



Andoh, Benjamin. (2003). The seclusion of psychiatric patients: a bird's eye view. *Mountbatten Journal of Legal Studies*, December 2003, 7 (1 & 2), pp. 51-58

Downloaded from <http://ssudl.solent.ac.uk/984/>

Usage Guidelines

Please refer to usage guidelines at <http://ssudl.solent.ac.uk/policies.html> or alternatively contact [ir.admin@solent.ac.uk](mailto:ir.admin@solent.ac.uk).

# The Seclusion of Psychiatric Patients: a bird's eye view

Benjamin Andoh

## Introduction

Although there have been several studies of seclusion over the years,<sup>1</sup> those studies have been largely from the viewpoints of psychiatrists, psychologists and other non-legal professionals. This paper aims to contribute to the literature by looking at the topic from a legal angle. It points out, among other things, that seclusion is one of the controversial aspects of mental hospital regime but is still necessary at certain times (such as when hospital staff members are controlling acutely disturbed, violent patients) and is justifiable under statute as well as the common law. The following issues are dealt with: the meaning of seclusion, its origins and its place in mental health law.

## What is seclusion?

Seclusion is an aspect of hospital regime, a temporary measure which involves the isolation of a patient who is so acutely disturbed as to present a risk to himself or to others (unless secluded) usually in a room or an area to which access is denied to other patients. Also the patient being secluded cannot leave the room/area of his/her own accord. Basically a form of restraint, it is used, especially in a locked room, as a last resort, i.e., when all reasonable measures or steps to placate a patient or modify his/her behaviour have failed. Thus, it has been officially defined as “the supervised confinement of a patient in a room, which may be locked to protect others from significant harm”, its sole aim being to contain severely disturbed behaviour likely to result in harm to other people.<sup>2</sup>

It constitutes, *prima facie*, an interference with, or restriction of, the freedom of movement

---

<sup>1</sup> See William A. Fisher, “Restraint and Seclusion: a Review of the Literature”, *Am. J. Psychiatry*, vol. 151, no. 11, Nov. 1994, pp.1584-91.

<sup>2</sup> Department of Health and Welsh Office, *Code of Practice, Mental Health Act 1983* (HMSO, 1999), paras.19.16-19.23.

of the patient in question. But, it is justifiable under the law. Thus, it is one of the controversial aspects of hospital regime.<sup>3</sup>

## Origins

As a method of controlling or managing patients who are violent, etc., seclusion<sup>4</sup> is not a new thing. In fact it has existed for some centuries. As far back as the pre-asylum phase in the development of the law relating to mental disorder in England, when not much was known about mental disorder, some patients, then known as lunatics or insane, were kept separately in isolated or secluded places while others, who, because of their lunacy, were likely to be violent if left to wander about, were tied or chained and kept in some secure place or private house.<sup>5</sup> For example, William Norris, a violent lunatic who could kill with his bare hands, was chained and kept in a cell at the Bethlem Hospital<sup>6</sup> for nine continuous years.<sup>7</sup>

Since the building of county asylums,<sup>8</sup> which later became mental hospitals under the Mental Treatment Act 1930, the practice of seclusion has continued to exist simply because

---

<sup>3</sup> Which, broadly speaking, encompasses everything a patient goes through while in hospital. See, e.g., B. Andoh, "Legal Aspects of Mental Hospital Regime in England and Wales", *Med. Sci. Law*, 2002, vol. 42, no. 1, pp.14-26.

<sup>4</sup> Often accompanied by restraint.

<sup>5</sup> See, e.g., K. Jones, *A History of Mental Health Services* (London: Routledge and Kegan Paul, 1972), pp.10-24. In France Pinel reported the use of seclusion during that period as follows: "If a madman suddenly experiences an unexpected attack and arms himself ... , the director - always mindful of his maxim to control the insane without ever permitting that they be hurt - would present himself in the most determined and threatening manner but without carrying any kind of weapon ... . At the same time the servants converge on him at a given signal, from behind or sideways, each seizing one of the madman's limbs ... . Thus, they carry him to his cell while thwarting his efforts and chain him if he is very dangerous or merely lock him up ... . The employees are expressly forbidden to retaliate even if they are hit." See D.B Weiner, "Phillipe Pinel's 'Memoir on Madness' of December 11, 1794: a fundamental text of modern psychiatry", *Am J. Psychiatry*, 1992, vol. 149, pp. 725-732. Thus, in describing the basic principles of restraint and seclusion, Pinel emphasised the the balance between safety and patients' rights and also the non-punitive use of those measures.

<sup>6</sup> One of the public/subsription hospitals at the time. Those subscription hospitals were non-state-sponsored. The Bethlem's financial sources were subscriptions and legacies by members of the public. See Jones, *op. cit.*

<sup>7</sup> See *Report of the Select Committee on Madhouses* (1815).

<sup>8</sup> Under the County Asylums Act 1808 and Lunatic Asylums and Pauper Lunatics Act 1845.

of the necessity for it in the care and management of violent patients. Today it enjoys express approval by the Government.<sup>9</sup>

One possible reason for this is the support, evident from the literature on restraint and seclusion, to the conclusion that seclusion and restraint do work (in that they can prevent injury as well as reduce agitation)<sup>10</sup> and, secondly, that the vast majority of in-patient programmes for severely symptomatic persons seem to find it quite impossible to operate without the use of some form of seclusion or restraint.<sup>11</sup> No wonder it has been regarded as a positive therapeutic intervention.<sup>12</sup>

But, just as seclusion has long been used, its use has been long criticised. For example, in 1868, a few years after Broadmoor was built, the Commissioners in Lunacy complained more than once of its use in that institution.<sup>13</sup> Apart from it being seen as an inefficient way of handling mental patients, it results in sensory deprivation if a patient is secluded in a room with no entertainment or diversion, it is oppressive, it causes feelings of anger, despair and isolation, it worsens hallucinations and delusions and it can even cause more violence.<sup>14</sup>

### **Its place in mental health law**

As already mentioned, seclusion is a measure of last resort. Although it is not necessarily

---

<sup>9</sup> See Department of Health and Welsh Office, *Code of Practice, Mental Health Act 1983*, (HMSO: London, 1999).

<sup>10</sup> See, e.g., A. Alty and T. Mason, *Seclusion and Mental Health: A Break with the Past* (London; Chapman, 1994); and R. Whittington and T. Mason, "A new look at seclusion: stress, coping and the perception of threat", *J. Forens. Psychiat.*, 1995, v.6, 285-304.

<sup>11</sup> See, e.g., Fisher, *op. cit.*

<sup>12</sup> See, e.g., P.S. Appelbaum and T.G. Gutheil, "The Boston State Hospital Case: 'involuntary mind control', the constitution and 'the right to rot'", *Am. J. Psychiat.*, 1980, v.137, 720-3.

<sup>13</sup> Then known as a criminal lunatic asylum. The complaint was as in the following way: "That this is not in our opinion an efficient way of dealing with mental disease, however complicated with criminal habits and even dangerous violence, we conceive it our duty once more to put on record; but the same remonstrance, in effect, having been made unavailingly at every visit of the Commissioners since Broadmoor was opened, it is with no expectation of any kind of present result that we repeat it now ...". See Appendix (F) to the 23<sup>rd</sup> Report to the Lord Chancellor of the Commissioners in Lunacy for 1869.

<sup>14</sup> See judgement of Stanley Burton J. in *S v Airedale National Health Service Trust* [2002] WL 1876000.

medical treatment, as defined by the Mental Health Act 1983,<sup>15</sup> it is therapeutically useful: together with restraint it is primarily effective in preventing injury and reducing agitation. Moreover, approval of it by the Government is clear evidence that it still has a place in English mental health law.

Because it is subject to abuse and as such a matter of concern for patients and their families, etc., the Code of Practice, Mental Health Act 1983<sup>16</sup> has guidelines relating to its use. According to the Code, it should be used as a last resort and for the shortest possible time, but not as a threat or punishment of a patient, as part of a treatment programme, because of staff shortage or where there is a risk of self-harm or suicide. It also acknowledges that informal patients, too, may be secluded although it goes on to say that such an occurrence should be taken as indicating the need to consider formal (i.e., compulsory) detention.<sup>17</sup>

The procedure for seclusion is similarly prescribed by the Code. The decision whether seclusion should be used can be made in the first instance by a doctor or nurse in charge. If the decision is taken by the nurse in charge, the responsible medical officer<sup>18</sup> or duty doctor must be notified immediately and must attend at once unless the seclusion is for up to five minutes.<sup>19</sup> During the period of seclusion there must always be a nurse readily available within sight and sound of the seclusion room. Where, however, the patient has been sedated, the nurse should be present with him/her at all times.<sup>20</sup> The patient is to be observed for the purpose of monitoring his/her condition and behaviour as well as identifying the time when the seclusion can be ended. The observation of the patient should be continuous, its level being decided on an individual basis and a documented report of it must be made every 15 minutes.<sup>21</sup>

---

<sup>15</sup> Which issue is looked at below.

<sup>16</sup> Department of Health and Welsh Office, *op. cit.* It came into effect on April 1, 1999. Its preparation by the Secretary of State is authorised by s.118, Mental Health Act 1983. Although the Act does not make compliance with the Code a duty, failure to observe it can be referred to in evidence in legal proceedings because of its status as a statutory document.

<sup>17</sup> *Ibid.*, para 19.16.

<sup>18</sup> I.e., the doctor in charge of the patient's treatment.

<sup>19</sup> Code of Practice 1999, para.19.18.

<sup>20</sup> *Ibid.*, para. 19.19.

<sup>21</sup> *Ibid.*, para. 19.20.

In addition, the need to continue seclusion must be reviewed every two hours by two nurses (one of whom must not have been involved in the decision to seclude), and every four hours by a doctor. Where the seclusion goes on for over eight hours continuously, or over 12 hours intermittently over a period of 48 hours, there should be a multi-disciplinary review of it by a consultant or other senior doctor, nurses and other professionals not involved in the incident leading to the seclusion.<sup>22</sup>

The Code also specifies the conditions of seclusion (e.g., the facilities to be provided in the seclusion room).<sup>23</sup>

It is noteworthy that there is a statutory document, namely, the Code of Practice in its present form, regulating the use of a controversial measure like seclusion of patients. Section 118 of the Mental Health Act 1983. as a result of which we have the Code, which officially recognises the need for seclusion as a measure of last resort and prescribes the procedure for, and conditions of, it, therefore, ought to be applauded.

Seclusion is a sensitive control measure involving a clash on interests: the rights of the secluded patient and the rights of other persons. So, to have its boundaries officially mapped out must be reassuring to supporters of patients' rights.

One pertinent question, however, is whether seclusion is a type of medical treatment.

### **Is seclusion treatment?**

It is often thought in non-legal circles that seclusion is a type of medical treatment. From a legal point of view, however, that is not correct. Section 145(1), Mental Health Act 1983 defines medical treatment broadly, as including nursing, "care, habilitation and rehabilitation under medical supervision". Thus, according to the Court of Appeal in *B v Croydon Health Authority*,<sup>24</sup> it includes force-feeding because acts which are ancillary to acts likely to alleviate or prevent a deterioration of a mental disorder are within the broad definition in the Act.

---

<sup>22</sup> *Ibid.*, para. 19.21.

<sup>23</sup> *Ibid.*, para. 19.22. See also *The Queen on the Application of Colonel Munjaz v Ashworth Hospital Authority (now Mersey Care NHS Trust), Secretary of State for Health, The Mental Health Act Commission* [2002] WL 1446118, and *S v Airedale NHS Trust* [2002] WL 1876000.

<sup>24</sup> [1995] Fam. 133.

In *S v Airedale National Health Service Trust* the question whether seclusion is a type of medical treatment was, among other things, answered in the negative. There Stanley Burton J. viewed seclusion of itself as not treatment, the reason being that it was used to contain a patient because of the risk he/she posed to himself/herself or others rather than to alleviate or prevent the deterioration of an illness or of its symptoms (even though it could remove the opportunity to display violence to other persons). Also, the Code of Practice 1999 specifically states that seclusion should not be used “as part of a treatment programme”.<sup>25</sup> This gives support to the view that seclusion is not a type of medical treatment.

Nevertheless, there are both statutory and common-law justifications for it.

### Legal justifications

Contrary to popular conception, and as acknowledged by the Code of Practice 1999, informal patients, too, (not only compulsorily detained patients) can be secluded. In either case there are justifications (both common-law and statutory) available. This fact must be a relief to hospitals and other establishments providing in-patient care because of the controversial nature of seclusion, as already stated.

In the case of compulsorily detained patients justification for this *prima facie* trespass to the person may be said to be provided, first, by s.120(1)(b)(ii), Mental Health Act 1983, which grants implied power to control patients, according to *R v Mental Health Act Commission, ex parte Smith*.<sup>26</sup> This is supported by the Court of Appeal’s endorsement of the finding of the judge at first instance in *R v Broadmoor Special Hospital Authority, ex parte S*<sup>27</sup> that the express power in ss.3 and 37 of the Mental Health Act 1983 to detain a patient included, *inter alia*, a power to control and discipline patients.<sup>28</sup> Other justifications are s.3(1), Criminal Law Act 1967 (which authorises the use of reasonable force to prevent the commission of an offence), self-defence (which allows the use of reasonable force to defend oneself or another

---

<sup>25</sup> Para. 19.16.

<sup>26</sup> *The Times*, 18<sup>th</sup> May 1998.

<sup>27</sup> *The Times*, 17<sup>th</sup> February 1998.

<sup>28</sup> *Pountney v Griffiths* [1976] AC 314; [1975] 3 WLR 140; [1975] 2 All ER 881. In the Divisional Court Lord Widgery CJ said “... the conception of detention and treatment necessarily implies that the staff at the hospital, including the male nurses, can and on occasion must use reasonable force in order to ensure that control is exercised over the patients” ([1976] AC 314, at 318).

person)<sup>29</sup> and the doctrine of necessity which excuses acts done in the patient's own interests.<sup>30</sup>

As regards informal patients the justifications include only necessity, self-defence and possibly s.3(1), Criminal Law Act 1967.<sup>31</sup>

Since this paper looks at seclusion from a legal angle, it must be mentioned that, in the case of compulsorily detained patients only, the Mental Health Act 1983 affords some protection to staff of mental hospitals and other persons acting purportedly in pursuance of the provisions of the Act. That protection has two aspects, namely, substantive and procedural. The substantive protection is contained in section 139(1) of the Act which provides that no person shall be liable to any criminal or civil proceedings in respect of any act he does purportedly in pursuance of the provisions of the Act or any rule/regulation made under it unless he did the act in question in bad faith or without reasonable care. Thus, any members of staff of a hospital, who seclude a compulsory patient (i.e., a patient subject to compulsory detention) *bona fide* and with reasonable care will be protected.<sup>32</sup>

The procedural protection, provided for by section 139(2) of the Act, is that in civil proceedings leave of a High Court judge is needed while in criminal proceedings the prosecution must be brought either by the Director of Public Prosecutions or with his consent.

It is interesting to note that the protection has existed since at least 1890 although its earlier forms<sup>33</sup> were meant to protect persons involved in compulsory commitment procedures from litigation with no solid basis.<sup>34</sup>

---

29 *R v Duffy* [1967] 1 QB 63; *R v Williams* [1987] 3 All ER 411.

30 *R v Bournemouth Community and Mental Health Trust, ex p. L.* [1998] 3 All ER 289.

31 Which may be described as the statutory version of self-defence because persons acting in self-defence are in effect usually acting to prevent a criminal offence being committed, and must use reasonable force in so doing (*R v McInnes* [1971] 3 All ER 295).

32 See, e.g., *Pountney v Griffiths*.

33 S.330, Lunacy Act 1890 and s.16, Mental Treatment Act 1930.

34 In fact the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency (1957) recommended retention of the protection because baseless claims should not be encouraged. See Report of the Commission, 1957, Cmnd.169, para. 490.



## **Conclusion**

Seclusion is, without doubt, an aspect of the regime in mental hospitals. It is a temporary measure of controlling patients who are violent and agitated. Though it has been in use, as well as criticised, for a long time indeed, it still has a place in English mental health law. Irrespective of it being controversial, it is useful as a measure of last resort. It has, therefore, received official recognition in the form of the Code of Practice 1999. It is not, strictly speaking, medical treatment. But, it is justifiable under both statute and the common law. Also, regarding only compulsorily detained patients, protection for staff of mental hospitals using it in good faith and with reasonable care is granted by the Mental Health Act 1983.

**Dr Benjamin Andoh**  
**Southampton Institute**