First, his position as our first Professor of Epidemiological Psychiatry. His early survey dealt with the major psychoses in an English county, and showed that well before the arrival of neuroleptics, length of hospital stay was becoming shorter, more patients were being discharged but admission rates were greatly increasing. A later study was concerned with the epidemiology of childhood behaviour disorders, and gave social scientists a developmental framework for viewing a phenomenon like bedwetting, as well as helping to drive a nail into the coffin of the child guidance movement. I will not speculate today about which of these would have caused him the greatest satisfaction. However, his best known work has been concerned with the epidemiology of the neuroses. His survey into psychological ill-health in general practice had profound implications for the model that social psychiatrists now use for non-psychotic mental illness. It was no longer possible to conceptualise neurosis as a state of the organism, to be terminated only by psychoanalysis or death. He master-minded a vigorous programme of research in the General Practice Research Unit over a period of 30 years, and throughout that time provided the world with the cutting edge for the advancement of knowledge in that area. He has been awarded the Donald Reid Medal and the Rema Lapousse Award for Epidemiology, and his activities have excited a major programme of primary care research in the United States.

Secondly, as an editor he is a purveyor of excitement both new and old. *Psychological Medicine* maintains a tradition of sustained scholarship for new advances, while his activities in encouraging developments in publishing books on the history of psychiatry have helped a whole subject to take off. *Themes and Variations in European Psychiatry* was followed by the three volume *Anatomy of Madness*; and these seem to have spawned several related volumes by others. His thoughtful *Psychiatrists on Psychiatry* provided an unusual 10-point view of the subject, with the editor in grand elenchic form.

Third, his own record as an author; he is distinguished in style and provocative in tone. Members of the college who have searched dusty volumes for such classics as his paper on 'Morbid Jealousy' or on 'The Age for Neurosis' may now refer to a recently published collection of his papers entitled *Conceptual Issues in Psychological Medicine*. In lighter vein, one remembers his witty book on *Sherlock Holmes and the Case of Dr Freud*. If he was wrong about lithium, he was surely right about Holmes.

Fourth, he has made a substantial contribution to psychopharmacology, having been co-director of the research unit at UCL, co-edited a standard textbook on clinical psychopharmacology, and having had a creative interest in clinical trials of drug treatments.

Finally, in conjunction with others he has made extensive contributions to advances in nosology and classification. He has contributed to the WHO's classification of mental disorders for both adults and children, and has grasped the nettle posed by classification of psychological problems by family doctors.

These are my formal reasons, but I hope you will allow me to add some informal ones as well. Mr President, I commend him to the College for his ability to stimulate others; for his wicked sense of humour; for the outrageous intuitive leaps he makes while interviewing a patient; for having fathered unnumbered professors of both psychiatry and statistics at home and abroad; and for his kindness to the point of lunacy as an undergraduate examiner in Manchester. Norman Sartorius has commented that "years later, when most of the other knowledge gained at the Maudsley's courses has become obsolete and forgotten, the Shepherdian stamp of critical and salutaory scepticism is still present in all his old students, immediately recognisable and infinitely useful".

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The seclusion of psychiatric patients

PUBLIC POLICY COMMITTEE

(1) *Seclusion*

Seclusion is defined as the supervised confinement of a patient specifically placed alone in a locked room for a period at any time of the day or night for the protection of the patient, staff or others from serious harm. The containment of a patient in a room such as

a seclusion room when the door is not locked does not count as seclusion.

The decision to confine a patient is wholly a matter of professional judgement based on a close knowledge of the patient and his propensity for inflicting physical injury on patients or staff. It is made usually by consultation between medical and nursing staff. Although the nursing staff may initiate the action of secluding the patient, it is important that the consultant shall decide the on-going management of the process and together with the multidisciplinary team formulate a treatment plan for the patient which must take into account the necessity for seclusion as part of this plan. This will come into play especially in those situations where it is considered that seclusion is necessary as a pre-emptive measure. There may be occasions when a manipulative or disruptive patient, although unlikely to inflict injury on others, may be secluded because of the risk that he will provoke or incite other patients to behave violently.

(2) *Staff deployment*

The aim of nursing staff on the wards and units is to use their resources in such a way as to minimise the need for seclusion. Many potentially dangerous situations are avoided daily in treatment situations in just this way. Careful observation and timely, effective intervention avoid unnecessary tensions and confrontations. A patient considered to present a particular risk may be made subject to special observation so that nursing staff are immediately on hand to intervene should this become necessary.

The presence of a full complement of staff on the wards and units may itself be a disincentive to some patients to behave in a disruptive or dangerous manner, but there will be times when the full staff complement will not be available, or staff cannot be spared in sufficient numbers to contain a developing situation, or when two or more patients need special observation at the same time and resources are stretched. Inevitably, and properly, these factors will influence the judgement of the nurse-in-charge as to whether the risk of somebody being injured has become unacceptable.

It is important, therefore, that nursing procedures for secluded patients are well defined and understood. There should be procedural notes for nursing staff dealing with the practical aspects of seclusion – regular observations, providing meals, exercise and sanitary facilities. These are necessary but not sufficient in themselves. There is a danger that regular adherence to a set pattern of procedures leads to a situation where those carrying them out lose sight of the primary objective which is to ask whether the seclusion needs to continue. For this purpose, it is essential that the nurse has sufficient contact with the secluded patient to exercise the appropriate professional skills.

(3) *Design of seclusion rooms*

The concept of 'the padded cell' is now a redundant one in psychiatric practice. The design of seclusion rooms may vary according to the needs of particular groups of patients, but the following basic guidelines should apply.

It is particularly important that a reasonable temperature be maintained, but that sources of heat should be arranged so that the patient can have no direct contact with them. It is essential that the patient can be observed in all areas of the seclusion room, this usually being done by an observation panel in the door. To ensure that the patient has some degree of privacy there should be a facility available (such as venetian blinds) as an integral part of the panel. Floor, furnishings, etc., should be as indestructible as possible and there should be no materials or means of patients harming themselves. It is also important that with highly disturbed patients, the seclusion room has surfaces which can be easily cleaned and that such cleaning is done at regular intervals. Some form of bedding should always be provided, although the nature of this depends on the degree of disturbance of patients contained. The patient should be clothed in appropriate clothing.

(4) *Independent review*

The role of the medical staff, senior nurses and other disciplines throughout any period of seclusion is to provide independent advice and guidance to the nursing staff based on their own knowledge of the patient. The involvement of the senior nursing staff serves another purpose. Patients are vulnerable to abuse by being secluded unnecessarily or for too long a period. Staff are similarly vulnerable to allegations by secluded patients about the conditions of seclusion and their treatment which may be difficult to refute. The best safeguard for both patients and staff is the involvement of senior nurse managers as well as other professional staff; including, where necessary, members of the Management Team of the Hospital or Unit. Relatives, particularly parents or guardians of children under 16 years of age, should be informed and consulted as appropriate. It is also important that in hospitals and units where seclusion is used that the incidence of seclusion is monitored by the management on a regular basis, e.g. monthly statistical information concerning seclusion may make a valuable basis for medical audit and consideration should be given to its use as such.

The Code of Practice for England and Wales states "*If seclusion needs to continue,* a review should take place every 2 hours, carried out by 2 nurses in the seclusion room, and every 4 hours by a doctor. If seclusion continues for more than 8 hours consecutively or for more than 12 hours intermittently over a period of 48 hours, an independent review must take place with the RMO, a team of nurses and other health-care professionals who were not directly involved in the care of the patient at the time the incident which led to the seclusion took place. If there is no agreement on ensuing action the matter should be referred to the unit general manager".

(5) *Exceptions*

It is imperative to ensure that all instances of seclusion are properly recorded, not only for the protection of the patient, but also to protect the staff. It should not be accepted from the definition that the use of isolation in a locked room is a means of imposing good order and discipline. It should be emphasised that seclusion should never be used punitively or as a tool of social training.

Another generally excluded category is that of patients who present a danger of harm to themselves. These may be divided into those prone to self-injury and mutilation and those who are potential suicides. The latter are few in number and at times of risk special observation and denial of access to harmful materials is, where resources allow, preferable to seclusion. Staff need to be particularly on their guard if patients with known or suspected suicidal tendencies seek seclusion as a means of gaining the opportunity to harm themselves.

(6) *Time out*

Time out is a professional procedure involving exclusion from certain activities developed as part of a treatment programme in agreement between the patient (and parents or guardians of children under 16 years of age) and the clinical team. The term 'time out' should not be used to describe seclusion. Where 'time out' involves the technical seclusion of a patient the full seclusion procedure should be employed. Any seclusion should be dealt with as such and the proper procedures followed. The differences between 'time out' and 'seclusion' are helpfully described in the Report of a DHSS Study Team on 'Helping Mentally Handicapped People with Special Problems' (1984).

In the majority of cases, a patient who is secluded on more than rare occasions is a detained patient. If an informal patient becomes unexpectedly disturbed under the duty of care the patient may be secluded without being sectioned. However, if it emerges that the patient is going through a protracted episode of disturbed behaviour and seclusion is going to have to become part of the management then consideration should be given to detaining the patient. It is particularly important that seclusion (and 'time out', if used) should be seen as the primary responsibility of doctors who should support and guide nurses involved in the necessity of using such a facility. Therefore, all episodes of seclusion should be recorded carefully and then discussed by the appropriate multidisciplinary team in order to consider the most suitable management of the patient. It is important that seclusion is not viewed as a punitive regime but very much as an integral part of a treatment programme which in some instances will be essential to meet the needs either of the patient, other patients or the staff caring for them.

Comments on the up-dating of the College publication: 'Isolation of Patients in Protected Rooms during Psychiatric Treatment'

(1) We consider that the title of this paper is no longer acceptable as it is now felt that even in the Special Hospitals, protected rooms are only necessary in very rare cases of patient management.

(2) The classification of 'nursing in isolation', 'seclusion' and the 'padded room' is no longer appropriate. In view of the definition of seclusion it should be considered that all nursing in isolation amounts to seclusion and should be regarded as such. However, the paragraphs following this classification still seem very relevant to practice today. We suggest, however, that some of the guidelines are made more specific and therefore overleaf is a proposed re-drafting of the item.

Reference

DHSS (1984) *Helping Mentally Handicapped People with Special Problems.* Report of a DHSS Study Team. Department of Health Publications Unit, No. 2 Site, Manchester Road, Heywood, Lancs OL10 2PZ.

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