to the facilities and staff in my hospital and I have been stimulated to look critically at our own services and consider how they could be improved.

Would I recommend such an attachment to others? Again, yes: to consultants with a special interest in rehabilitation who have not had much training in the field, I would suggest that they wait until established in post for a while so that they may benefit from their own experience first. The content of such an attachment is open to debate. If I were doing it again I might try to spend time at a larger number of centres for shorter periods of time, but the choice of programme depends on each individual's needs. The recently appointed Demonstration Centres would be obvious places to visit (Nottingham, Northampton and Netherne as well as the Maudsley).

My thanks go to all the staff at the Maudsley and at Southampton who made my attachment so enjoyable and interesting.

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Locking up Patients by Themselves

The locking up of psychiatric patients has become a delicate issue, and raises more than questions of consent and of civil liberties. Up to about 20 years ago it was very formally regulated. No patient could be secluded without the authority in writing of the medical superintendent or the responsible consultant, and the hours of starting and finishing seclusion had to be recorded in a special book. Woe betide any nurse or junior doctor who was found to have shut up a patient without higher authority or without record. One of the duties of a ward doctor in a psychiatric hospital was to do surprise checks on single rooms to see if someone was locked in unofficially. This and the other rules with the force of law had been established because of many abuses earlier uncovered.

With the changes in hospital organization in the NHS all these binding regulations were swept away. It is now up to individual hospitals to decide what to do, though the DHSS has recommended that each hospital should have known, established procedure, and the College (*Bulletin,* May 1981, 5, 96) issued a supporting statement that 'it is imperative that doctors should take a primary responsibility for support and guidance of nurses involved in the necessity to use such a facility. Within the NHS therefore, all such actions should continue to be recorded, whether by day or night, and should then be discussed by the appropriate "multidisciplinary team'..."

On the other hand, a correspondent writes: 'I suspect the majority of hospitals have no explicit policy, and that where there is one, much variation in the ways of dealing with violent behaviour will be found. For example, some hospitals have protected rooms, others have wards for disturbed patients in which a violent individual can be isolated from the others by means of an armour-plated barrier, and yet others use certain rooms not specifically designed for seclusion ... on an *ad hoc* basis which would seem unsatisfactory.'

To encourage hospitals to think about this subject and review their policies, we publish below a paper on the subject recently circulated for internal use at the Maudsley.

Procedure for the Seclusion of Patients in the Bethlem Royal and Maudsley Hospitals

Seclusion is containment of a patient alone in a room or other enclosed area from which that patient has no means of egress.

There are two circumstances under which seclusion may be used in the Bethlem Royal and Maudsley:

1. As an emergency procedure to control a potentially dangerous situation;
2. As part of a planned programme of treatment prescribed by the clinical team.

[Of these two circumstances, only the emergency procedure has wider application and is discussed here.]

Institution of seclusion

Authorization to seclude must be obtained from the patient's doctor. The Sister/Charge Nurse or designated deputy at the time may, however, initiate this procedure in cases of grave emergency before calling for help.

At the commencement of seclusion, the Sister/Charge Nurse or designated deputy, will contact the Unit Nursing Officer and the patient's doctor. They will then visit the Unit without delay and see the patient. If the doctor agrees to the continuation of the seclusion, he will sign the Seclusion Book to that effect. If he feels the seclusion should be terminated,

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he will be required to enter his decision in the 'reasons' column of the book. In the event of the Unit Nursing Officer or the patient's doctor not being immediately available in person, the Duty Doctor and the Duty Nursing Officer should be contacted to visit the ward and sign the appropriate documents. The doctor is required to consult with the nurse or other professional staff in charge of the seclusion, and is then responsible for deciding whether it should be continued and, if so, under what conditions and for how long.

Characteristics of the room

If at all possible, the room to be used must be suitable for the purpose, taking into account the reason for seclusion. (In certain circumstances it may be necessary to use an unsuitable room if it is the only one available to staff dealing with the emergency.)

It may be necessary to ensure: (i) that the windows cannot be opened or the glass broken; and (ii) that the room contains no furniture or articles which the patient could use to cause damage or injury. (These conditions can only be guaranteed where a room has been specifically designed for seclusion.)

If possible, articles which could cause damage or injury should be removed from the patient before seclusion, for example, matches, shoes, or objects that could be used as weapons. Reading material may be made available, if appropriate.

Method of observation

Patients in seclusion should normally be observed continuously from outside the door of the room. In circumstances when this is not possible, the observation must be made at least every ten minutes. Seclusion must be used for the minimum amount of time necessary to ensure the well-being and safety of both the patient and others.

Review and reporting

Within two hours a primary review by nursing and medical staff will be made by the Sister/Charge Nurse or designated deputy, the Nursing Officer and, if possible, the patient's consultant or the Senior Registrar or Duty Doctor.

Not less than every four hours a secondary review should take place (unless the patient is asleep and the decision is that he is left overnight in the room). The Nursing Officer or Duty Nursing Officer and the Senior Registrar (or Duty Doctor) must attend in person at this review.

When a patient has had to be secluded for a period of more than 12 hours consecutively, or for more than 24 hours intermittently, over a period of 48 hours, the Senior Nursing Officer should be informed in writing by the Unit Nursing Officer and the patient's consultant and the House Governor or Deputy House Governor should be informed by the Registrar. If a patient is secluded for more than 24 hours, a report must be made to the MTO [Management Team of Officers at the Maudsley].

Recording

Proper records must be kept at *every* time of seclusion. Recordings must be made in the Day/Night Report Book, and the record of seclusion should include the following:

1. Date.
2. Name of patient.
3. Case number and legal status of patient.
4. Time commenced.
5. Total duration of seclusion.
6. Reason for seclusion, e.g. emergency action to deal with violent behaviour, serious threats of violence to others.
7. Medical Officer's signature.
8. Signature of Sister/Charge Nurse or Nursing Officer.
9. Frequency of observation.
10. Primary review signature.
11. Secondary review signature.

The decision to end seclusion will normally be made by the doctor in consultation with the Sister/Charge Nurse or designated deputy who will inform the Nursing Officer. The doctor may end seclusion at any time, but if he does so against nursing advice, he must personally supervise the ending of the seclusion.

Ethnic Minorities and Psychiatry

The Runnymede Trust, an education and research charity working in race relations, is considering the possibility of a small research project on the subject of the provision of psychiatric services to ethnic minorities in Britain. We would like to hear from any doctor or nurse who might be interested in co-operating with such research. Please write, giving details of qualifications and experience, to Paul Gordon, Research Officer, Runnymede Trust, 37a Grays Inn Road, London WC1 8PP.

New Editorship

At a meeting of the Editorial Committee of the *Journal of Mental Deficiency Research* on 25 May, Mr Brian Rix, Secretary General of the Royal Society for Mentally Handicapped Children and Adults, paid tribute to the Editor, Dr Barry Richards, on the occasion of his retirement. The journal, as a result of Dr Richards' efforts over its 25 years' existence, has become internationally respected, a high academic standard having been maintained in the rapidly changing field of mental handicap. The new Editor will be Dr William Fraser.

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