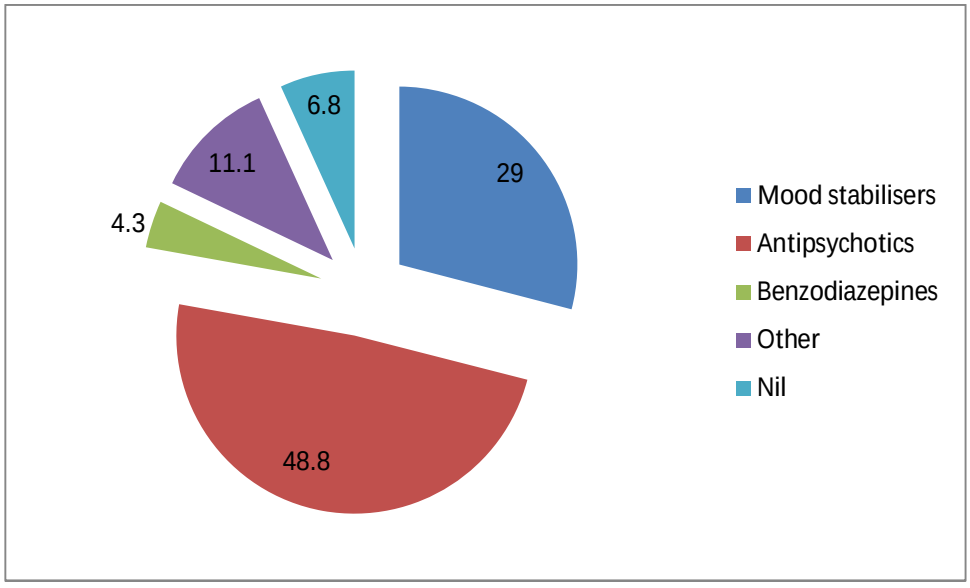

Figure 17 Percentage of users according to medication classes in users who were secluded during a 6 month period at Sterkfontein Hospital

CHAPTER 4: DISCUSSION

During the 6 month study period a total of 112 users were secluded, 95 of whom were male users. The mean number of users secluded per month was 38.5. There were 802 seclusion episodes per month. Of those users secluded, the average amount of time spent in seclusion per month was 259 hours per user. Younger male users were secluded the most (mean age of seclusion 29 years). Of the total number of users secluded 35.7% of users were involuntary users, the remaining were admitted in the forensic section of Sterkfontein Hospital. Schizophrenia was the commonest diagnosis of those users who were secluded, followed by Cognitive Impairment and Bipolar Mood Disorder.

Bearing in mind the ethical debate surrounding seclusion and the fact that seclusion is legal and allowed, questions arise surrounding seclusion guidelines. Such questions would be how seclusion should be carried out, when to seclude, how long seclusion should be permitted for and how often seclusion should take place in the individual user.

To my knowledge this is the first study in South Africa that delineates the number of hours and numbers of times a sample of users have been secluded over a specified period of time.

An international review of the incidence of seclusion showed a vast range in the frequency and duration of seclusion (13). These ranged from seclusion episodes of nearly 300 hours per seclusion episode in the Netherlands to rare seclusions in the UK. All the other countries fell in between these 2 extremes. Very limited data exist in developing countries (13, 15). A

study done at the University of Harare demonstrated that seclusion was common (8.5% of patients admitted during the study period) (16).

This research study reveals seclusion episodes between these 2 ranges (Netherlands and UK), with a mean of 12.5 hours per seclusion episode. One user (in May) spent 1 hour /month in seclusion, while another user (in July) spent 640 hours /month in seclusion i.e. 26.7 of the 31 (24-hour) days in July. The mean hours/month per user of 259 hours represent about 11 (24-hour) days per month. This is a lot of time spent in seclusion. The MHCA in South Africa defines seclusion and states that user “shall be subject to observation at least every 30 minutes”. It does not specify a minimum time that users may be secluded neither does it state after what time period or after what number of seclusions a new order of seclusion should ordered. This allows clinicians carte blanche on the amount of times and hours a user might be secluded. With such freedom comes great responsibility to ensure that the human rights of the user are not abused and that seclusion is prescribed only for very specific indications and after other measures have been tried and proven unsuccessful.

A review by Fisher et al. (4) in USA revealed no clear cut demographic trends (age race, gender). A fairly consistent finding was that younger users more likely to be secluded, as is evident in our study in which the mean age group of users secluded was 29 years, with 57.2% of users being under the age of 30 years. The review by Fisher found no association with gender. Younger patients, admitted involuntarily with a diagnosis of Schizophrenia were more likely to be secluded as found in an Australian study (23).

Our study showed that males were secluded more often than females; however this could be due to more male users being admitted in the hospital at that time. This is probably likely as 74 of the 612 usable beds in Sterkfontein Hospital are allocated to female users.

Just over a third of the users (35.7%) secluded were admitted as involuntary users in terms of the MHCA. The remainder were forensic users at Sterkfontein Hospital. One would expect that the involuntary users were most likely to be secluded as they had been admitted under section 33/34 of the MHCA and would by definition have mental illness of such a nature that they were likely to inflict serious harm to self or others and would therefore be more likely to warrant seclusion than their counterparts in the forensic wards, the majority of whom were chronic users and often stable. Those in the acute state wards have often had medication initiated whilst in prison prior to transfer to SFH. It is possible that they would be more stable clinically and therefore less likely to require seclusion compared to the acutely ill users referred in terms of Section 33/34 of the MHCA. However when one looks at the reasons that the forensic users were secluded, it reveals that just over three quarter of the users had been secluded for their own safety and slightly less than a quarter were secluded for aggression or threat of violence. This would be expected as some of these users were adolescents who would require protection of their safety. Of the adult users in the forensic wards those with cognitive impairment would warrant protection of their safety by virtue of their diagnosis.

Just over half the study population were secluded for ‘users own safety’ (52.38%). These were users that were vulnerable and not safe if bedded with rest of the ward population as they may have been at risk of sodomy/sexual exploitation. Sexual relations in these vulnerable users would raise the issue of their capacity to consent and most likely amount to sexual exploitation as such users would not have had the capacity to consent. The MHCA

(18) states that seclusion may only be used to contain severely disturbed behaviour, which is likely to cause harm to others and where other treatment techniques have failed. The regulations of the MHCA only provides for seclusion if the safety of others are involved and not when “own safety” is involved. These users did not exhibit any dangerous or disturbed behaviour and should not have been secluded in terms of the MHCA indications for seclusion. These users by definition were being secluded (isolated in a space, where his or her freedom of movement was restricted) though not for the correct reasons as indicated in the MHCA. The practice of secluding vulnerable users for their own safety should be avoided as it impacts on their human rights and does not contain the actual perpetrators of violence in these settings. This reflects strongly on the capacity and the type of facilities as well as the inappropriateness of the grouping of vulnerable individuals together with violent aggressive individuals.

One may consider restraint for users displaying aggression or a risk of violence, however, the MHCA differs in indications for restraint. The MHCA states that restraints may be used to ensure that a user does not harm him/her or others; preventing harm to oneself is not an indication for seclusion but is an indication for restraint. These users could not have been restrained either as they were not at risk to harming themselves, but were at risk of harm from others. Perhaps these users should have been termed ‘bedded in side room’ and the rest of the seclusion policy would not have been needed to be followed. To ensure that whilst in the locked room these users were not overlooked perhaps a policy /protocol could be drawn up stating that these users be observed at regular intervals etc. In terms of the MHCA over half the numbers of seclusions our study revealed were not endorsed.

The remaining users in our study (48%) were secluded for aggression or the risk of violence. These reasons are more in keeping with the reasons outlined in MHCA. The most common

reason for seclusion in an Australian study was risk to others (74%), followed by risk to self (61%) and risk of absconding (55%) (22). This is consistent with the review done by Fisher who found that precipitants of seclusion included agitation, uncooperativeness, disorderly conduct and para suicide, violence and threats of violence (4).

The commonest diagnosis of users secluded in our study was Schizophrenia, followed by Intellectual disability and Bipolar Mood Disorder. This seems to be consistent with findings in the Australian study and that found in the review by Fischer in 1994 (4, 23). In his review Fisher found that the diagnoses associated with higher seclusion rates were psychosis, manic symptoms, character disorders, Mental retardation and abnormal EEGs (4).

When correlating the reasons for seclusion with diagnosis it becomes apparent that when users were secluded for their own safety the commonest diagnosis was Schizophrenia (38.1%) followed by Cognitive Impairment (33.33%). A second diagnosis of Cognitive Impairment and Dementia was found in 20% of users, thus cognitive impairment seemed to be a factor in users being secluded for their own safety. Possibly due to the nature of their disability they are vulnerable and open to abuse by other users in the ward.

Violence seems to be common in the care of adults with intellectual disabilities and seclusion may be effective in this patient population (24, 25). This might account for intellectual disabilities being the second commonest diagnosis in those who were secluded. However when one looks into the reasons these users were secluded, it is seen that of the 18 users with Cognitive Impairment who were secluded, 14 were secluded for their own safety (77.8%) and only 4 because they were aggressive or violent.

When users were secluded for physical aggression, both physical and verbal aggression and risk of violence; once again Schizophrenia was the commonest diagnosis (83.3%, 50%, 50% respectively), however the actual numbers are small (n=5, n=3, n=2 respectively). When secluded for verbal aggression the commonest diagnosis was Bipolar Mood Disorder (40 %). Paranoid ideation and perceptual disturbances in such users might account for the agitated behaviour that required the use of seclusion. In the manic state of their illness, users with Bipolar Mood Disorder could become restless, agitated, aggressive and disinhibited and might have required seclusion for containment of such behaviour.

The purpose of including the discharge medication was to contribute to the psychopathology and clinical profile of the users that were secluded. There is an overlap in the total number of medications (n=162), this is because users were often on more than 1 medication at a time. In terms of medication close to half the users were discharged on an anti-psychotic (48.76%). This is in keeping with Schizophrenia being the commonest diagnosis (31.4%), as well as antipsychotics being prescribed for Bipolar Mood Disorder, Substance Abuse and behavioural control in Intellectual Impairment and Dementia. 35.8% of users were discharged on a Mood Stabiliser. Mood stabilisers are used to treat Bipolar Mood Disorder and may be prescribed for behavioural containment in users with Cognitive Impairment. These 2 diagnoses make up approximately a third of the diagnoses of users secluded (34.3%). It is therefore not surprising that over a third of the discharge medication was a Mood Stabiliser. Of note 7 users were discharged on Clonazepam. The medications noted in the study were discharge medication and not medication used prior to seclusion. If these users were discharged on Clonazepam, which is a sedative hypnotic, it is likely that users who had been previously secluded for aggressive or violent behaviour might have been put on such medication for behaviour control. Such medication would be likely to be continued on discharge for a short period to prevent further aggression in the community.

CHAPTER 5: **LIMITATIONS**

Data collection depends on the accuracy and completeness of clinical records. The clinical records of 26 users were not found and therefore the clinical profile of these users could not be included. This means that the age, diagnosis and discharge medication of these users is unknown.

Clinical practices may also differ amongst clinicians such that different prescriptions may have been given in a subsequent time period depending on the prescription styles of subsequent doctors. This could affect the medication and management of users.

The legal categories of users were obtained from the ward in which the users were from, the data was collected per month per ward (from the MHCA form 48) and not analysed per ward (legal category) but per month. This meant that in wards with both observation and state users it was not differentiated whether the users were observation or state users. This prevented the researcher from describing each legal category in terms of gender and age and prevented the researcher from determining the reasons for seclusion amongst only the observation users.

As this was a retrospective review the reasons for seclusion were recorded directly from the MHCA form 48, the way in which various clinicians distinguished “risk of violence” from verbal aggression” depended on the clinician prescribing the seclusion.

The study describes clinical profile in terms of gender, age, diagnosis and medication that users were discharged on. It does not describe what medication the user was given, if any, prior to seclusion.

Diagnosis 2 is the second diagnosis that was noted on in clinical records of users. On the clinical records 16 users had a second diagnosis, it is not clear whether this was a co morbid or differential diagnosis

Data on the number of users that were admitted during the study period could not be obtained and therefore the percentage of users that were secluded could not be calculated.

The results of the study reveal that the reason for just over half the number of seclusions was to protect such users and not because these users were a risk to others. This gives us an inflated number of seclusions that should occur, as indicated by the MHCA. As these users' clinical profiles were noted and included in data analysis we get an imprecise clinical profile of users that are likely to be secluded for containment of aggressive behaviour. To compensate for this, the reasons for seclusion were separated into 2 groups: 'users own safety' and physical and verbal aggression, and risk of violence. Using these 2 groups comparisons were made between age, sex, diagnosis and user status.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

Just over half the seclusions occurred for user's own safety. Perhaps these users should be termed as being "bedded alone" instead of recorded as being secluded. This would reduce the number of seclusion by more than half and give us a better indicator of the number of users that needed to be secluded as indicated by the MHCA. These users had to be recorded on the seclusion register (Form 48) as they had been placed in a locked room as in keeping with The MHCA, which states that if a user is isolated in a space, where his or her freedom of movement is restricted, he is by definition being secluded and therefore requires observation every 30 minutes and register to be completed. However the indications for seclusion were not as per the MHCA, i.e. only to be used to contain severely disturbed behaviour. The recommendation is to the National Department of Health that they modify these regulations when users are placed in a locked room for their own safety. Observations should be done on such users but perhaps a separate register should be kept for such users.

Younger male users with psychosis were most likely to be secluded. This can be taken into consideration when dealing with such users and perhaps greater caution and care can be taken when dealing with this profile of users so that seclusion might be prevented. Perhaps a screening assessment on admission of such users might identify potential users that might be secluded so that alternative methods to seclusion might be initiated earlier on such as de-escalation techniques or chemical restraint if required. This screening assessment could be included in the training sessions that the staff undertakes.

Sterkfontein hospital has a policy/procedure on the management of violence and aggression. Staff is trained regularly in such techniques. Perhaps it might be useful to have the procedure steps enlarged and placed in clear view in wards as a reminder to ward staff of which procedures to follow. It could also be used as a template in training sessions for management of aggressive users. Difficulties in managing aggression might also arise as state and observation users are housed in the same physical environment, mixing the observation users who might not have a mental illness with users who have a mental illness is not ideal.

It is hoped that we move towards a seclusion free environment. In order to do this more research needs to be conducted in this field to ascertain rates of seclusion as well as formulating a clinical profile of users most likely to be secluded, and to clarify other factors that might be involved in seclusion practices. Such information would allow us to reduce seclusion practices to a minimum.

REFERENCES

1. Michael K. Champion, MD: Commentary: Seclusion and Restraint in Corrections - A Time for Change. Journal of the American Academy of Psychiatry and Law, 2007; 35:4:426-430.

2. Pollard R, Yanasak EV, Rogers SA, Tapp A: Organizational and Unit Factors Contributing to Reduction in the Use of Seclusion and Restraint Procedures on an Acute Psychiatric Inpatient Unit. The Psychiatry Quarter, March 2007; 78:73-81.

3. Brown JS, Tooke SK: On the seclusion of psychiatric patients. School of Nursing, Oregon Health Science University, Portland 97201. Social Science and Medicine, 1992 Sep; 35(5):711-21.

4. Fisher, William A: Restraint and Seclusion: A Review of the Literature. The American Journal of Psychiatry; Nov 1994; 151:1584-1591.

5. Busch AB, Shore MF: Seclusion and restraint: a review of recent literature. McLean Hospital, Belmont, USA. Harvard Review of psychiatry; 2000 Nov; 8(5):261-70.

6. Huckshorn KA: Re-designing state mental health policy to prevent the use of seclusion and restraint. National Technical Assistance Center, National Association of State Mental Health Program Directors (NAMSHPD), Alexandria, USA. Administration and policy in mental health, 2006 Jul; 33(4):482-91.

7. Mohr WK, Petti TA, Mohr BD: Adverse effects associated with physical restraint. Rutgers University, College of Nursing, Newark, New Jersey, USA. Canadian Journal of Psychiatry, June 2003; 48(5):330-7.

8. Sequeira H, Halstead S: The psychological effects on nursing staff of administering physical restraint in a secure psychiatric hospital: ‘‘When I go home, it’s then that I think about it’’. British Journal of Forensic Practice, 2004; 6: 3-15.

9. Muir-Cochrane E, Holmes C, Walton JA: Law and policy in relation to the use of seclusion in psychiatric hospitals in Australia and New Zealand. School of Nursing and Midwifery, Division of Health Sciences, University of South Australia. Contemporary Nurse, a journal for the Australian Nursing Profession, Oct 2002; 13(2-3):136-45.

10. Muir-Cochrane E, Holmes C, Walton JA: Legal and ethical aspects of seclusion: an Australian perspective. School of Nursing, Division of Health Sciences, University of South Australia, City East Campus, North Terrace, Adelaide, South Australia 5000, Australia. Journal of Psychiatric and mental health nursing, 2001 Dec; 8(6):501-6.

11. Bloch S, Green SA: An ethical framework for psychiatry. British Journal of Psychiatry, 2006; 188:7-12.

12. Hellerstein DJ, Staub AB, Lequesne E: Decreasing the use of restraint and seclusion among psychiatric inpatients. New York State Psychiatric Institute, New York, NY, USA. Journal of psychiatric practice, 2007 Sep; 13(5):308-17.

13. Steinert T, Lepping P, Bernhardsgrutter R, Conca A, Hatling T, Janssen W, Keski-Valkama A, Mayoral F, Whittington R: Incidence of seclusion and restraint in psychiatric hospitals: a literature review and survey of international trends. Social Psychiatry and Psychiatric Epidemiology, Sept 2010); 45:889-897.

14. Smith GM, Davis RH, Bixler EO, Lin H, Altenor A, Altenor RJ, Hardentstine BD, Kopchick GA: Pennsylvania State Hospital System’s Seclusion and Restraint Reduction Program. Psychiatric services, September 2005; 56 (9):1115-1122.

15. Gaskin CJ, Elsom SJ, Happell B: Interventions for reducing the use of seclusion in psychiatric facilities: review of the literature. British Journal of Psychiatry, Oct 2007; 191:298-303.

16. Sebit MB, Siziya S, Acuda SW, Mhondoro E: Use of seclusion and restraint in psychiatric patients in Harare Hospital Psychiatric Unit, Zimbabwe: gender differences. The Central African Journal of Medicine, Nov 1998; 44(11):277-80.

17. Mental Health and Poverty Project, Policy Brief 4, 2008. Developing Effective Mental Health Laws in Africa. Developed by Mental Health Policy and Service Development, Department of Mental Health and Substance Abuse, World Health Organization, Geneva. Accessed January 2013. Available at: http://www.who.int/mental_health/policy/development/MHPB7.pdf.

18. Mental health care Act, 2002 (Act no. 17 of 2002). Accessed January 2012. Available at http://www.kznhealth.gov.za/mentalhealthregs.pdf.

19. Petersen I, Lund C. Mental health service delivery in South Africa from 2000 to 2010: One step forward, one step back. South African Medical Journal; October 2011; 101(10):751-57.

20. Ramlal S: The Mental Health Care Act No 17 – South Africa. Trials and triumphs: 2002-2012. African Journal of Psychiatry, 2012; 15:407-410.

21. Ramlall S, Chipps J, Mars M: Impact of the South African Mental Health Care Act No. 17 of 2002 on regional and district hospitals designated for mental health care in KwaZulu-Natal. South African Medical Journal, 2010; 100: 667-670.

22. Bateman C: Dismal use of legal safety net for mental health patients. South African Medical Journal, February 2012; 102(2): 68-70.

23. Tunde-Ayinmode M, Little J: Use of Seclusion in a Psychiatric Acute Inpatient Unit. Australas Psychiatry, Dec 2004; 12 (4): 347-351.

24. Strand M, Benzein E, Saveman BI: Violence in the care of adult persons with intellectual disabilities. Journal of Clinical Nursing, 2004; 13:506-514.

25. Rangecroft ME, Tyrer SP, Berney TP: The use of seclusion and emergency medication in a hospital for people with learning disability. British Journal of Psychiatry, 1997; 170:273-277.

APPENDIX A

Department of Health
Lefapha la Maphelo
Departement van Gesondheid
Umnyango wezempilo
CEO'S OFFICE
STERKFONTEIN HOSPITAL

25 APRIL 2008

DR DR GAVEETA CHIBA
PSYCHIATRY REGISTRAR

RE : REQUEST TO REVIEW RECORDS FOR RESEARCH PURPOSES

Dear Dr Chiba

Your letter dated 24/05/2008 refers:

Please be informed that permission has been granted to do your MMed Psychiatry Research at Sterkfontein Hospital under the supervision of Dr Subramaney.

Thank you

K.A. Mustafa

Dr. K.A. Mustafa
Chief Executive Officer
Sterkfontein Hospital

EQUIRIES: Dr K.A. Mustafa
PRIVATE BAG X2010, KRUGERSDORP 1740
TEL (011) 951-8257 FAX (011) 956-6907 EMAIL : hosman@global.co.za

APPENDIX B

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Chiba

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER M080505**
PROJECT	A retrospective record review of patients secluded at a Tertiary Psychiatry Hospital
INVESTIGATORS	Dr G Chiba
DEPARTMENT	Psychiatry
DATE CONSIDERED	08.05.30
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 08.12.12 **CHAIRPERSON** .....
(Professor P E Cleaton Jones)

*Guidelines for written "informed consent" attached where applicable

cc: Supervisor : Dr S Subramaney

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

APPENDIX C

Faculty of Health Sciences Medical School, 7 York Road, Parktown, 2193
Fax: (011) 717-2119 / Tel: (011)717-2075/6

Reference: Ms Tania van Leeve E-mail: tania.vanleeve@.wits.ac.za
27 June 2008
Person No: 8401014V
PAC

Dr C Chiba
Postnet Suite #42418
Private Bag X1
Melrose Arch
2076

South Africa

Dear Dr Chiba

Master of Medicine in the specialty of Psychiatry: Approval of Title

We have pleasure in advising that your proposal entitled "*A retrospective review of patients secluded at a tertiary psychiatric hospital*" has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Bern
Faculty Registrar
Faculty of Health Sciences

APPENDIX D

DATA COLLECTION SHEET

File no	Date of seclusion	Sex	Age	No of hrs in seclusion	Reason for seclusion	DOA	DOD	Dx	Meds

DOA – date of arrival
DOD- date 0f discharge
Dx – diagnosis
Meds – medication

APPENDIX E

DEPARTMENT OF HEALTH

REGISTER

[Regulations 36 and 37 of the Regulations]

MHCA 48

MECHANICAL RESTRAINT AND SECLUSION

Date on which restraint or seclusion was employed	NAME OF PATIENT	AGE	FILE NO	MEANS EMPLOYED FOR (A) MECHANICAL RESTRAINT (B) SECLUSION	NUMBER OF HOURS FOR WHICH EMPLOYED	Name of medical practitioner who completed and signed the certificate stating grounds on which restraint or seclusion was employed (NB: these certificates should be dated) (NB: copy of signed certificate attached)

APPENDIX F

health and social development

STERKFONTEIN HOSPITAL

SECLUSIONS POLICY/PROCEDURE

Accountable Manager	C Makutulela
Policy Author	Nursing Management
Review Date	May 2011
Next Review Date	May 2013
Version	2
Policy Number	39

1. DEFINITION

Seclusion means the isolation of a user/patient in a space where his/her freedom of movement is restricted.

2. SHORT TERM SECLUSION

Patient/users may only be secluded if a doctor's prescription is issued on the day of seclusion and be exercised for the prescribed period.

3. DAY SECLUSION

The professional nurse in charge of the ward must obtain permission (written or telephone prescription) from a doctor. Whenever possible such permission must be obtained prior to secluding a patient. In emergency situations, a doctor must be contacted within half an hour after secluding a patient/user to request a permission/prescription.

4. NIGHT SECLUSION

The nurse in charge of the ward must notify the Operational Manager in charge of the hospital to secluding a patient/user. In emergency situations he/she must be informed within half an hour after secluding the patient/user. The nurse in charge of the ward must then contact the doctor on call to request the prescription.

5. LONG TERM SECLUSION

Patients/users identified as being in need of protection or who may be a danger to other patients/users, are bedded in a locked side room at night on the prescription of the attending doctor of that unit. Such prescription is valid for one month.

6. SECLUSION OF MINORS

All minors i.e. persons under the age of 18 years must be secluded at night if they have been admitted in an adult ward, this is for their own protection. The only exception to this would be when a Consultant Psychiatrist directs, in writing, that the patient should not be secluded.

7. DOCUMENTING TELEPHONIC PRESCRIPTION

The following should be documented on the patient"s prescription chart by a person who obtained the telephonic prescription for seclusion:

7.1 Date and time of obtaining the doctor's prescription
7.2 Name of the doctor who is prescribing
7.3 Signature of the professional nurse who is taking the prescription
7.4 Signature of the witness. The witness may be a professional, enrolled or auxiliary nurse.

10.5 In case of long term seclusion, a patient/user may be given a material after an assessment by the ward doctor, such material must be searched prior to giving it to the patient/user.

10.6 No patient/user may be bedded or secluded in a side room if it is cold and the heating system is not functioning. The only exception to this is a patient who cannot be controlled in any other way and the doctor on call authorized the seclusion. The professional nurse in charge of the hospital must be notified of this seclusion and the nursing staff must ensure the adequate warmth of the patient.

11. INTERNAL EXAMINATIONS

Nursing personnel are NOT permitted to carry out a vaginal or rectal examination on a patient/user. This must be done by the doctor and should be done in the presence of a professional nurse if it is suspected that the user has concealed unauthorized items.

12. OBSERVATIONS DURING SECLUSION

Patients/user to be observed EVERY ½ HOUR and at each visit the seclusion form to be completed IN FULL e.g.

- Fluid given? What? How much?
- Asleep?
- Awake – doing what?

If a patient has been given sedation prior to seclusion and depending on his/her mental condition, the **blood pressure, pulse and temperature** must be taken prior to seclusion and ½ hourly thereafter or according to the doctors' prescription.
When physically assessing the user in the seclusion room, more than one nurse must be present.

13. CRITICAL ONE HOUR OBSERVATION

This is a special observation done for patients/users that have been identified as high risk of self harm or setting fire while in the seclusion room.

The observation procedure is as follows:

13.1 The patient/user and the seclusion room must be thoroughly searched for any objects or fire lighting materials before the patient/user is secluded.

13.2 If the patient/user has a history of setting fire or concealing objects all the bodily orifices must be searched by the doctor

13.3 The seclusion must be prescribed by the doctor

7.5 In the event of the doctor having given telephonic prescription for seclusion, he/she must enter written confirmation in the prescription chart within 24 hours of giving the prescription.

NB: THIS MUST BE DONE BY THE DOCTOR WHO PRESCRIBED A SECLUSION

8. DOCUMENTATION OF SECLUSION

8.1 The M.H.C.A. 48 is to be completed (NB: the doctor must sign and put qualifications)
8.2 Professional nurses must do initial assessment and search the user/patient for unauthorized items prior to seclusion. The following documents should be completed:

- S.H.K. 338 (Green) - NIGHT 19:00 – 07:00
- S.H.K. 337 (Blue) - DAY 07:00 – 19:00

8.2.1 The reason for seclusion should be stated
8.2.2 Date and time of requesting prescription to seclude the patient
8.2.3 Time at which seclusion began and ended: the length of time for which the patient was secluded
8.2.4 All seclusion forms must be signed by relevant practitioners (Doctors and Nurses and their qualifications).

9. THE PRESCRIPTION CHART

9.1 The doctor who prescribed seclusion must complete the appropriate entry on the preacription chart within 24 hours.
9.2 A report should be made in the day/night nursing management report
9.3 A detailed entry should be made in the patient/user's cardex.

10. GENERAL PROCEDURE WHEN SECLUDIND A PATIENT/USER

10.1 A thorough search of the room must be done prior to seclusion

10.2 The patient/user must strip all his/her clothes, (in privacy in the presence of a professional nurse) and his/her body must be searched for e.g. cigarettes, matches and lighters. He/she should be cordless pajamas to wear.

10.3 No patient/user is to be stripped of all clothes and left naked unless specifically requested by a doctor on the prescription chart. Stripping must be done in the presence of professional nurse.

10.4 The room may only contain the following:

- Mattress
- Blankets
- Plastic potty (depending on the patient's/user's condition)
- Plastic water bottle (depending on the patient's/user's condition)

13.4 The level of observation must be increased during the first one hour while the patient/user is still aroused or not sedated.

13.5 The frequency of observation should be increased when the level of risk increases.

13.6 The level of observation should only be reduced following risk assessment and the risks no longer exist.

13.7 All recording must be done in the patient/user file, cardexes and observation charts.

14. POLICY REVIEW

This policy will be reviewed on a 2 yearly cycle, or before where necessary, to ensure any relevant changes in legislation are incorporated.

Approved by: [illegible] Signature: [illegible] Date: 25/10/2011

APPENDIX G

GAUTENG PROVINCE

STERKFONTEIN HOSPITAL

MANAGEMENT OF VIOLENCE AND AGGRESSION POLICY/PROCEDURE

Accountable Manager	C Makututela
Policy Author	BH Shuping
Reviewed by	Nursing Policy Review Team
Reviewed Date	July 2012
Next Review Date	July 2015
Version	02
Policy Number	04

1. INTRODUCTION

Sterkfontein hospital is committed to ensuring health, safety and welfare of employees, patients, visitors or the general public regardless of gender, disability, sexual orientation, age and religion so far as practicable in its premises.

2. PURPOSE

The purpose of this policy is to:

- To provide guidance to managers, supervisors and employees on management of aggressive and violent behaviour
- To clarify the hospital's procedure in the management of violent or aggressive user, staff or visitors.
- To ensure that all procedures are followed in the management of aggression and violent situations

3. DEFINITIONS

3.1 Aggression

Aggression is any behaviour that is perceived by the victim as being deliberately harmful and damaging either psychologically or physically. It may also be directed towards property.

3.2 Violence

Any incident where staff or patients are abused, threatened or assaulted in circumstances relating to their work/admission, involving an explicit or implicit challenge to their safety, well-being or health.

3.3 Physical Assault

The intentional application of force from another person to another, without lawful justification, resulting in physical injury or discomfort

3.4 Non Physical Assault

The use of inappropriate words or behaviour causing distress and/or constituting harassment

4. LEGAL AND OTHER REFERENCES

- Mental Health Care Act 2002
- Criminal Procedure Act 1977
- Common Law
- Civil Law
- Human Rights Act 1998 (Article Two, Article Three, Article Eight)
- Occupational Health and Safety Act 1993
- Injury to Patient Protocol No.11
- Seclusions Policy/Procedure No.39

5. SCOPE

This policy applies to all employees (inc casuals & trainees) management, supervisors and directors in Sterkfontein hospital.

6. LEGAL REQUIREMENTS FOR STERKFONTEIN HOSPITAL

- To provide information, training, instructions and supervision to ensure all staff can manage aggression and violence competently.
- Ensure the safety and absence of risk to health of all employees
- Establishing what hazards to Health and Safety are attached to any task which is performed and to take precautionary measures to eliminate them.

7. GUIDELINES AND PROCEDURE

When managing an aggressive or violent person consider the following guidelines:

- **Primary prevention**: prevent violence before it happens
- **Secondary prevention**: reactive response de-escalation
- **Tertiary prevention**: physical interventions, post incident reviews and debriefs

  (See Annexure A)
- **Seclusions**

8. USE OF MECHANICAL MEANS OF RESTRAINT

Mechanical means of restraint (e.g. handcuffs, bandages) should not be used during the transfer of a mental health care user, unless pharmacological or other means of calming or sedating such user are inadequate to ensure that the user does not harm himself/herself or others.
Where mechanical means of restraint (e.g. handcuffs, bandages) is required in order to administer pharmacological treatment, such means should be applied for a short period as is necessary to effect the treatment.

8.1 Procedure

- All mechanical restraint must be prescribed on the patient's prescription chart and the register to be completed and signed by the doctor.
- While the mental health care user is under mechanical restraint should be observed every 30 minutes. The observations must also be recorded on the SHK 338 (night) and SHK 337(day.)
- The form of mechanical means of restraint, the time period used, the times when the mental health care user was observed and the reasons for administering such means of restraint should be outlined in a register by a medical practitioner.
- The deputy director of nursing must receive a report (matron's report) on a daily basis of the use of mechanical means of restraint and to inform the HHE.

The form MHCA 48 should be send to the mental health review board on a quarterly basis by HHE.

9. SAFETY RULES AND GUIDELINES

To ensure your safety, and that of your colleagues, patients, visitors, contractors etc. Please observe and obey the following rules and guidelines:

- Observe and practice the safety procedures established.
- DO NOT risk by attending a violent person on your own.
- Maintain a safe distance
- Call for help when you are being attacked
- In case of injury, no matter how small, report at once to your supervisor.
- In case of serious injury e.g. fractures to legs, back or neck or any accident resulting in unconsciousness, or a severe head injury, the patient is not to be moved until proper medical attention has been given.
- In all physical interventions, only the approved techniques must be applied
- DO NOT attempt to restrain an armed person, maintain a safe distance and call for help

10. RESPONSIBILITIES OF EMPLOYEES

- To maintain a healthy and safe working environment
- Take steps to eliminate health and safety risks
- Attend trainings or workshops provided for the management of aggression and violence
- Comply with this policy and other related policies
- Everyone is expected to apply and take part in physical restraint
- Make recommendations to Management where Health and Safety is concerned

11. RESPONSIBILITIES OF MANAGERS

- Regularly reviewing of the policy.
- Ensuring that newly appointed staff receive a full and comprehensive training in the management of aggression, violence and assault.
- To ensure all staff attend regular refresher training
- To ensure that debriefing takes place and reported
- Investigate incidents of violence
- To carry out Health and Safety audits
- Ensure that employees comply with the policy

12. REPORTING

- All incidents where physical interventions (Restraint) has been applied must be reported in detail and be reflected on the patient's cardex and the manager's report.
- All injuries must be reported
- All relevant forms must be completed and copies be kept in the user's cardex.

13. MONITORING AND REVIEWS

- The consistent and effective application of this Policy will be monitored on an ongoing basis through the regular collection, collation and analysis of information relating health and safety as well as incidents and it will be reviewed every third year or at any stage when necessary.

Authorised by: _____ Signature: _____ Date: _____

Annexure A

MANAGEMENT OF AGGRESSION AND VIOLENCE GUIDELINES

Primary prevention

Prevent violence before it happens

- Create and maintain a therapeutic relationship at all time with users
- Listen, observe and talk to the patient in a low and calm voice
- Find out what frustrate the patient
- Be more factual and concentrate on the problem
- Encourage reasoning and discourage acting out
- Give the patient clear instructions
- Control environmental factors e.g. noise, movements, smell etc.
- Maintain a safe distance
- Control your emotions

Awareness of these pre-incident indicators is important (not an exhaustive list)

- Raised voice
- Hostile response
- Expression of fear
- Prolonged eye contact
- Large movement of gestures
- Verbal threats
- Tense facial expression
- Expression of violent delusions or hallucinations

Consider retreating and/or summon help if:

- Fist clinches
- Stance changes
- Face pales
- Raise hands or pointing towards you
- Lips tightens
- Eye brows furrow

Secondary prevention

Reactive response de-escalation

- Maintain control and remain calm
- Ask questions to distract – seek details which they may have to think in order to recall
- Remind the person of the relationship
- Offer options but not promises that you may not be able to fulfil
- Acknowledge and check feelings
- Manage the pitch/tone/volume, speak clearly and give unambiguous instructions
- Think about your hand movement
- Maintain a safe distance
- Call for more help

Tertiary prevention

Physical interventions

- Call for more staff
- Apply an approved restraint techniques (Basic Control and Restraint) to a violent patient(s) **[Only when verbal interventions have failed]**
- Continue to de-escalate the patient
- Consider PRN medication
- If patient does not comply, consider seclusion (See Seclusion Policy No.39)
- Other staff members to take other patient, visitors etc to safe area
- DO NOT attempt to restrain an armed person, but call for more help and keep a distance from the person

Post incident reviews and debriefs

- Check if anyone was injured including the client and refer for medical help
- Reassure those who has been injured
- Allow reflection
- Encourage those who has exposed to verbalise their feelings
- Refer for counselling if necessary

Review Comments