

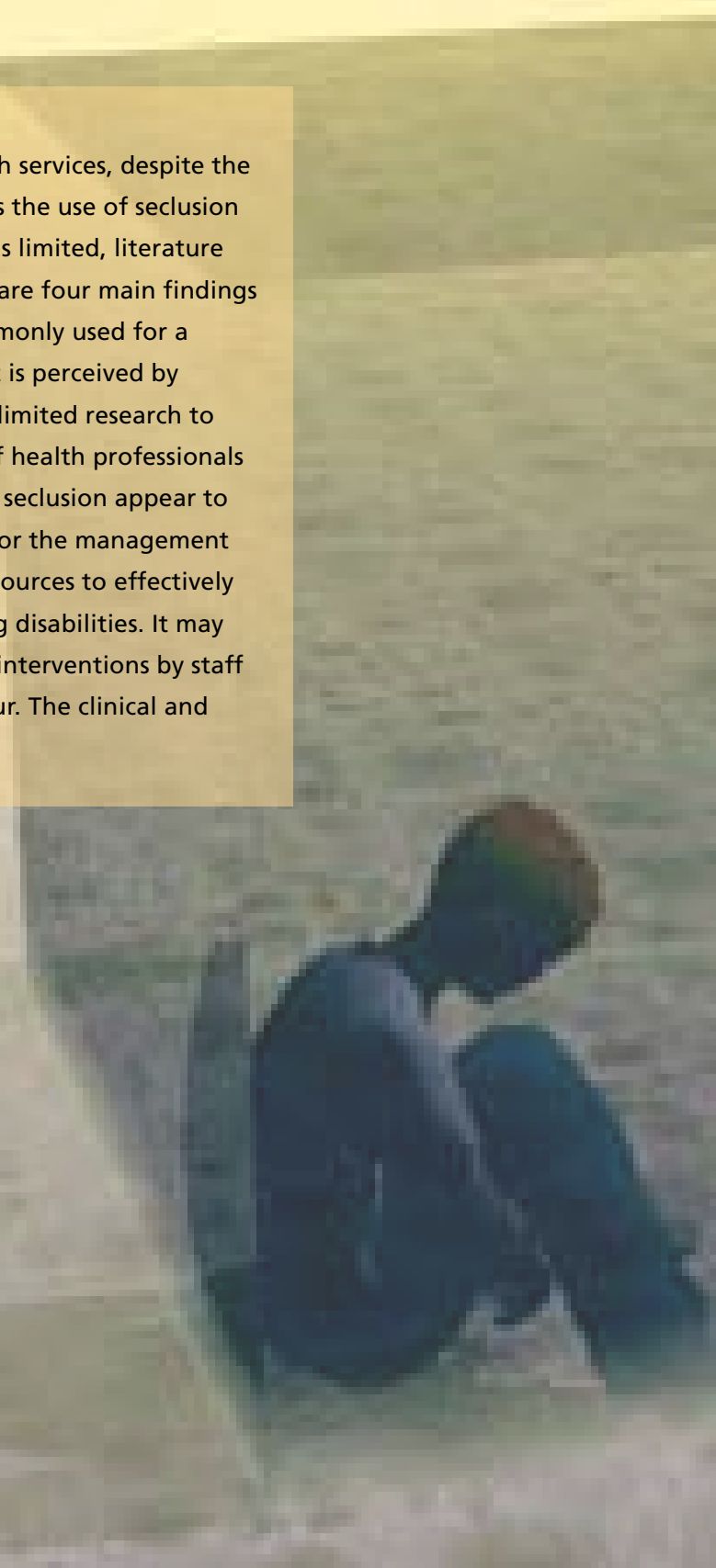
The use of seclusion in learning disability services

Abstract

Seclusion is commonly used in learning disability health services, despite the lack of demonstrated effectiveness. This article reviews the use of seclusion in learning disability services. As relevant literature was limited, literature from the mental health field is also considered. There are four main findings from this review. First, it appears that seclusion is commonly used for a number of reasons across learning disability services. It is perceived by health professionals to be effective, although there is limited research to support this. Furthermore, there is a lack of training of health professionals in the use of seclusion. In general, staff perceptions of seclusion appear to be negative, although they still tend to use seclusion for the management of challenging behaviour. This may reflect a lack of resources to effectively manage challenging behaviour in people with learning disabilities. It may also reflect a lack of skills, knowledge or evidence for interventions by staff and management in people with challenging behaviour. The clinical and research implications of these results are discussed.

The literature outlines a number of definitions for seclusion, most of which fit with the Code of Practice of the Mental Health Act, England and Wales (revised 1999) (Department of Health 1999a) [Q THIS WAS ALSO REVISED IN 2008. CAN YOU PLEASE UPDATE?], which states: 'seclusion is the supervised confinement of a patient in a room, which may be locked, to protect the patient and others from significant harm'.

For the purpose of this article, it is important to distinguish between 'time out' and seclusion', as these two terms are being used interchangeably in practice and relevant research. In contrast to the definition of seclusion above, time out is the withdrawal or reduction of positive reinforcement for a set period following the target behaviour (Nelson 1997) [Q this is a US reference, please supply a UK based one for like-for-like comparisons]. Furthermore, it is worth noting that confusion remains over whether seclusion is therapeutic, punitive or purely a reactive strategy designed to maintain safety for the person or others. In the present review, we are interested in seclu-



Keywords

- Learning disabilities
- Seclusion
- Challenging behaviour

These keywords are based on the subject headings from the British Nursing Index. This article has been subject to a double-blind review.

sion alone.

Introduced as an alternative to mechanical restraints in the early 19th century (Alty and Mason 1994), seclusion continues to be a commonly used intervention in psychiatric services across the world (LeGris *et al* 1999, El-Badri and Mellso 2002, Hoekstra *et al* 2004) and in learning disability services (Emerson *et al* 2000, Allen 2002, Lowe 2005), although there is significantly less literature describing the use

of seclusion in the latter.

Considered controversial, it can be argued that seclusion is punitive, a violation of basic human rights and counterproductive in developing therapeutic relationships (Meehan *et al* 2004, Tunde-Ayinmode and Little 2004). Proponents argue that seclusion is a necessary, therapeutic practice that assists people to become calm and to regain control (Wynaden *et al* 2002, Meehan *et al* 2004). A third justification for the use of seclusion is that it is simply a form of containment in the absence of realistic options (Mason 1996) [Q can you supply a later reference that this is still a justification?].

Aims of the present review

A number of papers have considered the use of seclusion in mental health practice. However, there are significantly fewer studies exploring the use of seclusion in services for people with learning disabilities. This article aims to explore the literature in relation to seclusion in learning disability

services, presenting the major issues and implications for practice. Furthermore, this article will identify the gaps in the literature and suggest future areas for research. It may be important to note that no previous reviews in the area of seclusion and people with learning disabilities were found.

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Method

A literature review was conducted using CINAHL, BNI, PsychINFO and OVID Medline. In addition, an internet search was conducted exploring the Cochrane Library, Mental Welfare Commission, Scottish Executive, Department of Health, and Nursing and Midwifery Council websites. The keyword 'seclusion' was searched for individually and in combination with 'learning disability' and the synonym 'learning disability' and 'challenging behaviour'. Articles published between 1995 and 2008 were obtained and their reference lists scrutinised to identify additional articles. Articles which, on inspection, focused on other strategies, such as restraint or time out, were excluded. The total number of papers included in the review is 12. The results are presented in terms of the themes identified which include: incidence, the use of seclusion, perceptions of seclusion, effectiveness, education and safeguards for ethical use of seclusion.

Results

Incidence

Emerson *et al* (2000) reported 20 per cent of people experiencing seclusion as a management strategy when they investigated the treatment of challenging behaviour in 500 adults with learning disability. When Robertson *et al* (2005) compared the nature and prevalence of strategies to manage challenging behaviour over two

Service users thought seclusion was often used as a means of staff exerting power

settings, they found that seclusion was used with between 17-56 per cent of adults with severe challenging behaviour. In one setting few people had challenging behaviour and in the second the majority of people had challenging behaviour. However, they do not explain the wide variation in the range of adults secluded.

Allen (2002) explores a number of studies of children and adults with challenging behaviours, concluding that up to two-thirds of children and between 25-33 per cent of adults studied were sometimes or usually subjected to seclusion. Although further research is required it appears that approximately a quarter of people with learning disability and challenging behaviour are experiencing seclusion.

Use of seclusion

The reasons generally cited for secluding someone are: uncontrollable behaviour, aggression towards others, objects or oneself (Meehan *et al* 2000, El-Badri and Mellsoop 2002, Meehan *et al* 2004). El-Badri and Mellsoop (2001 YEAR? NOT IN REFS) found that men, non-Europeans and people with a diagnosis of schizophrenia, bipolar disorder or substance misuse were more likely to be secluded. Tunde-Ayinmode and Little (2004) in their Australian study concur: they found that young males with a diagnosis of schizophrenia, admitted involuntarily were most likely to be secluded.

Although seclusion is frequently used as a response to aggression (El-Badri and Mellsoop

'Comparing the prevalence of seclusion in learning disability services and mental health services may be of interest to further expose any over-reliance of controlling responses in a population unable to articulate their objections'

2001 YEAR? NOT IN REFS, Robertson *et al* 2005), in mental health, rather than learning disability practice, it may be easier to identify underlying conditions such as schizophrenia or substance abuse. In learning disability services it is suggested that seclusion is used as a response to challenging behaviour in general rather than for people with specific presentations such as schizophrenia.

Mason (1996) explored the use of seclusion in a forensic hospital and found that people with learning disabilities were secluded more frequently than those without learning disabilities. They also found the learning disability group did not respond well to seclusion and exhibited undesirable behaviours such as head banging and faecal smearing while in seclusion.

Lowe (2005) considered treatment approaches for people with learning disabilities and challenging behaviour. She reviewed data on reactive strategies and behaviour plans for 429 adults and children rated as 'extremely' or 'very' challenging by carers. Lowe (2005) found most intervention programmes consisted solely of reactive strategies. In addition, seclusion was found to be used in a quarter of all cases in response to challenging behaviour. It should also be recognised that services may use 'time out' from positive reinforcement as a behavioural approach to managing challenging behaviour, and that in practice this can be confused with seclusion.

Confusion over the terms and their meanings may lead to potential abuse of seclusion under the auspices of a behavioural programme.

Perceptions of seclusion

Much of the literature regarding seclusion explores the perceptions of staff and service users. Meehan *et al* (2004) explored perceptions of nursing staff and people with mental

health needs towards the reasons for seclusion, the effects of seclusion and staff and service users' feelings during seclusion. Sixty nursing staff and 29 service users who had experience of seclusion completed an attitude to seclusion questionnaire. Significant differences were found between the two groups.

Nurses viewed seclusion to be necessary, not punitive, but rather a therapeutic practice to enable people to 'calm down'. In comparison, service users believed seclusion to be frequently used for minor disturbances and as a means of staff exerting power and control. This perceived abuse of power is further supported by Parkes (2003) who found that people in a medium secure unit were more likely to be secluded for aggression towards staff rather than towards other service users. This suggests that criteria for the use of seclusion may be subjective or based on factors other than therapeutic benefit.

In the study carried out by Meehan *et al* (2004), 22 per cent of service users were in favour of the abolition of seclusion compared with 2 per cent of staff. Neither group believed increased staffing would reduce the need for seclusion. This is further supported by Alty's (1997) study where only 5 per cent of nurses felt seclusion should no longer be used. Opportunities to explore this issue further, to consider if more information regarding possible alternatives to seclusion could alter views, would be of interest.

An earlier, smaller study (Meehan *et al* 2000) involved semi-structured interviews with 12 service users to elicit perceptions of seclusion. Findings suggest seclusion has a profoundly negative effect which persists for some time. Service users viewed seclusion as involving a perceived lack of communication between staff and service users and perceptions relating to punishment, abandonment, fear, isolation and depression. Participants felt under-informed about the seclusion



process, what behaviours might result in seclusion and the amount of time they were likely to be secluded.

Lack of interaction with staff while in seclusion was a considerable source of frustration. In addition, perceptual disturbances such as hypersensitivity to external stimuli and hallucinations – similar to those experienced by prisoners on solitary confinement – were reported.

Negative effects are further supported by Hoekstra *et al* (2004) who carried out semi-structured interviews with seven people with long-term mental health needs who had experienced seclusion. This study reported that the seclusion process could be hard to come to terms with. Factors which affect coping with seclusion and the aftermath are: perceived fear of recurrence, lack of opportunity to talk about the experience, iniquitous treatment by carers during seclusion, and confrontation with others being secluded. Although this last factor is not explored further as to how this might occur (Hoekstra *et al* 2004).

Factors identified as having a positive effect on coping include time, understanding why seclusion occurred, opportunities to discuss it, distraction and rapid recovery of control. These findings support Brown and

allowing people to regain control, with a rationale underpinned by utilitarian principles. In practice, the likelihood of having staff operating at expert level covering the whole 24-hour care period is unlikely given the long-standing issues of stress (Sharp *et al* 2002) and recruitment and retention in learning disability and challenging behaviour services.

Effectiveness

Emerson and colleagues (2000, 2001) outline a persuasive argument in relation to the need to use evidence-based approaches for the management of challenging behaviour, especially when the alternatives lack reliable evidence.

Salias and Fenton (2000) undertook a Cochrane review and found no controlled studies evaluating the value of seclusion for those with serious mental health problems. Acknowledging reports of serious adverse effects from qualitative studies, they suggest that alternative methods of dealing with unwanted behaviours should be developed. Further, they question the continued use of seclusion while there is a lack of well-designed, randomised controlled trials to demonstrate its value. Although clearly

ance of controlling responses in a population unable to articulate their objections.

Rangecroft *et al* (1997), in one of the few studies considering seclusion in learning disability services, examined all incidents requiring emergency medication or seclusion over a six-month period in a large hospital for people with learning disabilities. By focusing on the precipitating factors, course and outcome of those receiving emergency medication or seclusion, they found that emergency medication and/or seclusion were more likely to be used in people with learning disabilities and psychiatric disorders, particularly bipolar disorder. Although two-thirds of the incidents involved males, females had many more incidents with a frequency of six episodes for each female, compared to 2.4 for each male. They found that the duration of seclusion in their study (mean = 14.6 minutes) had a substantially better outcome for people than the often high doses of major tranquillisers used, concluding that despite concerns about the use of seclusion it may have certain advantages in this population.

Education

In a UK study, Alty (1997) carried out face-to-face interviews with 64 mental health nurses about their education and training regarding seclusion. Of the participants, 73 per cent had been involved in seclusion, but only 28 per cent recalled receiving education or training in this area. Alty (1997) identified nurses as having mixed feelings about the use of seclusion, however 78 per cent still disagreed when asked if seclusion should no longer be used.

Alty's (1997) study indicates that nurses gain their understanding and perception of seclusion from their area of practice rather than from education and that education in this area is lacking. If practice is poor or abusive, this increases the risk of poorly used seclusion never being challenged. Staff may become immersed in the culture rather than being in a position to challenge and change practice.

Misuse of power and abuse of vulnerable

'If practice is poor or abusive, this increases the risk of poorly used seclusion never being challenged'

Tooke's (1992) view that the way in which seclusion is practised is significant to how it is perceived, whether it is viewed as therapeutic, controlling or punitive.

Wynaden *et al* (2002) explored the decision-making process of seven mental health nurses and one doctor through interviews within 48 hours of making the decision to seclude someone. This study, carried out in Australia, is limited by the size and geographical restrictions of the sample but suggests that philosophy of care in a service will influence decision making. They highlight the importance of power issues in decision making for seclusion, suggesting that experts should make relevant decisions. In this study reasons for initiating seclusion was based on

there are evidence-based approaches to the treatment and management of challenging behaviour, evidence suggests that staff teams are not consistently understanding and using these (Hastings 1996, Emerson *et al* 1997, McKenzie *et al* 2005). At times this may result in the use of seclusion as a form of containment in the absence of the skills and knowledge base required to respond differently.

The debate about using approaches with little evidence for them could be further explored by considering the lack of reliable evidence on the beneficial effect of seclusion to treat challenging behaviour. Comparing the prevalence of seclusion in learning disability services and mental health services may be of interest to further expose any over-reli-

people is a recognised part of the history of mental health care (Sullivan 1998) and learning disability services. Given that seclusion has been used throughout that history, there is a danger that this is an area where such abuse of power may continue.

Safeguards

In contemporary practice settings there are, of course, a range of safeguards that are intended to prevent the kinds of abuses that were previously common. The Codes of Practice of the Mental Health Act (1983), covering England, Wales and Northern Ireland and Mental Health (Scotland) Act 1984 (now repealed) (see below) provided guidance on good practice in relation to the use of seclusion. This guidance includes the need for hospital authorities to produce written policies on seclusion that include the circumstances in which seclusion can be used and arrangements for monitoring and regular review.

In a recent, widely reported case *R v. Ashworth Hospital Authority ex parte Munjaz* (2005) (UKHL 58) [Q is this the Cormac reference? If not, which is the citation for this?] a patient challenged the seclusion policy of Ashworth Hospital. The challenge was based on the claim that the policy breached his human rights under Article 3 (the right not

to receive inhuman or degrading treatment or punishment), Article 5 (the right to liberty and security) and Article 8 (the right to private and family life) of the Human Rights Act (1998). The House of Lords rejected his appeal on the basis that Ashworth Hospital's seclusion policy was lawful, even though it differed from the guidance provided in the code of practice (Patrick 2006).

Although this legal case centred on the status of the code of practice it also raised wider issues, in particular, the rights of individual patients versus the rights of others; namely, other patients, staff and visitors (Parsons 2006). There is a great deal of health and safety legislation designed to

protect staff working in the NHS (Department of Health (DH) 1999b, 2002, Scottish Executive 1999). There are also many guidelines developed for the prevention and management of aggression in the NHS (Royal College of Psychiatrists 1998, UK Central Council (UKCC) 2002). The rights of workers to a safe workplace need to be considered along with the rights of people to the least restrictive informal care options. In a review of the Ashworth case and previous cases brought before the courts concerning seclusion and restraint (predominantly in relation to secure settings), Parsons (2006) concludes that considerations of safety 'appear to "trump" patient care'.

Despite these court rulings, there remains a need to carefully consider the use of seclusion in current practice and to question the ethical as well as legal justification for it.

In Scotland, although the Mental Health (Care and Treatment) (Scotland) Act 2003 (MHS) is now in force, unfortunately seclusion is not specifically mentioned in the act or the accompanying code (Patrick 2006). The act, however, sets out a number of principles that practitioners must take into account when making decisions. These principles (see Box 1) would appear to oppose, rather than support, the use of seclusion. The literature

Box 1. Principles of the Mental Health (Care and Treatment) (Scotland) Act (2003)

- Non-discrimination
- Equality
- Respect for diversity
- Reciprocity
- Informal care
- Participation
- Respect for carers' views
- Least restrictive alternative
- Maximum benefit to the client
- Child welfare

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discussed earlier [Q which?], highlighted service users' negative perceptions of seclusion; it felt punitive and the experience led to fear and isolation. It is difficult to envisage how a decision to use seclusion could be balanced with the need to take account of the principles, particularly with regard to the obligations to encourage participation, provide the least restrictive alternative, and take account of the past and present wishes of the service user. It is likely, however, that the health and safety of others will continue to provide utilitarian-based ethical and legal justification for seclusion.

In an era of increased participation of service users and a greater awareness of the rights of people who use mental health and learning disabilities services, it is likely that such justifications will meet with increasing scrutiny, particularly given the harmful effects of seclusion cited by service users in the literature.

Conclusions

Although the use of seclusion has been shown to be ethically and legally justifiable in some circumstances, it remains a controversial and highly restrictive treatment. As such, it should be subject to greater legal safeguards and standards of ethical examination and research

to demonstrate its effectiveness. Further study regarding the use of seclusion, how it is recorded and regulated by services and external bodies, such as the Mental Welfare Commission in Scotland, would appear necessary, given the controversial and highly disputed nature of this approach.

There is considerable debate surrounding the therapeutic versus punitive nature of seclusion (Meehan *et al* 2004). Mental health service users clearly consider seclusion punitive and see it as related to power and control (Martinez *et al* 1999, Meehan *et al* 2000). The lack of research on seclusion in learning disability practice, the widely acknowledged vulnerability of this group of people, as well as the problems people with learning disabilities may experience in articulating their views, make this finding a concern. One area for future study should be what are the benefits, if any, of seclusion for people with learning disability? The psychological impact of seclusion should also be further examined and processes identified to involve people in their treatment, for instance using the MHS (2003) advanced statements to enable people with mild-to-moderate learning disabilities to choose between emergency medication, restraint or seclusion as their preferred reac-

tive strategy. Involving people in treatment decisions becomes more complex as the level of disability and communication difficulties increases.

Brown and Tooke's (1992) suggestion that the method in which seclusion is practised is significant to how it is perceived is a salient point. Ensuring high-quality, evidence-based practice is a complex matter with good quality continuing education a critical component. Further research into the education of staff in the use of seclusion and alternatives to seclusion should be explored. The training needs of staff with regard to their current knowledge of behavioural approaches is equally as imperative, as their understanding of when and how seclusion should be used ■

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