

## SECLUSION AND LEARNING DISABILITIES: RESEARCH AND DEDUCTION

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### Introduction

The growing concern over the use of seclusion in health care settings has emanated, to a large degree, from the human rights issue having been given a greater profile in the American courts (Gutheil, 1980; Appelbaum and Gutheil, 1980). The litigation was brought in the Boston State case on behalf of a patient with severe learning disabilities who claimed that he had the right to refuse treatment (seclusion) even in the case of an 'emergency'. The court case and the resultant decision, which was, to say the least, equivocal, launched extensive research into the issues of seclusion and restraints in a wide variety of settings and over a range of clinical conditions. However, despite the pivotal litigation involving a patient with a profound mental handicap it is this patient population which has received the least attention in the published literature pertaining to the use of seclusion.

Seclusion is defined as "the supervised confinement of a patient alone in a room which may be locked for the protection of others from significant harm"

(HMSO, 1990). However, this British definition has not generally been adhered to in a number of studies and across various settings in Britain. Seclusion has been used for the elderly (Bogaert, 1980) and for the child (Fassler and Cotton, 1992). It is sometimes referred to as a therapeutic intervention, at other times as a form of punishment, and on many occasions merely a form of containment in the absence of realistic alternatives (Mason, 1994a). In reviewing these three fundamental rationales for the use of seclusion in relation to those patients who are mentally impaired we can dismiss, or at least qualify them considerably. Clearly the therapeutic rationales are limited if we remove such concepts as, firstly, time-out which is fundamentally different from the use of seclusion, and secondly, destimulation which can be provided without the forced isolation of a locked room. As regards punishment, there can be no place for the use of seclusion as a form of sanction, although it is accepted that the concept of time-out is often confused with this in terms of the removal of a negative reinforcement. Finally, it may

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well be that some mentally impaired patients become violent and a serious risk to others and thus warranting the use of seclusion. However, to what extent this is the case with patients with a mental impairment requires further investigation.

## Literature Review

As mentioned above the use of seclusion is now a well researched area with some authors discussing the theoretical rationales (Gutheil, 1978; Mason, 1993) whilst others concentrate on national and international comparisons (Mason, 1994b; Crenshaw and Francis, 1995). There are those that have studied the issue in relation to other forms of control, for example, restraints (Bell and Palmer, 1983) preventive aggression devices (PADS) (Monroe *et al.*, 1988) and medication (McLaren, *et al.*, 1990). Whilst still others have reported on seclusion as a consequence of staffing levels (Morrison, 1990), staff experience (Oldham, *et al.*, 1983) and gender of staff (Convertino *et al.*, 1980). The ever-growing complexity of the use of seclusion is reflected in the wide areas of study surrounding its implementation.

A major focus in the literature involves the patient characteristics and seclusion use. For example, diagnostic categories have been studied (Campbell *et al.*, 1982), age ranges (Oldham *et al.*, 1983), and ethnicity (Flaherty and Meagher, 1980) all with inconclusive results. The use of seclusion has also been studied in relation to the culture in which it is used. Westermeyer and Kroll

(1978) found that it existed in non-psychiatrised countries within traditional societies who used seclusion as the penultimate strategy in the management of extremely violent people. Mason (1995) also studied the cultural use of seclusion in a forensic health care setting in Britain and argued that it was a major strategy of maintaining control and power over patients.

Tardiff (1981) reported that 4.6 per cent of the patients secluded in his study were classified as mentally retarded and interestingly stated that the non-psychotic group was more likely to receive all forms of emergency control measures. Way and Banks (1990) recorded that 12.3 per cent of their patients being secluded were diagnosed as mentally retarded. These latter authors concluded that "the probability of seclusion and restraint was 2.2 times higher for a patient with a diagnosis of mental retardation than for patients without that diagnosis" (Way and Banks, 1990).

The major concerns emanating from previous research and the published literature involve the extent to which seclusion is used on those patients with a range of learning disabilities and the length of time they are being maintained in such regimes. These issues take on an even greater significance when we raise questions as to the use of seclusion on patients with learning disabilities in secure hospitals and units, particularly in relation to those patients having a reduced ability to voice concerns and complaints.

## Method

This study was carried out in a special hospital for England and Wales who cater for those patients considered "dangerous, violent or having criminal propensities" (HMSO, 1977). Data on all seclusion episodes over a twelve month period were collected, as were patient characteristics on both total populations of secluded and non-secluded groups. Secondly, Semi-structured interviews were carried out on a 10 per cent sample of all seclusion episodes within seven days of their occurrence. The person responsible for initiating the decision to seclude was the person interviewed. This semi-structured component was undertaken to establish such factors as the reasons offered for initiating the seclusion, staffing levels, use of PRN (as required) medication and alternative interventions attempted prior to using seclusion.

The quantitative data would provide information on diagnostic categories of those patients secluded, the length of time they were in seclusion, and the rationale for its use. The qualitative data would provide a descriptive account of the patients responses to seclusion and any changes in observed behaviour.

## Results

The classification by diagnosis was taken from the Special Hospitals Case Register and is somewhat simplistic in nature, however, it suffices as a starting point for describing a general breakdown between those patients who could be deemed to have some form of

learning disability and those who have not.

The Mental Health Act Classification used is as follows:

- MI - Mental Illness
- PD - Psychopathic Disorder
- MIMP - Mentally Impaired
- SMIMP - Severely Mentally Impaired
- MI+PD - Mental Illness and Psychopathic Disorder
- MI+MIMP - Mental Illness and Mental Impairment
- MI+SMIMP - Mental Illness and Severely Mentally Impaired
- PD+MIMP - Psychopathic Disorder and Mental Impaired

The two major groups, those termed mentally ill (MI) and those with a psychopathic disorder (PD), constitute the largest in number. A third categorisation can be excluded for the purposes of this study which is formed by the conjoining of those with both MI and PD.

In TABLE I we can see the Mental Health Act Classification (MHAC) of the secluded group of patients over the study period.

This first table shows that a total of 251 patients were secluded over the year of the study which is 35 per cent of the total population. Collapsing the table to show a distinction between those with, and those without, some form of learning disability we can see the results in TABLE II.

We can see from this table that 12 per cent of females and 15 per cent of males that were secluded were considered to have some form of mental impairment. The gender differences were not statistically significant.

**TABLE I**  
**Mental Health Act Classifications (MHAC) and Scheduled Patients**

MHAC	Secluded Patients				
	Female	%	Male	%	Total
MI	17	26	110	59	127
PD	38	58	43	23	81
MIMP	4	6	17	9	21
SMIMP	-	-	6	3.5	6
MI + PD	2	3	5	2.7	7
MI + MIMP	1	1.5	-	-	1
MI + SMIMP	-	-	3	1.6	3
PD + MIMP	3	5	2	1	5
Totals	65		186		251

**TABLE II**  
**Scheduled Patients with and without a Learning Disability, by Gender**

Learning Disability	Secluded Patients					
	Female	%	Male	%	Total	%
With LD	8	12	28	15	36	14
Without LD	57	88	158	85	215	86
Totals	65		186		251	

TABLE III shows the number of secluded patients by gender in relation to the number of seclusion episodes.

The information in TABLE III shows that there were 65 female patients secluded a total of 331 times, with 186 males secluded 492 times. In total this indicates that 251 patients had 823 episodes of seclusion. Again collapsing the table to highlight a distinction between those with and without a learning disability we can see the results in TABLE IV.

TABLE IV suggests that although the number of patients with a learning

difficulty who are secluded appear to be relatively low in comparison to those without a learning disability they are, in fact, secluded on average more frequently. This was statistically significant on Chi squared test (10.7, d.f. = 1,  $p = 0.01$ ). These figures would indicate that those patients with a learning difficulty are secluded almost twice as often.

Turning our attention to the length of time that patients are secluded we note from TABLE V that the mentally ill group of patients are secluded on average for the longest period.

**TABLE III**  
**Mental Health Act Classification (MHAC) by Seclusion Episodes and Gender**

MHAC	Secluded Patients					
	Female		Male		Total	
	Number of Patients	Seclusion Episodes	Number of Patients	Seclusion Episodes	Number of Patients	Seclusion Episodes
MI	17	90	110	273	127	363
PD	38	162	93	87	81	249
MIMP	4	30	17	94	21	124
SMIMP	-	-	6	12	6	12
MI + PD	2	6	5	7	7	13
MI + MIMP	1	1	-	-	1	1
MI + SMIMP	-	-	3	7	3	7
PD + MIMP	3	42	2	12	5	54
Totals	65	331	186	492	251	823

**TABLE IV**  
**Number of Seclusions, Episodes, Gender and Averages**

	Secluded Patients								
	Female			Male			Total		
	Learning Disability	Number of Patients	Seclusion Episodes	Average	Number of Patients	Seclusion Episodes	Average	Number of Patients	Seclusion Episodes
With LD	8	73	9.1	28	125	4.4	36	198	5.5
Without LD	57	258	4.5	158	367	2.3	215	625	2.9
Totals	65	331		186	492		251	823	

**TABLE V**  
**Seclusions and Length of Time**

Mental Health Act Classification	Days in Seclusion				
	Female	Male	Total	Number of Seclusions	Average
MI	67	1416	1483	363	4.0
PD	144	168	312	249	1.2
MIMP	15	80	95	124	0.7
SMIMP	-	7	7	12	0.6
MI + PD	6	5.3	11.3	13	0.9
MI + MIMP	0.2	-	0.2	1	0.2
MI + SMIMP	0	4.4	4.4	7	0.6
PD + MIMP	45	17	62	54	1.1

From the literature we were able to pool the major reasons for the use of seclusion into eight categories. The ninety five semi-structured interviews revealed the following tabulated data. (TABLE VI).

If we now arrange the data to encompass the basic division between those

with, and those without, a learning disability we see the results in TABLE VII below.

It can be seen in TABLE VII that those with a learning disability are less often secluded for actual violence than those without such a disability. The "other" reasons given were 'disturbed',

**TABLE VI**  
**Reasons Given for the Use of Seclusion**

Reasons for Seclusion	Secluded Patients	
	Number	%
Threatened Violence to Patients	10	10.5
Actual Violence to Patients	21	22.1
Threatened Violence to Staff	17	17.9
Actual Violence to Staff	23	24.2
Threat of Self-Harm	11	11.5
Actual Self-Harm	4	4.2
Threat of Property Damage	6	6.3
Actual Property Damage	3	3.2
Total	95	99.9

**TABLE VII**  
**Reasons Given for Seclusion for those with and without a Learning Disability**

Reasons for Seclusion	Secluded Patients	
	With LD	Without LD
Threatened Violence to Patients	2	8
Actual Violence to Patients	-	22.1
Threatened Violence to Staff	1	16
Actual Violence to Staff	-	23
Threat of Self-Harm	2	9
Actual Self-Harm	1	3
Threat of Property Damage	2	4
Actual Property Damage	2	1
Other	5	-

'angry' and 'shouting', and 'deteriorating in mental state'.

Subjects were asked what other interventions were attempted prior to using seclusion. It can be seen that the major nursing approach was for the patient to talk with the Primary Nurse. However, often a number of interventions were attempted before seclusion was used (see TABLE VIII).

TABLE VIII shows that the emphasis on talking reduces dramatically with those patients who are considered to have a learning difficulty with a shift towards more behavioural approaches.

Finally, staff were asked to assess the patients immediately prior to seclusion and again one hour following its implementation. The results show that, at least in the initial phases of seclusion, patients with a learning disability do not appear to improve. There is evidence to suggest that certain behaviours actually worsen

whilst in seclusion and other behaviours are initiated by it. For example, head-banging and faecal smearing appear to be triggered to some degree by the patients being secluded (see TABLE IX).

## Discussion

From this study it would appear that there are three central questions which require further debate. These questions relate to (a) what is the justification for secluding someone with a mental impairment, (b) what are the benefits, if any, of seclusion for this patient population, and (c) how does one judge the appropriate length of time to be left in seclusion. These questions then need to be related to the Code of Practice (HMSO, 1990).

The rationale for secluding patients with learning difficulties appear, from

TABLE VIII  
Interventions Attempted Prior to Seclusion

Interventions (Not Mutually Exclusive)	Secluded Patients	
	With LD	Without LD
Talking with Primary Nurse	8	52
Talking with Other Nurses	4	36
Resting in Room	6	11
Occupational Therapy	-	1
Diversional Activities	5	7
Ignoring Behaviour	7	5
Time Out	3	14
PRN (as required) Medication	3	13
Other	-	-

**TABLE IX**  
**Assessments Undertaken Prior to and 1 Hour After Seclusion**

Assessments (Not Mutually Exclusive)	Secluded Patients with a Learning Difficulty					
	Prior to Seclusion			1 hour after Seclusion		
	Mild	Severe	Total	Mild	Severe	Total
Verbally Abusive	2	4	6	1	4	5
Threatening Violence	2	3	5	2	2	4
Physically Violent	1	2	3	1	1	2
Provoking Other Patients	-	2	2	1	1	2
Agitated (physically restless)	2	2	4	1	2	3
Anxious (subjectively worried)	-	-	-	2	2	4
Pacing	1	2	3	2	5	7
Suspicious	1	1	2	1	2	3
Perplexed	1	1	2	2	4	6
Appears Hallucinated	2	-	2	-	1	1
Head Banging	1	1	2	4	3	7
Rocking	-	1	1	5	7	12
Attention Seeking	1	2	3	2	2	4
Faecal Smearing	-	1	1	3	2	5

this study, to involve a range of disturbed behaviours, for example, shouting, banging furniture, striking out at others. However, they do not appear to fall into the category of "serious risk of harm to others" as the Code of Practice demands. Spontaneous disturbed behaviours are a frequent sign of some severely mentally impaired patients and even those of a relatively minor impairment can have emotional mood swings from one extreme to another. However, in only a very few cases would the disturbed behaviour constitute a serious risk of harm to others. It has been noted in other studies that staff may use seclusion for punitive reasons (Whaley and

Ramirez, 1980) although these may not necessarily be particularly vindictive. Staff often feel that it is important to *do something* when a patient becomes disturbed and it is tempting to opt for the easy choice of shutting away a loud and noisy patient. Furthermore, when the patient is lashing out there is a duty to protect other patients which may provide an impetus for using seclusion. This is understandable in practical terms but there needs to be a clear appreciation that in all settings, including the forensic one, the risk to others must warrant the criterion of "significant harm". Moreover, despite the 'looseness' of the term "significant" it should be clear that lesser

restrictions than seclusion should be attempted, or considered, before the use of seclusion.

The second question revolves around the extent to which seclusion is beneficial to those patients with learning difficulties. Patients with learning difficulties in this study were secluded on average more frequently but tended not to respond as well to seclusion as those without a learning difficulty. This raises serious questions as to the propriety of seclusion for this patient population. It has been observed in sensory deprivation studies that fantasy regression and bodily illusions are promoted in normal subjects and that in the case of non-psychotic patients "there is little argument that sensory deprivation is harmful.".. (Mason, 1994a). However, the picture is less clear with some psychotic patients who may tend towards the withdrawn state that constitutes sensory deprivation (Freedman and Greenblatt, 1960). Sensory deprivation may sound too harsh a term in comparison to seclusion, however, with the time-scales found in this study and the suggestion that isolation exceeding 48 hours is classified as torture (Goldfeld, *et al.*, 1988) its use would appear appropriate.

Notwithstanding the foregoing there are those who prefer the more acceptable principle of isolation which addresses the issue of the patients vulnerability to "... a variety of forms of pathological intensity in relationships" (Gutheil, 1978). The isolation principle is founded on the notion of decreasing the emotional input to which the patient is believed to be vulnerable. There is also the principle of 'decrease in sensory input' as a rationale for seclusion. This

need for 'destimulation' is well reported in the literature (Fitzgerald and Long, 1973; Kilgalen, 1977; Schwab and Laymeyer, 1979).

It may well be that secluding patients with learning difficulties 'destimulates' them (Rosen and DiGiacomo, 1978), isolates them and provides a "relief from such torment" (Plutchik *et al.*, 1978), and through the "reduction of sensory stimulation can help the patient to tolerate incoming stimuli" (McCoy and Garritson, 1983). However, from this study in a forensic setting two points are raised in opposition to these principles in relation to those patients with learning difficulties. Firstly, there was little evidence to suggest that patients were in such comforting surroundings whilst in seclusion. Disturbed behavioural signs were slow to calm and there were a range of behaviours that appeared to be exacerbated following the use of seclusion. Secondly, if such calming effects were produced by 'destimulation' then it begs the question as to why being locked alone in a room is such a relief and raises the fundamental point of whether it is the patient's pathology that requires attention or the ward environment?

The third question concerns the assessment of patients whilst in seclusion and the Code of Practice insistence that seclusion must be for the shortest possible duration. The practical issues are, ensuring that the patient is settled, and balancing the risk to others if seclusion is terminated too soon. Again, this is possibly another contributing factor in determining the lengthy seclusions seen in this study. Clearly, if a patient's behaviour is apparently worsening whilst in seclusion then due consideration must

be given to terminating it and providing contingencies. It is at this point that the study highlights the need for further research into the use of seclusion particularly in relation to those patients with learning difficulties.

## Conclusions

This study highlighted three central questions pertaining to the use of seclusion with mentally impaired patients. These are questions of justifying the use of seclusion, the efficacy of its use, and the assessment for terminating it. These questions are profoundly important for two practical reasons. Firstly, staff must be safe within their operational practices in relation to the professional (and ultimately legal) requirement to conform to the Code of Practice. Secondly, those patients with learning difficulties often have a reduced capacity for speaking out, complaining, or articulating their fears and anxieties, and thus, this becomes part of our role.

## Summary

This paper focuses upon the use of seclusion in the forensic hospital with patients classified as having some form of mental impairment.

The results indicate that mentally impaired patients are secluded more frequently than are those non-mentally impaired but that the former group do not appear to respond as well to seclusion as those without a mental impairment. It was also observed that the use of seclusion for the mentally

impaired group triggered undesirable behaviours whilst in seclusion.

Questions relating to the efficacy of seclusion for this patient population are raised, particularly in relation to the Code of Practice and ethical issues.

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