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Legal and Ethical Argumentation
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In this issue of the journal a number of authors dealt with the use of seclusion in psychiatric patients as a mode of treatment. In addition to an editorial review of the current status of geriatric and Alzheimer’s disease in the Middle East. Another topic that was dealt with is the use of restraints on patients.

Restraint is one of the most controversial practices in contemporary mental health service delivery. The use of physical restraint in acute and residential health care facilities is a widespread practice in many countries. The authors discussed the restraint use in psychiatric settings from different viewpoints, they examined both sides of this controversial issue based on ethical, legal, and clinical considerations. A comprehensive search of several electronic databases was used in PubMed, and MEDLINE, in order to determine restraint use in psychiatric settings. The following key words were used to search the electronic databases: Restrain, Patient, Psychiatric Settings. The authors concluded that there are many alternatives that effective, safe to patient and staff, that are legal, easy to apply, and accepted politically instead use of physical restraint.

The use of seclusion is one of the most controversial practices in psychiatric care and touches this important topic clinically, ethically and legally. One of the authors provides and highlights on the conflict with use of seclusion with aggressive psychiatric inpatients, and presents the opinions on using seclusion from the ethical and legal perspective. This argumentative essay provides a comprehensive overview related to the use of seclusion on both options, the drawbacks and benefits of it, opponents’ and proponents’ opinions on legal, and ethical issues which is responsibility to protect patients. The position of the author is to reduce or eliminate seclusion in psychiatric setting and should reduce or eliminate using it, which affect on legal and ethical context of care.

A second author looked at the Seclusion among psychiatric inpatients from the legal and ethical perspective. The paper was carried out using various data bases using combinations of the following search terms: seclusion, psychiatric patients, legal and ethical perceptive. The new findings are especially significant because seclusion is a complex ethical dilemma in psychiatric health services. In summary the author suggests to provide educational programs for nurses in psychiatric health settings about how to deal with aggressive patients in emergency situations. A third author stressed that aggression and violence toward self and/or others are common behaviors among psychiatric inpatients. Seclusion is the most controversial intervention to control those behaviors. The use of seclusion is one of the most decisive decisions but it has many legal and ethical arguments. Legally, many policies and laws in various countries support the use of seclusion for aggressive patients in psychiatric settings. While, the use of seclusion is approved in mental health services, many patients’ rights are violated. Ethically, seclusion is used exclusively to prevent expected harm. Therefore, the use of seclusion for that purpose will not violate patients’ autonomy and human dignity. Conversely, it is argued that nurses have to respect and preserve human dignity; those are interfering with seclusion. From proponents and opponents’ viewpoints, despite that the use of seclusion is a controversial intervention, it remains commonly used for psychiatric inpatients to prevent the aggressive and violence.

The final paper discussed the current situation of Alzheimer’s disease and geriatric in the Middle East. Middle Eastern countries have certain cultural, social and economic characteristics in common with similar aspirations. The percentage of elderly in the Middle East is expected to increase with improvement of the health care delivery in the area. Countries of the region, like other developing countries, need to define the policies and programs that will reduce the burden of aging populations on the society and its economy. There is a need to ensure the availability of health and social services for older persons and promote their continuing participation in a socially and economically productive life.
Alzheimer’s and Geriatrics in the Middle East

Abdulrazak Abyad

Correspondence:
A. Abyad, MD, MPH, MBA, AGSF, AFCHSE
Abyad Medical Center and Middle East Longevity Institute
Azmi street, Abdo Center
Tripoli, Lebanon
Website: http://www.amclb.com
Tel: 00961-6-443684
Email: aabyad@cyberia.net.lb

Abstract

Middle Eastern countries have certain cultural, social and economic characteristics in common with similar aspirations. The percentage of elderly in the Middle East is expected to increase with improvement of the health care delivery in the area. Countries of the region, like other developing countries, need to define the policies and programs that will reduce the burden of aging populations on the society and its economy. There is a need to ensure the availability of health and social services for older persons and promote their continuing participation in a socially and economically productive life.

Introduction

The population of the world is aging rapidly. It is currently estimated that more than half (58%) of all people who are 65 years and older live in developing nations. The world’s older population experiences a net increase of 1.2 million each month, 80 percent of which occur in Third World nations (1,2,3). It is projected that by the year 2025, the total elderly population will reach 976 million with 72% living in developing regions (2,3,4). Also, as in the west, the growth rate is fastest for the oldest old, those most likely to have chronic diseases and be in need of health services. It is apparent that the problems of the frail elderly and development of geriatric programs and understanding of geriatric principles are international problems (5). The Region is passing through the “Health Transition Phase,” which is characterised by an unprecedented increase in both number and proportion of adults and elderly persons. Improvement of health care has been achieved by a combination of technical advances, social organisation, health expenditure, and health education (6-13). The epidemiological consequences of these changes will lead to an increased rate of chronic disorders of old age and the aging of the population itself, will make enormous demands on the health care system. As yet, there are no satisfactory geriatric care services available for the elderly. Different countries in the region have started different programs which tend to be rudimentary and fragmented with no national programs available on a national level (9-13).
Epidemiological data

There is a lack of appropriate knowledge about the nature and extent of health problems in the region. Life expectancy at age 65 years is a better reflection of the success of a nation in the aging process. Life expectancy at birth reflects factors such as infant mortality, poor control of infectious diseases in childhood and youth, violent deaths, and an increase in genetic diseases with early mortality. Table 1 shows the life expectancy for the region compared to other areas in the World. In the developed world, life expectancy is relatively increased for both genders. The Arab countries show wide variations in their life expectancy ranging from as high as 75 years in Kuwait to 63.9 years in Egypt and as low as 50.4 years in Yemen(9-13). Unofficial data in different nursing home facilities in Lebanon revealed a 25 to 30 percent level of depression among residents and 10 to 15 percent of dementia.

<table>
<thead>
<tr>
<th>Life expectancy at birth (years)</th>
<th>Males</th>
<th>Females</th>
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<tr>
<td>Lebanon</td>
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<td>Developed countries</td>
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<td>Japan</td>
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<td>82.6</td>
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<td>United States</td>
<td>72.6</td>
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<td>Kuwait</td>
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<td>Developing countries</td>
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<td>World</td>
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Socioeconomic and Political Factors

Middle-Eastern culture ensures respect for the elderly, and views them as a source of spiritual blessing, religious faith, wisdom and love. Despite the general feeling among most people in the region that sending an elderly parent to a nursing home violates our sense of sacred duty towards them, many individuals and groups are faced with situations, where they have no other alternative (9-13).

Elderly people in the area receive social and economic support from the informal sources of extended kin networks, and particularly from their own children. There are various systems of pensions for only a minority of the elderly in the region. However, traditional patterns of family responsibility will diminish with economic development(9-14). Young city dwellers may become more preoccupied with the future of their children than with the difficulties of their parents. Women, who traditionally bear the main responsibilities for providing family care, enter the labor force for reasons of personal choice and economic necessity and are no longer available to care for aged relatives(9-13).
The social and cultural patterns that still protect the elderly from isolation in society need to be encouraged and supported. Financial, social and emotional assistance to family members who care for their elderly should be provided from governmental and nongovernmental agencies. However, new services will have to be instituted to supplement a decaying, informal system and personnel must be produced to provide these services. Some writers from the developing countries challenge the belief that families can be depended on to take care of old people(9-15).

Governments of the area are still assuming that families will take care of their own elderly. The changing economic and shifting migration patterns lead to the projection that the provision of long-term care will be an important part of health care planning (1,9-13). Government is unwilling to make major commitments to elderly health (9-14). Interventions for the elderly, whether preventive or curative, are almost always far more expensive (9,10,14-18). There is little incentive to direct limited resources in order to add an additional few years of life.

Health Services and Role of the Health Care Team

Diversity is a key term that describes the elderly population. The elderly, like other age groups, encompasses people with varied levels of needs, abilities, and resources. Accurate information on the conditions and needs of older persons is crucial for planning health service development and training of personnel. Given the growth of the aging population in the region, the need for intermittent or continuous long term care services will undoubtedly grow, including nursing facilities, home care, and community-based long term care. It is important to achieve a balance of care between community and institutional services, both for humanitarian and economic reasons. The elderly in the region are growing at a much faster rate, than the elderly in more developed countries. This is a fact that is often overlooked, and, it has very important implications. During the past two decades most Middle Eastern countries have placed increasing emphasis on improved health care. However health care systems in the region have ignored the needs of the elderly. There are only sporadic programs that take care of the elderly, mainly initiated by the community or within the private sector.

Special Care Unit on Alzheimer

For the first time in the Middle East the Social Service Association an NGO in the north of Lebanon with a 300 bed geriatric and psychiatric hospital, started a special inpatient Alzheimer unit fully equipped with 13 beds occupancy and internal garden.

Education and training aspects for all professions involved

A. Role of the Academic Institutions

Medical schools in the area generally press for strong basic science programs and sophisticated tertiary care. There is a limited supply of primary care physicians and well-trained family physicians, in addition to major deficiencies in the number of physicians trained in geriatrics, occupational or environmental health, and preventive medicine(9-12). There is little evidence of the responsiveness of academic institutions to the problems associated with the aging population. They are fixed in a mid-twentieth-century mode, patterned after traditional schools in the developed world (9-12).

B. Health Professionals

One of the most important areas in caring for the elderly is to focus on the need for geriatric and gerontological education and training for a wide range of health professionals and para-professionals who provide care to elderly persons, in order to meet the future demand for quality long-term care services(9-12, 19).

Health professionals at all levels have received little or no training in the care of the elderly. Clinical training of health professionals should include participation in interdisciplinary work in order to gain knowledge and appreciation of the roles of all health and social service workers to be better able to work as a team (19 ).

A rising geriatric population, with increasingly unmet health care needs, strongly suggests the necessity for better educational preparation of those health professions actually or potentially serving them. The absence of sufficient numbers of trained geriatricians and gerontologists, among health professionals, seriously undermines the ability of the country’s health care system to adequately assess, treat, and rehabilitate the growing aging population. This shortage leads to inappropriate care, higher costs, and poorer patient outcomes.

C. Implications for Nursing

As this century progresses nurses in the Middle-East will be increasingly concerned with the aging population. It is a prime responsibility of nursing to encourage elderly people to optimise their physical, social, and psychological function during changes in their state of health. The keys to enable the nursing profession to effectively cope with the challenge of caring for the elderly lie in specialised training that equips nurses with the knowledge needed. There are no gerontological nurses in the Region. There is a need for nurses to stress emphasis on health rather than illness(21) in addition to stressing the holistic aspect of nursing practice with older adults(22). There is a need to incorporate gerontological nursing preparation into basic nursing education (23).
The role of the geriatric nurse, in primary and managed care, can best be described as that of the health care provider who assesses the clients' needs and strengths on an ongoing basis, who provides continuity of care, and referrals to appropriate health professionals and agencies, as well as coordination of the clients' total care.

D. Social Work

Geriatric social work is built on a bio-psycho-social theoretical foundation. The need for social services for the elderly will be increasing in the next few decades. There will be increased need for social, emotional and environmental support services for the elderly. Concomitantly, there will be even greater need for geriatric social work education. Social workers are key members of the interdisciplinary team required to deal with the complex problems of older persons. The teamwork recognises that such problems necessitate a comprehensive and planned approach to their resolution.

Case management is an essential component of the provision of care to older people, partly because of the fragmentation and discontinuities in the service delivery system, and partly because of the emphasis on cost efficiency and effectiveness. Although other professions are engaged in the provision of case management, the expertise of geriatric social workers continues to be a strong justification for the centrality of their role as case managers, and for this being part of their assignments on geriatric interdisciplinary teams.

Educational needs of those preparing for careers as geriatric social workers include an emphasis on the skills, knowledge, and values required for effective team work. Social workers are key members of the interdisciplinary team required to deal with complex problems of older persons. The teamwork recognises that such problems necessitate a comprehensive and planned approach to their resolution.

A number of significant issues in geriatric education for social workers must be considered. These issues must be confronted by the profession, in the context of the extraordinary changes, which are occurring in the health and social service system, and in these settings in which geriatric social workers practice. Emphasis should be made on managed care strategies, designed to contain health care costs, and rationalise the system, and the key role that social workers are being called upon to play as case managers. Also, increasing emphasis should be made on community based geriatric services, outside the walls of hospitals and long-term facilities, an emphasis which underscores the importance of the preparation of geriatric social workers for work with families, for linkage and advocacy roles, among others.

E. Special Training programs in the Region

In Egypt an increasing number of the elderly either live alone, with elderly spouses, and/or with only one or two family members. The Care With Love program which is a training program for Home Health Care Providers was established. The purpose of the program is to create a sustainable well trained cadre of Home Health Care Providers in Egypt in order to staff units for Home Health Care Services. The first training course was run in 1996 and 115 trainees joined the program taking various courses between 1996 and 1999 of whom 99 had graduated (24). Ain Shamas University in Cairo started a series of courses on old age psychiatry.

In an attempt to cover the gap, the Middle East Academy for Medicine of Ageing was founded to stimulate the development of health care services for older people in the region. It was established by a number of professors and teachers from the Middle East and Europe. The Model of MEAMA was taken from the European Academy for Medicine of Ageing. The first course took place between 2003 and 2005. The course has been built up with 4 sessions, on each of 4 days, that cover important topics of health-related problems in older people (25). The second advanced postgraduate course in Alzheimer (2006-2008) started in November 2006. The highly successful format of intensive student participation in working groups, giving short presentations and leading discussions, as well as state-of-the-art lectures by experts in the field will be followed again. This intensive study course composed of four sessions is directed towards physicians, nurses, social workers, and health care officers, responsible for the health care of older people. In addition to faculty members of medical, nursing, social and physiotherapy schools interested in developing the field of Alzheimers and gerontology.

F. Special Organisations

The Middle East Association on Aging and Alzheimer’s (MEAAA)

In an attempt to answer some of the deficits in the region, the MEAAA was established in order to support various activities in the field of aging and Alzheimer’s disease. Currently the association has representation from several countries in the Middle East. The purpose of The MEAAA is to advance the scientific and scholarly study of aging and to promote the scientific study of aging in both the biomedical and behavioral/social sciences; by direct members and member organizations, and to promote cooperation among these organizations. In addition to stimulate communications among scholarly disciplines, and among professionals including researchers, teachers, administrators, and others.

MEAAA recently helped in co-organizing the first Middle East Congress on Aging in Istanbul where a number of the members participated in the scientific committee.

The Middle East Journal of Age and Ageing (ME-JAA)

The Middle-Eastern Journal of Age and Ageing started in July 2004. The Mission of the Journal is to promote geriatric...
medicine, gerontology and ageing related issues in the Middle-East. The ME-JAA is a peer-reviewed journal to meet the needs of scientists, practitioners, policymakers, and the patients and communities they serve in the Middle-East.

**The Middle East Network on Aging Research (MENAR)**

Despite the fact that 93% of potential years of life lost are in developing countries, only 5% of research dollars are spent on health problems of developing countries(1). Research is needed to optimise the strength potential of older persons and to improve their opportunities to perform rewarding roles in society. There is a substantial research need in the ageing field in the Middle-East. Research is an essential prerequisite in developing the specialty further in the area, and in developing evidence-based practice. Therefore the Middle East Network on Ageing Research (MENAR) was established in 2006 and is linked to a number of international organizations dealing with elderly issues including InterRAI international. The aim of the MENAR is to develop Alzheimer and Gerontology Research in the area.

**Solutions and Future Directions**

Two expert committees from the World Health Organization(26,27) recognise that the sophisticated and specialised services for the elderly found in the developed world are irrelevant for the immediate future and may not even be appropriate as long term objectives for developing countries. The World Health Organization(27,28) developed a tentative model for a realistic approach to meeting the needs of the elderly citizens in developing nations. In this model, the needs of elderly people should, as far as possible, be met within the system of care developed for the population as a whole. Patterns of care should be based on functional assessment of the elderly. It envisages a system of care built up from the primary care resources of the community. Special emphasis should be given to programs that assist the family in its traditional role of supporting the elderly. Institutional long-term care services should be made available only when other alternatives are exhausted.

The severely impaired and dependent aged will need a wide range of professional care as will their families. In the process of creating adequate services, it is important to realise that home care and institutional services are complementary and multidirectional. Care of such patients needs the shared responsibility of both families and professional service providers. Services can be alternately provided in the home, the community, or the institution. The role of those concerned with aging in Lebanon or the Middle East is to provide communities and concerned professionals with the knowledge and skills to solve their problems, not to import solutions from developed countries after other alternatives have been explored. Health promotion and prevention should be key factors in any program. Geriatric and gerontological information should be a part of the education of all health professionals. Environmental design of hospitals and clinics should take into consideration the needs of the elderly.

**Public Awareness**

Aging is a biological process. It is not a disease. In order to increase the population’s awareness of it, it is important to provide ready and correct information on the needs and abilities of old people. Bringing gerontological content to the school curriculum of children as preparation for adult life is one alternative to improve the public image of elderly patients. Many youngsters show signs of prejudice against old persons, bordering on what is now called ageism(29,30).

**Conclusion**

The demographic changes and social and economic developments in the Region have created new realities in an unprecedented growth of the elderly population. Trends, such as rapid urbanisation, a move from extended families to nuclear families, and technological developments make the problem of aging in the Middle East an acute one. Inappropriate application of costly technology could easily result, accompanied by diversion of resources from existing primary-care services in deterioration of the existing health care system. Many of the most effective measures promoting independence and autonomy promise to result from environmental changes and community organisation, e.g., transportation and physical adaptations for those with impaired mobility, provision of appropriate technology for the hearing or visually impaired, encouragement of mutual help groups. What is essential is to ensure the best possible quality of life for the greatest possible number of our aged.

**References**

Restraint Use in Psychiatric Settings: An Argumentative Essay

Rami Sami ELshalabi

Correspondence:
Rami Sami ELshalabi, RN, MSN, CNS
Master in Psychiatric and Mental Health Nursing
Princess Salma Faculty of Nursing, Al-albayt University, Mafraq, Jordan
Email: r.elshalabi@yahoo.com

Abstract

Background: Restraint is one of the most controversial practices in contemporary mental health service delivery. The use of physical restraint in acute and residential health care facilities is a widespread practice in many countries.

Purpose: To discuss the restraint use in psychiatric settings from different points view, we will examine both sides of this controversial issue based on ethical, legal, and clinical considerations.

Method: A comprehensive search of several electronic databases was used in Pub Med, MEDLINE, in order to determine restraint use in psychiatric settings. The following key words were used to search the electronic databases Restrain, Patient, Psychiatric Settings.

Conclusion: There are many alternatives that are effective, safe to patient and staff, legal, easy to apply, and accepted politically instead of use of physical restraint.

Key words: Restraint, Restraint, Patient, Psychiatric Settings

Case Scenario

Ali 40 years old is an inpatient in an acute mental health unit, and has a diagnosis of bipolar disorder, with multiple suicide attempts. He is experiencing psychotic symptoms, trying to hit other patients, refusing oral medication and he has become aggressive and agitated. The psychiatrists and nurses decided to restrain the patient on bed by force and give medication without consent.

In 2005, there was a case where a woman was admitted to a country hospital psychiatric inpatient unit, where guards and technicians restrained her, and during the restraint process, her face was down on the floor for thirteen to fifteen minutes and she then died of asphyxiation. Also in 2005, an Alzheimer’s patient was hospitalized and within 24 hours after she was restrained, was found dead related to an accidental asphyxiation (Regan, Wilhoite, Faheem, Wright, & Hamer, 2006).

These scenarios reflect one of the current debatable issues of restraint use and more questions that need to be answered. What ethical arguments can be presented for and against restraint? Does restraint protect patient autonomy? Is restraint legal according to human rights? Does physical restraint require informed consent? Who is the person authorized to give the approval? On the other hand, is it ethical to let the patient hit other patients? What if the patient suicides? What are the consequences and the solutions, if restraint was not applied to the patient? Is there any criterion to apply physical restraint on the patient?

The aim of this paper is to discuss restraint use in psychiatric settings from different viewpoints. We will examine both sides of this controversial issue based on ethical, legal, and clinical considerations.
Restraint is one of the most controversial practices in contemporary mental health service delivery (Happell & Gaskin, 2011). The use of physical restraint in acute and residential health care facilities is a widespread practice in many countries (Goethals, Dierckx de Casterlé, & Gastmans, 2011). In addition, restraint is still a common practice with a prevalence of 30% use of physical restraint alone and another 30% use physical restraint combined with pharmacotherapy in the emergency department (Knox & Holloman, 2012).

The term restraint includes either physical restraint or chemical restraint; physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the patient's body that restricts freedom of movement (Regan, et al., 2006). Chemical restraint is a medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient’s medical or psychiatric condition (Regan, et al., 2006).

Restraint is often used to control the behavior of people with mental conditions in a variety of settings including hospitals and psychiatric treatment facilities (Haimowitz, Urf, Huckshorn, 2006). Psychiatric settings use medical intervention as a restraint to reduce risk demonstrated by violent patients from harming themselves and others (Regan, et al., 2006). Restraint is intervention used in the treatment and management of violent behaviors in psychiatry (McCue, Urcuyo, Lili, Tobias, & Chambers, 2004).

Decisions about the use of physical restraints are complex and ethically laden; the complexity of physical restraint depends on patient characteristics, nurse-related factors, including nurse's perception of patient behavior, their willingness to take risks, and their own comfort. In addition, context-related factors include other health care members, the presence of family and the care organization (Goethals, et al., 2011). Restraints involve using force, as a result, applied without consent (Horsburgh, 2003).

Restraint of any kinds are governed by protocols that ensure that it is properly and appropriately applied, although patients are not autonomous at the time when a decision to restrain them is taken, explaining to them why the restraint is necessary, protects their right to self-determination, in doing this autonomy will be considered (Draper, MacDiarmaid-Gordan, Strumidlo, Teuten, & Updale, 2006).

Restraints are useful to prevent injury and reduce agitation but the use of restraint in the treatment of mentally ill patients is a highly controversial and potentially dangerous practice (Lewis, Taylor, & Parks, 2009). In addition, it can produce physical and psychological effects on both patients and staff (McCue, et al., 2004). The improper use of restraints can lead to patient harm and potential civil litigation, the researcher and clinicians have focused on physical restraint because lack of consensus within the field about the appropriate use of restraint, can damage therapeutic relationships, and produce significant physical and psychological risk; including death related to asphyxia, aspiration, cardiac events brought on by exertion and medication-interaction (Haimowitz, et al., 2006).

Restraints should always be considered a last resort as they present a significant threat to human rights, dignity, autonomy and well-being, also there are situations when nurses have to prevent harm to a patient, however, using belt and cuff devices are unacceptable and have resulted in deaths and serious harm (Gallagher, 2011). The use of restraints puts patients at risk for physical injury, death, and can be traumatic even without physical injury (Knox & Holloman, 2012).

The definitions of restraints are incompatible with the principle of autonomy in procedures involve restricting the patient, and limiting their freedom. Moreover the use of coercive power to achieve compliance violates the principle of autonomy (Moher, 2010). Safety is an important argument for using restraints, but also beneficence, dignity, freedom, and respect for autonomy should be considered (Goethals, et al., 2011).

**Proponents of Physical Restraint Use**

Nursing staff may need to restrain a patient in order to protect the patient from injury, or protect him or her from unnecessary risk or harm. Also patients have a right to be free from physical restraint except in an emergency or when isolation or restraint is a part of a treatment program (McBrien, 2007).

It is arguable that in care settings, there is an ethical requirement not only to avoid harm, but also to create benefit for the client (Horsburgh, 2003).

Physical and chemical restraint may be used when a patient attempts to remove invasive devices (Regan, et al., 2006).

**Author Point of View**

Based on the evaluation of both opponents, and proponents of restraint, the author of this paper agrees with the opponents of restraint; each patient has the right to refuse treatment and the right to be free from restraints. As it was illustrated that restraint is a very complex issue that underlines many ethical and legal issues and arguments, furthermore the patient’s autonomy, freedom, and respect of decision making should be considered, moreover as it was illustrated above that restraint can cause very serious harm on patient physical and mental health, that can lead to death.
Recommendations

- Nurses should use advanced directives to negotiate intervention strategies with patients to manage behavior.

- Patients must be evaluated face to face by physician or registered nurse who has met specified training within 1 hour of restraint.

- The administration for an organization should develop policy for assessment and management for uncontrollable behavior and restraints.

- Required training program about how to deal with uncontrollable behavior and managing it.

- Increased staff visibility in the patient environment rather than present in nurses’ station; it helps the staff to identify the problems and intervene early.

- Staff training is important to the patients and staff themselves, the patient has a right to be safe when in uncontrollable behavior.

- Do a personal safety plan on admission, it helps health care providers to gather information about the patient’s response to distress and identify what interventions will be most helpful keep them in control.

- Chemical restraint by use of medication to control patient behaviors; the most often medication used in chemical restraint Diazepam (Valium), Lorazepam (Ativan), and Haloperidol (Haldol). This alternative is highly effective, legal to use, easy to apply through different routes (IM, IV) to the patient, lower cost to the organization, is safe for patient and staff, and accepted politically.

Summary and Conclusions

The purpose of this paper was to discuss restraint use in psychiatric settings. Restraint is still an argumentative issue that nursing deals with almost daily in their practice. Also it should be considered as a last resort and practitioners should consider alternative interventions to promote safety and respect the dignity of the person. There are many alternatives that are effective, safe to patient and staff, legal, easy to apply, and accepted politically instead of use of physical restraint, such as complete assessment of the patient and devise a personal safety plan that can help the staff how to deal when a distressful situation occurs, staff training that give the staff have expert power when dealing with the patient as a skillful and knowledgeable person, increase staff visibility in the patient environment which helps the staff to detect and intervene in the distress situation early. The lack of evidence supporting the use of physical restraints, the negative consequences of restraint for patient, and the low availability of alternatives complicate decision-making to apply restraints.

References


Arguments of Legal and Ethical Use of Seclusion Among Psychiatric Inpatients

Anas Husam Khalifeh

Correspondence:
Anas Husam Khalifeh, RN, MSN
Master Degree in Psychiatric and Mental Health of Nursing
Jordan
Email: anaskhalifeh@yahoo.com

Abstract

The use of seclusion is one of the most controversial practices in psychiatric care and touches this important topic clinically, ethically and legally. Argumentative papers and writers arise which show a position, expect counterarguments, and response to opposing points of view in the systematic frame; in psychiatry the arguments need to improve knowledge, improve clinical outcomes and health behavior, and the ability to be involved in decisions. The purpose of this argumentative essay is to highlight the conflict with use of seclusion with aggressive psychiatric inpatients, and presents opinions on using seclusion from the ethical and legal perspective. This argumentative provides a comprehensive overview related to use of seclusion on both options, the drawbacks and benefits of it, opponents’ and proponents’ opinions on legal, and ethical issues which have the responsibility to protect patients. The position of the author is to reduce or eliminate seclusion in the psychiatric setting, which affects on the legal and ethical context of care.

Key words: Seclusion, Psychiatric, Psychiatric setting, Legal, Ethical, Policy

Introduction

The environment related to healthcare is rapidly changing and developing, so, forces of healthcare reform may lead to further changes. Therefore, we need to understand legal and ethical dimensions of practice which provides the foundation for professional nursing (Ellis & Hartley, 2012). As a result, argumentative papers and writers arise which show a position, expect counterarguments, and response to opposing points of view in the systematic frame. Argumentative essay is defined as a position of issue whereby the writer tries to induce the reader to implement an action or procedure or viewpoint concerning the argument (Nippold & Ward-Lonergan, 2010).

The fields of psychiatry show argument issues need to improve knowledge, clinical outcomes and health behavior, and the ability to be involved in decisions (Coulter, Parsons, & Askham, 2008). Mental disorders include a wide range of problems, with different symptoms and a significant proportion of the global burden of disease. A combination of abnormal thoughts, emotions, and behaviors are associated with interference with personal functions; these are the characteristics of mental disorder (World Health Organization [WHO], 2014).

Among these patients are those who experience psychosis and need management and control of challenging behaviors (Whittington, Bowers, Nolan, Simpson, & Lindsay, 2009). Aggressive behavior is violent or agitated behavior that has risk of harm to self and harm to other patients or staff, be it physical or emotional, so, there must be an effective and safe intervention to prevent injury to everyone and manage this behavior (Huf et al., 2011; Siever, 2008).

Bonner and Wellman (2010) stated management of aggression and violent behaviors remains a challenge to mental health care practitioners. Psychiatric hospitalization which experiences these behaviors could be managed by several ways of restrictions and coercive interventions that include: seclusion, physical restraints, time out and chemical restraints (Hashmi, Shad, Rhoades, & Parsaik,
2014; Janssen et al., 2012; Migon et al., 2008). Seclusion is defined as isolating a patient in a locked designed room; which is non-stimulating and which is specially prepared and safely separated from other patients and has a window for observation (Bowers et al., 2011; Stewart, Van der Merwe, Bowers, Simpson, & Jones, 2010).

The use of seclusion is one of the most controversial practices in psychiatric care and touches this important topic clinically, ethically, and legally (Happell & Harrow, 2010; VanDerNagel, Tuts, Hoekstra, & Noorthoorn, 2009). Psychiatric nurses should be familiar with legal and ethical aspects of care and treatment of patients with mental disorders which focus on the rights of patients and the quality of care they should receive (Kumar, Mehta, & Kalra, 2011).

Case Use of Seclusion

Ashraf is a 37 year old man who has schizophrenia, who has been experiencing auditory hallucinations and paranoia, and who was admitted involuntarily to the closed ward of a mental health hospital by police as a resulting of him trying to assault his neighbors because he thought people were wanting to harm him. Having arrived at the inpatient unit, the nurse asked him how he was feeling?, and he answered “I need a cigarette now”. The nurse refused to give him a cigarette until he answered the questions. After one day, Ashraf expressed sense of discomfort about other patients and told the nurse that he was upset and asked for a cigarette, but the nurse ignored him. Then he yelled at the nurse, after that he became aggressive and hit other male patients in the unit, therefore, the nurses and psychiatrists put Ashraf in a seclusion room by force.

This case shows one of most important legal and ethical issues that face the nurse in the psychiatric unit. Furthermore, involuntary treatment is common and the standards of care in mental health hospitals are generally poor and weak regarding basic human rights for patients which is common and obvious in many developing countries (Irmansyah, Prasetyo, & Minas, 2009). Moreover, Kontio et al. (2010) stated there is a lack of evidence that the aggressive behavior caused by patients with serious mental disorders could be alleviated by using seclusion or restraint. So, we need to think about these questions and answer them. Are there rights for mental ill patients?, is there a legal authority affecting on seclusion?, what about the mentally ill patient's autonomy?, does the use of seclusion respect the mentally ill patient's right?, it is ethical to use seclusion?.

The purpose of this argumentative essay is to provide and highlight on the conflict about use of seclusion with aggressive psychiatric inpatients, and presents the opinions of using seclusion from the ethical and legal perspective. The position of the author is to reduce or eliminates seclusion for psychiatric inpatients by improving use of legislation and nurses’ role in this issue.

Background

Introduction

Mental disorders are widespread affecting men and women, in all stages of life, rural and urban areas, rich and poor countries; the fact is 60% of clients attending primary care settings have a diagnosable mental illness (WHO, 2008). Mohr (2010) stated that mental illness affects on more than one dimension; cognitive, behavioral, emotional, and social functioning; and impacts on a patient’s ability to participate in the treatment plan. In the Arab world, mental disorders are located in the second place for disability (Mokdad et al., 2014).

Furthermore, seclusion is used widespread in psychiatric settings with aggressive inpatients (Happell & Harrow, 2010). There are several reasons causing the isolated of psychiatric inpatients in seclusion, such as: violence to property, verbal aggression or threats, threats of self harm or actual self harm, physical aggression to others, and severe psychiatric symptoms or disturbed behavior (Bowers et al., 2011). On the other hand, the use of seclusion is considered as one of the most important controversial management strategies with humanitarian, ethical and legal issues associated with it (Happell & Harrow, 2010).

The author searched and found many studies and policies which showed conflict regarding use of seclusion with aggressive psychiatric inpatients. Many studies preview show that authors advocated against their use of seclusion in psychiatric field, conversely others consider as necessary the use of seclusion to manage these aggressive behaviors. The purpose of the background is to provide a comprehensive overview related to use of seclusion on both options and drawbacks and benefits of it. The background is composed of opponent and proponent opinions on legal and ethical grounds with the responsibility to protect patients.

Legal Arguments

Opponents of using seclusion. The low benefit limit for mental health on American health policies is considered one of the major causes of poor care and management for the mentally ill (Hamrick, 2013). However, there are many countries that put patient centered treatment and patients’ rights in their priorities through renewing their legislation (Sjostrand & Helgesson, 2008).

If the care of the mentally ill in mental health hospitals had no legal authority to interfere, there would be great deterioration (Diseth & Hoglend, 2014). So, in various countries there are policies established to reduce seclusion. Policy of the Australian government identified a safety priority by reduction or possible elimination of seclusion and facilitates the exploration of the indications and intervention to reduce seclusion (Happell & Harrow, 2010; Larue, Piat, Racine, Menard, & Goulet, 2010). The Dutch government and the Dutch branch organization for mental healthcare supported Dutch mental healthcare institutions to prevent seclusion to improve quality of care (Voskes, Kemper, Landeweer, & Widdershoven, 2013).
In addition, there are international policies and guidelines intent on reducing the use of seclusion and use the least restrictive practice, and limit clinical risk and improve safety as well as a respectful manner. The WHO developed policies and procedures to provide psychiatric nurses standards with using seclusion to reduce it, essentially in the legislation of health law, that includes protecting the right of mentally disordered persons, using the least restrictive treatment, confidentiality, use of informed consent to accept procedures, and improve the role of families and other sectors in promotion of mental health (Commonwealth of Australia, 2012).

Moreover, North East London released policy based on the Mental Health Act; Code of Practice that was designed to provide guidance on the use of seclusion as last choice and not adopted as a planned treatment technique or treatment programme. This policy was established to improve and ensure staff awareness regarding reducing the use of seclusion after using all alternative interventions and if unsuccessful, use of seclusion for the shortest period of time, not using seclusion as a punishment or threat or because of shortage of staff (North East London, 2012).

Proponents of using seclusion. The American Psychiatric Nursing Association (APNA), reported that the safety of nursing work in psychiatric settings is important (APNA, 2008). The patients’ perceptions toward seclusion is not always in congruence with legal status (Iversen et al., 2010). Psychiatric Hospitals Compulsory Admission Act regulated in the Netherlands the legal use of forced seclusion in psychiatry which is authorized in the mental health institution to avoid dangerous behavior occurring as a result of mental illness, for the involuntarily admitted (Legemaate, 2008).

Khudhur (2013) concluded 20 psychiatric nurses in Jordan who worked in mental health services reported that they considered seclusion as a treatment for violence and necessary. Dutch Special Admission in Psychiatric Hospitals Act regulated policy to use seclusion and restricted to to manage aggressive behavior which cannot be treated (Janssen et al., 2012).

There are many policies in the world established to use seclusion. The author found a policy from the Jordanian Nursing Council for National Center for Mental Health about the use of seclusion. It includes the purpose, reasons of action, and the guideline of action. This policy takes into consideration patient’s safety, safety of others, and patient's rights, in addition to observation of patients, renewal of order of seclusion by a doctor, and that it met the needs of patients (National Center for Mental Health [NCMH], 2011).

Ethical Arguments

Opponents of using seclusion. There are studies that show that the use of seclusion is an ethical dilemma with psychiatric inpatients. The Norwegian Psychiatric Association in 2009 concluded that it is unethical to remove the treatment criterion of seclusion (Diseth & Hoglend, 2014), and considered it an ethically important line in international guidelines, essential for nursing practice, and necessary to take balanced decisions (Janssen et al., 2008).

Ethical issues facing the psychiatric nurse in the area of caring for psychiatric inpatients are divided into more than one corner including autonomy, human dignity, and the right to self determination (Prinsen & van Delden, 2009). Many psychiatric inpatients feel loss of their dignity because they do not have the ability to affect on the treatment provided to them (Kogstad, 2009).

Moreover, Larsen and Terkelsen (2013) reported that patients feel not treated as a human being and are treated related to diagnosis which leads to hurting patients. In New Zealand the Ministry of Health improved the ethical principle guided practice which includes beneficence, non-malfeasance, and respect of the dignity of patients and human rights (Ministry of Health, 2008). Furthermore, the National Mental Health Commission, called to reduce use of seclusion and restraint because it is not therapeutic and isn’t in line with human rights (National Mental Health Commission, 2013).

On the other hand, the patient's feeling of seclusion is considered one perception of ethical issues, and there are many studies that have shown this concern and many patients are left with negative perception after being secluded. The feelings and experiences that were reported differs from one study to another and includes seclusion as a violation for autonomy or punishment (Keski-Valkama et al., 2009), as torture (Veltkamp et al., 2008), feeling anger and fear (Kontio et al., 2010), and feelings of isolation (Mayers, Keet, Winkler, & Fisher, 2010). Likewise, Kontio et al. (2010) stated that seclusion does not affect just on the psychiatric inpatient but also on the psychiatric nurse, which is an ethical problem that causes feelings of guilt when he/she can’t find alternative interventions.

Proponents of using seclusion. Freedom and the rights are considered important to the individual but the courts of law are more concerned for the mentally healthy individual than the individual with mental illness (Diseth & Hoglend, 2014). Furthermore, autonomy is considered important but Prinsen and van Delden (2009) stated that seclusion can be used as an intervention to reach autonomy instead of violating autonomy and human dignity.

There are some benefits for using seclusion and restraint despite the patient considering it unnecessary and punitive (Soininen et al., 2012). Happell and Koehn (2011) conducted a survey of nurses’ attitudes to seclusion from 123 nurses from eight mental health services from Queensland, Australia and despite the negative impact of seclusion in patients it continued support of the use of seclusion by staff to the management of consumer behaviors such as violence and aggression. Although, most circumstances where seclusion is considered justified appears to be when the patient is hitting a staff member (80%) and the patient is hitting another patient (70%).
Summary and Conclusions

The purpose of the background was to provide a comprehensive overview related to use of seclusion on both opinions. The background was composed from both legal and ethical argumentative perspectives. Every part showed opponents and proponents of using seclusion. Nurses are the first direct primary caregivers; they should know the legal and ethical issues which they may face.

So, the first part of the background showed opponents of using seclusion legally, this involved the legislation and effect of reducing use of seclusion. Furthermore, regarding the policies from more than one organization and country, this aimed to reduce use of seclusion. Proponents of using seclusion legally, involved the initiation of seclusions which focuses on the psychiatric nurse safety and improves quality of care. Psychiatric nurses were favorable to use of seclusion with aggressive psychiatric inpatients. There are polices to use seclusion, and one is mentioned from the Jordanian Nursing Council used in the National Center for Mental Health.

On the other side, ethical argument involved values and norms and there are inconsistencies including good care versus safety and non beneficence versus beneficence. Opponent’s perspectives were linked with human rights, autonomy, and right to self determination. The seclusion affects dignity, feelings, and on experience of using seclusion, it also affects both the psychiatric inpatient and psychiatric nurse. Proponent perspectives showed that the psychiatric nurse believes that seclusion is necessary and assists patients to calm down and feel better.

Table: Summary Table

<table>
<thead>
<tr>
<th>Authors &amp; year of publication</th>
<th>Objective</th>
<th>Design</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sjostrand and Helgesson (2008)</td>
<td>Discusses the rationale behind coercive treatment in relation to an idealized psychiatric case.</td>
<td>Review article</td>
<td>Coercive treatment cannot be defended for the sake of protecting others. While coercive actions can be acceptable in order to protect close family and others, medical treatment is not justified for such reasons but should be given only in the interest of patients. Coercive treatment may be required in order to promote the patient’s health interests, but health interests have to be waived if they go against the autonomous interests of the patient. Coercive treatment is, thus, acceptable only on the condition that (1) the patient cannot make an autonomous decision about treatment and (2) treatment is in the patient’s authentic interest.</td>
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<td>Happell and Harrow (2010)</td>
<td>The review was carried out to identify current knowledge of nurses’ attitudes to the use of seclusion</td>
<td>Review article</td>
<td>The research suggests that most nurses support the continued use of seclusion as a strategy for the management of violence and aggression. A deeper understanding of the factors that influence attitudes is necessary if seclusion rates are to be effectively reduced.</td>
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<tr>
<td>Larue, Piat, Racine, Menard, and Goulet (2010)</td>
<td>Explores and describes nursing interventions performed during episodes of seclusion with or without restraint in a psychiatric facility and examines the relationship between the interventions’ local protocols and best practice guidelines.</td>
<td>Descriptive study</td>
<td>The results show that many interventions are well grounded in nursing practice.</td>
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<tr>
<td>Author(s)</td>
<td>Title</td>
<td>Study Type</td>
<td>Summary</td>
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<td>Voskes, Kemper, Landeweер, and Widdershoven</td>
<td>To describe the implementation process of seclusion in psychiatry and other interventions and to provide recommendations to foster the project and to further improve the quality of care.</td>
<td>Case study</td>
<td>Applying the intervention in the right way implies more than following the steps laid down in the protocol. It requires a new way of thinking and acting, resulting in new relationships between nurses and patients.</td>
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<tr>
<td>Iversen, Sallaup, Vaaler, Helvik, Morken, and</td>
<td>To describe and explore patients’ perceptions of their stay at a Norwegian seclusion area.</td>
<td>Descriptive study</td>
<td>Patients experienced their stay as positive. The patients that were admitted voluntarily reported significantly better experiences with regard to the help received, support from the staff, and respectful treatment.</td>
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<td>Linaker (2010)</td>
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<tr>
<td>Legemaate (2008)</td>
<td>Review criteria according to the Dutch Mental Health Act of admission to a psychiatric hospital</td>
<td>Review article</td>
<td>International agreements and foreign legislation can serve as useful sources of introducing improvements into Dutch legislation.</td>
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<tr>
<td>Khudhur (2013)</td>
<td>To assess psychiatric nurse’s knowledge about using seclusion for hospitalized patients and to establish a guideline for using seclusion.</td>
<td>Descriptive study</td>
<td>Nurses believe in seclusion to be very necessary even in minor disturbances as a means of power and control.</td>
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<tr>
<td>Janssen, Noorthoorn, Nijman, Bowers, Hoogendoorn, Smit, and Widdershoven (2012)</td>
<td>The current study examined patient characteristics related to a patient’s risk of being secluded as compared between a substantial sample of admission wards. In the current study we make an effort to understand the contribution of patient and ward characteristics to the variance in seclusion use. This study is an effort to address the assumption of nurses and management that high seclusion rates are related to patient’s illness and characteristics.</td>
<td>Descriptive study</td>
<td>This study investigated differences in seclusion use between 29 admission wards. The findings show ward predicts most of seclusion use at the patient as well as ward level. A number of patient characteristics however do contribute to the final model.</td>
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<tr>
<td>Diseth and Hoglund (2014)</td>
<td>First, to provide an overview of research studies concerning the benefits or harmfulness of involuntary treatment after coerced admission and, second, to evaluate studies that try to compare involuntary with voluntary treatment.</td>
<td>A systematic review</td>
<td>Few studies have been conducted on the effect of compulsory mental health care, and the results have been contradictory.</td>
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<td>Janssen, Noorthoorn, de Vries, Hutschemeakers, Lendemeijer, and Widdershoven (2008)</td>
<td>To describe Dutch seclusion data and compare these with data on other countries, derived from the literature.</td>
<td>Review article</td>
<td>Numbers of countries have been working to reduce seclusion use.</td>
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<tr>
<td>Reference</td>
<td>Description</td>
<td>Methodology</td>
<td>Findings</td>
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<tr>
<td>Prinsen and van Delden (2009)</td>
<td>To discuss coercive measures, addressing the conflict between autonomy and beneficence/non-maleficence, human dignity, the experiences of patients and the effects of coercive measures.</td>
<td>Review article</td>
<td>The total lack of controlled trials about the beneficial effects of coercive measures in different populations however, argues against the use of coercive measures.</td>
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<tr>
<td>Kogstad (2009)</td>
<td>To investigate violations of dignity considered from the clients’ points of view, and to suggest actions that may ensure that practice is brought in line with human rights values.</td>
<td>Qualitative.</td>
<td>The mental health clients experience infringements that cannot be explained without reference to their status as clients in a system which, based on judgments from medical experts, has a legitimate right to ignore clients’ voices as well as their fundamental human rights.</td>
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<td>Larsen and Terkelsen, (2013)</td>
<td>This study presents various parties involved in involuntary treatment and discusses findings, using the concepts of vulnerability, guilty conscience, and ethical sensitivity.</td>
<td>Qualitative (observation and interviews).</td>
<td>Patients often felt inferior, while many of the staff felt guilty for violating patients’ dignity, although they ascribed responsibility for their actions to the “system.” The main themes are (1) corrections and house rules, (2) coercion is perceived as necessary, (3) the significance of material surroundings, and (4) being treated as a human being.</td>
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<td>Keski-Valkama, Sailas, Eronen, Koivisto, Lonnqvist, and Kaltiala-Heino, (2009)</td>
<td>To determine which demographic and clinical groups of psychiatric inpatients are at risk of being restrained/secluded, and whether there have been changes in the restrained/secluded patients’ profiles over a 15-year period in Finland.</td>
<td>Qualitative (survey).</td>
<td>Restraint and seclusion is used mainly among the acute and the most disturbed patients. Therefore, in order to reduce the use of restraint and seclusion, resources should be targeted especially to these groups.</td>
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<tr>
<td>Veltkamp, Nijman, Stolker, Frigge, Dries, and Bowers, (2008)</td>
<td>To examine patients’ preferences for coercive measures in case of emergency situations on acute psychiatric wards.</td>
<td>Qualitative.</td>
<td>Many patients on acute psychiatric wards have a clear preference between seclusion and medication. Patients appreciated receiving explanations of the reasons for the use of a restrictive measure and discussing their preferences with staff.</td>
</tr>
<tr>
<td>Kontio, Valimaki, Putkonen, Kuosmanen, Scott, and Joffe, (2010)</td>
<td>To explore nurses’ and physicians’ perceptions of what actually happens when an aggressive behaviour episode occurs on the ward and what alternatives to seclusion and restraint are actually in use as normal standard practice in acute psychiatric care.</td>
<td>Qualitative (interviews).</td>
<td>The participants believed that the decision-making process for managing patients’ aggressive behaviour contains some in-built ethical dilemmas. They thought that patients’ subjective perspective received little attention. Nevertheless, the staff proposed and appeared to use a a number of alternatives to minimize or replace the use of seclusion and restraint.</td>
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<tr>
<td>Mayers, Keet, Winkler, and Flisher, (2010)</td>
<td>In a collaborative two-phase study between mental health care providers and mental health service users, the perceptions and experiences of a group of service users who have been exposed to sedation, seclusion and restraint were explored.</td>
<td>Qualitative.</td>
<td>Service users reported inadequate communication between them and service providers and perceived that their human rights had been infringed during acute episodes of illness. Methods of containment were often seen as punitive rather than therapeutic. Sedation was most frequently used and was considered to be least distressing. Observing methods of forced/involuntary containment caused further distress.</td>
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</table>
To explore patients’ perceptions of their hospital treatment measured after secluded/restrained.  
Qualitative.  
Patients perceived that they received enough attention from staff, and they were able to voice their opinions, but their opinions were not taken into account. Patients denied the necessity and beneficence of secluded/restrained. Women and older patients were more critical than men and younger patients regarding the use of restrictions.

Report of the study of nurses’ attitudes to the use of seclusion.  
Quantitative (survey).  
Most participants considered certain behaviours particularly those involving harm to self, others or to property as appropriate reasons for the use of seclusion and were consistent with their perceptions of the likely practice on their unit.

**Argument Statement**

The developing of the healthcare environment causes the raising of issues that impact on professional practice including legal and ethical issues (Ellis & Hartley, 2012). Argumentative essay attempt to prove a position or issue on one side of the argument (Nippold & Ward-Lonergan, 2010). The position of the current author is to reduce or eliminate seclusion, supported through policies from international institutions and articles. Provided psychiatric nurses standards by WHO on use of seclusion aimed to reduce it, to protect rights of psychiatric patients, use seclusion as last choice, and the right to refuse or accept a procedure (Commonwealth of Australia, 2012).

Moreover, seclusion should be reduced as a way of ethical respect to patients and humanity. The Ministry of Health in New Zealand proved by report that practice of nurses guided by ethical principle involved respect of the dignity of patients and human rights (Ministry of Health, 2008), and the National Mental Health Commission reported that use of seclusion and restraint does not comply with human rights (National Mental Health Commission, 2013). Furthermore, nurses should respect the feelings of patients toward seclusion and their experiences about it.

**Recommendations**

The conflict and differences of perspectives legally and ethically of using seclusion in the psychiatric setting resulting recommendations helps to place a framework to reduce or eliminate using seclusion. The recommendations highlighted on more than one corner include organization, policy, and staff. The author recommends the following: seclusion should never be used as a threat neither as a punishment, because of shortage of staff, and the objective of facilitating staff. Establish programs aimed to safe therapeutic environments that reduce and eliminate the need for seclusion and educate nurses about using alternative interventions. Availabilities of policies should be in place to provide feasible alternatives to seclusion.

**Summary and Conclusions**

The purpose of this argumentative essay was to provide and highlight on the conflict about use of seclusion with aggressive psychiatric inpatients, and present the opinions of using seclusion from the ethical and legal perspective. Therefore, the divergent views and reactions on the use of seclusion presented and reflected on the purpose and showed in background a mismatch of legal and ethical perspectives.

The current author is against the use of seclusion in the psychiatric setting and we should reduce or eliminate using it; which affects on the legal and ethical context of care. It is support on the legal perspective through policies and codes included preservation of human rights and autonomy. It is support on the ethical perspective, by using seclusion will cause a negative impact on both patients and staff, and also cause disrespect of the patient’s dignity and not treating them as a human being.

As mentioned previously seclusion is one of the most important legal and ethical issues that face psychiatric nurses. The goal of giving importance to this issue is to improve quality of care and increase awareness and help psychiatric nurses to make the right decisions. In the background the current author presented legal and ethical issues which showed the importance of a body of law to affect on this issue and to protect rights for both patients and nurses.

In addition, respect is required for the autonomy and dignity of patients and leads to improve the quality of treatment. Conversely, there are policies and articles that showed seclusion supported the patient’s autonomy and psychiatric nurses favored the use of seclusion. The recommendations that are mentioned increase the safety of patients and staff and adjustments on structure of the organization which aims to reduce use of seclusion.

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References


Abstract

Background: Seclusion is one of the most used and oldest approaches for treating patients suffering from psychiatric diseases. In addition, it is considered one of the most challenging issues for mental and psychiatric health care givers in psychiatric settings.

Aim: This paper aims to address the use of seclusion among psychiatric inpatients from a legal and ethical perspective.

Methods: The review was carried out in various data bases using combinations of the following search terms: seclusion, psychiatric patients, legal and ethical perceptive.

Results: The new findings are especially significant because seclusion is a complex ethical dilemma in psychiatric health services.

Conclusion: In summary the author suggests to provide educational programmes for nurses in psychiatric health settings about how to deal with aggressive patients in emergency situations.

Key words: seclusion, psychiatric patients, legal and ethical perceptive and psychiatric settings.

Introduction

Seclusion is one of the most controversial practices in mental and psychiatric health services delivery [1]. Historically, seclusion is one of the oldest approaches in the treatment of people suffering from psychiatric and mental illnesses [2].

On the other hand, seclusion is still one of the most important strategies implemented to deal with severely aggressive and violent behavior among patients in mental and psychiatric health services [3-4]. However, the use of coercion methods such as seclusion and physical restraint in psychiatric unit is a serious issue for patient rights [5]. Moreover, aggression and violence have been identified as the main rationale of using seclusion [1].

Objective

This paper aims to provide an overview regarding the use of seclusion among psychiatric inpatients from a legal and ethical perspective.

Case Scenario

A 27 year old male has a four year history of severe depression with multiple suicide attempts as a result of chronic cannabis use. In addition, the patient’s character indicated some psychotic symptoms including; delusion and hallucination. He has had a history of trouble with the law for aggression/violent behaviours. His mother had contacted the crisis team when he became aggressive towards her. While he was being transferred to a psychiatric unit, the patient showed extreme aggression and then attacked nurses of the unit. As a result, the patient was physically restrained by three nurses and secluded in an isolation room.
This case scenario reflects one of the current debatable issues about using seclusion and more questions that need to be answered. Does the seclusion method protect psychiatric inpatient’s autonomy? Is the seclusion method legal according to patient rights?

Discussion

In this paper, the author addresses seclusion practice according to the principle of autonomy, respect of the patient, integrity and human dignity. In addition, the psychiatric patients have the right to refuse treatment or to be free of seclusion.

The issue of using seclusion practice, in mental and psychiatric health services, has remained controversial. Furthermore, involuntary admission and physical restraint used for patients forms a complex ethical dilemma in psychiatric and mental health services [6].

Each patient has many rights by law, such as right to treatment refusal, right to personal privacy, and right to be free from all forms of restraints. Patients also have the right to be free from coercive measures such as a seclusion practice except in emergency cases to keep the patient's physical safety [7].

Author’s Opinion

The author agrees that the use of seclusion is an old approach used to treat patients suffering from aggressive and violent behaviours in mental and psychiatric units. On the other hand, the author considers seclusion as a complex ethical dilemma in psychiatric health services. The author insists that each psychiatric patient has the right to refuse treatment and the right to be free from coercion measures such as seclusion except in emergency cases that threaten the patient’s life and safety.

Conclusion

Seclusion cannot be dismissed or accepted based on autonomy or human dignity principles alone. More knowledge on whether seclusion is beneficial is needed to complete the argument. On the other hand, from the patients’ perspectives, strategies, methods and measures to reduce the need for restrictions should be continually evaluated and developed.

The author suggests to provide educational programmes for nurses in psychiatric and mental health settings about how to deal with aggressive patients in emergency situations. Also, nurses should get acquainted and commit to the regulations of using coercive interventions.

References

The Use of Seclusion for Psychiatric Inpatients: Legal and Ethical Argumentation

Wasim Mustafa Hamdan (1)
Majd T. Mrayyan (2)

(1) Master’s Student of Psychiatric and Mental Health Nursing
The Hashemite University, Faculty of Nursing, Jordan
(2) Professor, Consultant of Nursing
The Hashemite University, Faculty of Nursing, Jordan

Correspondence:
Wasim Mustafa Hamdan
The Hashemite University
Faculty of Nursing
P.O. Box 150459,
Zarqa 13115, Jordan
Phone +962785100351, School’s Fax: +962 (5) 3903351
Email: wasim_hamdan@yahoo.com

Abstract

Aggression and violence toward self and/or others are common behaviors among psychiatric inpatients. Seclusion is the most controversial intervention to control those behaviors. The use of seclusion is one of the most decisive decisions, but it has many legal and ethical arguments. Legally, many policies and laws in various countries support the use of seclusion for aggressive patients in psychiatric settings. While, the use of seclusion is approved in mental health services, many patients’ rights are violated. Ethically, seclusion is used exclusively to prevent expected harm. Therefore, the use of seclusion for that purpose will not violate patients’ autonomy and human dignity. Conversely, it is argued that nurses have to respect and preserve human dignity; those are interfering with seclusion. From proponents and opponents’ point of views, despite that the use of seclusion is a controversial intervention, it remains commonly used for psychiatric inpatients to prevent aggression and violence.

Key words: seclusion, aggressive behaviors, violence, legal aspects, ethical aspects, proponents, opponents.

Introduction

Aggressive behavior and violence against self and others among inpatient with psychiatric disorders are common, and the risks of these behaviors are increasing (1). The use of seclusion is one of the common and the most controversial intervention to control the violent behavior toward the self and others (2).

Although there is no therapeutic evidence for the use of seclusion (3), it is necessary in some cases to prevent injuries (4). Furthermore, the decision on using seclusion has many ethical arguments as it is against the basic principle of patients’ autonomy and human dignity (4).

Violence and aggressive behaviors are any undesirable action of physical force that cause injury to self or others including suicide attempt (5, 6). Seclusion is considered as a therapeutic measure (7), and is defined as locking the patient inside a safe room alone until he/she has the permission to leave it from the staff (8). This is usually done to maintain the safety of patients and others in psychiatric settings (2).

An argumentative essay is a style of writing and a challenging communication task in which the writer takes a position and tries to convince the reader to perform an action or to adopt a point of view regarding a controversy via evidence based resources (9).
The purpose of the current paper is to argue the use of seclusion for psychiatric inpatients from legal and ethical aspects of both proponents and opponents. The current paper is organized as follows: the literature review including the proponents and opponents’ arguments from both legal and ethical sides, and an argumentative statement on the authors’ position. The position of the authors on this issue is that seclusion is one of the effective ways to reduce the violent behaviors of psychiatric inpatients as it maintains a safe treatment environment, thus it can’t be eliminated.

Background

The use of seclusion has many legal and ethical arguments (4). As it restricts patients’ autonomy, it raises a complex ethical dilemma in psychiatric facilities (10).

Worldwide, despite there being a tendency to reduce the use of seclusion in psychiatric settings, seclusion is still used (11). During the 12-month period of data collection in New Zealand, 9.1% of admitted patients to psychiatric units were secluded (12). Over a six-month period of data collection, seclusion was used in 11 mental health services in Australia, 6.8% of inpatients were secluded at least once (13). In some cases, the use of seclusion is the only way to prevent injuries and trauma (14). In the next section, proponent and opponent studies about seclusion, from both legal and ethical aspects, are presented.

Legal Arguments

In all situations, the safety and dignity of the secluded patient should be protected (15). Seclusion as intervention is regulated by the Mental Health Act 1986 (15). This policy regulated the use of seclusion for all inpatients with various ages in psychiatric settings (15).

Proponents. The Mental Health Act is the main law that decides the use of seclusion in mental health services to protect the health and safety of the individuals (15). The act sets out the requirements that staff applying seclusion must obey. Secluded patient’s safety, health care delivered, dignity (self-respect), privacy, and continuous assessment must be guaranteed (15).

In Jordan, the National Center for Mental Health (NCMH) sets a standardized policy that guides health care providers when using seclusion. The policy aims to ensure the patients’ safety and reduce violent behaviors throughout the seclusion technique, while protecting patient’s rights and human dignity (16). Findings summary are presented in Table 1.

Opponents. Since 1990, the New Zealand Bill of Rights Act prohibited the use of seclusion. This Act aimed at protecting the following rights: the right not to be subjected to torture or cruel treatment, the right to refuse medical treatments, and the right to freedom that includes the right not to be subjectively detained (17). Since 1983, United Kingdom Mental Health Act stressed that seclusion should be used only as a last resort, and the decision for seclusion should be based on knowledge of patient and their preferences, and only in order not to cause injury to others (18).

Seclusion of individuals with disabilities in psychiatric settings is an absolute ban, and prolonged seclusion may represent torture and poor treatment (19). Legal protection against torture or other forms of cruel, inhuman or humiliating treatments is essential in protecting people with disabilities, and ensuring that they maintain their physical and psychic integrity regardless as to where they stay (20). Findings summary are presented in Table 2.

Ethical Arguments

Proponents. The use of seclusion in psychiatric settings is an ethical dilemma as well as of legal concern (14). Although seclusion has a major role in preventing aggressive and violent behaviors and maintaining patients’ safety particularly in emergency cases, it is still controversial (2). Yan (21) in 2012 concluded that seclusion might not interfere with the ethical principles regarding humanity such as autonomy and human dignity when it is used with a good intention. Based on beneficence and non-maleficence principles of ethics, the researcher reported that seclusion is to be used to protect the patients and others from expected injuries, maintain the treatment environment, decrease the patients’ external stimulation, and create a therapeutic situation (21).

Findings summary are presented in Table 3.

Table 1: Summary of Findings of Proponents

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Setting</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Victorian Government Department of Health (15).</td>
<td>2011</td>
<td>Victoria, Australia</td>
<td>In all situations, the safety and dignity of the secluded patient should be protected.</td>
</tr>
<tr>
<td>National Center for Mental Health (16).</td>
<td>2013</td>
<td>Jordan.</td>
<td>Ensure the patients’ safety and reduce violent behaviors throughout the seclusion technique, while protecting patient’s rights and human dignity.</td>
</tr>
</tbody>
</table>
### Table 2: Summary of Findings of Opponents Legal Arguments

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Setting</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand Governmental Legislation (17)</td>
<td>2013</td>
<td>New Zealand</td>
<td>Prohibited the use of seclusion. This act aimed at protecting the following rights: the right not to be subjected to torture or cruel treatment, the right to refuse medical treatments, and the right to freedom that includes the right not to be subjectively detained.</td>
</tr>
<tr>
<td>Department of Mental Health, United Kingdom</td>
<td>2014</td>
<td>United Kingdom</td>
<td>Stressed that seclusion should be used only as a last resort, and the decision for seclusion should be based on knowledge of patient and their preferences, and only in order not to cause injury to others.</td>
</tr>
<tr>
<td>New Zealand Governmental Legislation (19)</td>
<td>2014</td>
<td>New Zealand</td>
<td>Seclusion of individuals with disabilities in psychiatric settings is an absolute ban, and prolonged seclusion may represent torture and poor treatment.</td>
</tr>
<tr>
<td>Quinn et al (20)</td>
<td>2002</td>
<td>United Nations</td>
<td>Legal protections against torture or other forms of cruel, inhuman or humiliating treatments is essential in protecting people with disabilities, and ensuring that they maintain their physical and psychic integrity regardless as to where they stay.</td>
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</tbody>
</table>

### Table 3: Summary of Findings of Proponents Ethical Arguments

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Setting</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tekkas et al (14)</td>
<td>2010</td>
<td>Turkey</td>
<td>The use of seclusion in psychiatric settings is an ethical dilemma as well as of legal concern.</td>
</tr>
<tr>
<td>Recupero et al (2)</td>
<td>2011</td>
<td>USA</td>
<td>The use of seclusion is still controversial.</td>
</tr>
<tr>
<td>Yan et al (21)</td>
<td>2012</td>
<td>Australia</td>
<td>Seclusion is to be used to protect the patients and others from expected injuries, maintain the treatment environment, decrease the patients’ external stimulation, and create a therapeutic situation.</td>
</tr>
</tbody>
</table>
Opponents. Although the use of seclusion may reduce the risk of aggression and violence (2), many staff who use seclusion and patients who were secluded perceived that seclusion interferes with human dignity and autonomy (22). In this study, several patients who were secluded described the seclusion room as like a prison, and they perceived seclusion as an offensive intervention, feeling of inferiority, and feeling they are not a human being. Furthermore, the staff who used seclusion described it as using a military style and feelings like offender and guilty (22). Patients described seclusion as a form of punishment, and they reported feelings of helplessness, anxiety, distress, shame, and loss (3). As a result, staff-patient relationships are breached, and poor treatment outcomes resulted (3).

The Canadian Nurses Association (CAN) Code of Ethics in 2008 stressed that nurses have to respect and preserve the human dignity of their patients, and that patients have the right to receive treatment and care while maintaining their dignity and humanity (23).

In summary, despite that the use of seclusion is a controversial intervention, it remains a common practice in psychiatric inpatient settings to prevent and control aggressive and violent behaviors toward themselves and others. Patient’s safety and maintaining the therapeutic environment are to be the main pillars of using seclusion. Concurrently, patient’s right and human dignity must be protected. Findings summary are presented in Table 4.

**Argumentative statement**

The caring and treatment of aggressive and violent patients are mostly attended with ethical and legal arguments between patients’ autonomy, the importance to maintain treatment, and prevent harming self or/and others (24).

The authors’ position is that seclusion is one of the effective ways to reduce aggressive and violent behaviors, thus it can’t be eliminated in inpatient psychiatric settings. Aggressive and violent behaviors against self and others are common among inpatients with mental illness (1). Thus, to protect the patients and others from suspected injuries and maintain a safe and effective treatment environment, seclusion can be implemented in psychiatric settings (2).

Legally, many countries support the use of seclusion to control aggressive and violent behaviors of psychiatric inpatients (15, 16). However, this was not done haphazardly; policies were developed to guide health care providers who use seclusion (15, 16). That is done to ensure safety and efficient treatment of patients (4). Even in the seclusion room, those policies ensured that patient’s rights and human dignity, medical assessment, and patient’s observation and monitoring was maintained (15, 16).

Ethically, seclusion is to be used only for certain reasons such as to prevent expected harm to self or/and others, prevent disturbance of the treatment plan, assist in treatment as part of enduring behavior therapy, and decrease the external patient stimulation (21). Therefore, the use of seclusion, for the previous indications, will not violate or interfere with patient’s autonomy and human dignity. Contrary, if the previous aims of seclusion not warranted, the patient’s and others’ autonomy and human dignity will be violated resulting in harm for both parties (21).

Findings summary are presented in Table 5.

**Recommendations**

Although the use of seclusion is a complex ethical decision, seclusion is a common intervention in psychiatric inpatient settings. For clinical settings, seclusion is to be used only to prevent and control aggressive and violent behaviors. Secluded patient’s rights and human dignity, medical assessment, and continuous patient’s observation should be assured.

For research, studies have to be conducted in Jordan and be about seclusion in psychiatric inpatients to identify the influence of seclusion on both health care providers and patients.

For education, teaching and training programs have to be implemented for psychiatric nurses about seclusion and how to deal with aggressive and violent inpatients in psychiatric settings.

The use of seclusion is a controversial intervention in psychiatric inpatient settings from both legal and ethical perspectives.
Summary and Conclusions

The purpose of this paper was to argue the use of seclusion for psychiatric inpatients concerning the legal and ethical aspects of viewpoints of proponents and opponents. The authors are for the use of seclusion for psychiatric inpatients while considering ethical principles beneficence and non-maleficence and covered by a formal policy to ensure patient’s rights and human dignity.

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References


