Seclusion in New Zealand Mental Health Services
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Acknowledgments

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Foreword

This report on seclusion practice in New Zealand has been a long time in preparation. Through the process it has attracted great interest from the sector and from service users. The discussions with service users, families, managers and clinicians generated a wealth of views.

The Commission has taken care to reflect these perspectives and to acknowledge the context in which seclusion occurs. Factors such as poor ward design, inexperienced staff, failure to share information across services, unclear policy and guidelines and high levels of acuity undoubtedly influence the use of seclusion. We have visited District Health Boards where seclusion practice has been dramatically reduced by an investment in staff training and the introduction of routine and thorough debriefing after each use of seclusion.

At the same time, we must also acknowledge that seclusion is a form of detention that has human rights consequences. The rights of those people placed in seclusion must be upheld and this requires rigorous adherence to legislative protections and the implementation of a thorough and transparent monitoring system.

The Commission would like to see seclusion eliminated. This has prompted debate and given rise to concerns about increased use of medication, physical restraint and the criminalisation of service users who require seclusion facilities.

We accept that a commitment to a substantial reduction in use is an important first step and believe a strengthened monitoring regime is critical to assessing progress towards that goal. We acknowledge the willingness of the Ministry to undertake the work required to help ensure seclusion is substantially reduced.

Jan Dowland
Chair
Mental Health Commission
Wellington
Seclusion is one management strategy for mental illness. It offers containment, isolation and reduction of sensory input. Ideally its efficacy should be measured in terms of a better outcome for the person than would have occurred had they not been secluded (Fisher 1994) and better outcomes for other patients, considering the duty of care that each unit has for all within their jurisdiction.

However, better outcomes are notoriously difficult to measure. ‘Better for whom?’ is a pertinent question. In a practical sense it might be measured in terms of safety and protection or a quieter environment that is less stimulating and more conducive to recovery.

Sadly, as with all treatments, worthy intentions and aims can fail. Seclusion can and is sometimes used for the wrong reasons (such as staff pressure) and can be used in the place of more appropriate and therapeutic interventions (such as engaging with a person and addressing their needs by explanation and reassurance). Thus it can be a substitute for interpersonal and therapeutic engagement (which take time and skill) and be symptomatic of poor unit design, lack of space, lack of options, lack of staff numbers and training. It can also be a reflection of inappropriate staff gender and ethnic mix.

This Mental Health Commission paper is a serious step to examine the extent of appropriate use, as well as abuse, of seclusion as a management strategy. It debates how an evidence base can be established through audit procedures that can be used to inform future policy and practice.

Many clinicians would like to restrict its use to when all other avenues of therapeutic intervention have been considered inappropriate and when its use can be combined with a ‘debrief’ and therapeutic feedback as to the reasons for its use.

‘Primum non nocere’ (‘first, do no harm’) is a fundamental obligation for all clinicians. It is in this regard that seclusion use must only be used as a thoughtful and planned intervention strategy to improve outcomes for all.

Dr D G Chaplow
Director Mental Health
Ministry of Health
Wellington
Introduction

“[seclusion] ... the confinement of an individual in a locked room from which they have no means of egress is widely regarded as one of the most restrictive practices used in modern psychiatry”

In June 2001, the Mental Health Commission initiated a review of seclusion practice in New Zealand mental health services. The project was instigated because of concerns expressed by clinicians, service users and researchers about the legitimacy, therapeutic value and reported overuse of seclusion. Often perceived as a punishment by service users and traumatizing for all involved, seclusion has been widely debated around the world.

There are many opinions. Topping-Morris stated that seclusion is ‘anti-therapeutic’, while others suggest it is a ‘treatment relic of the past’ and an ‘embarrassing reality’. Those who support seclusion see it as a valid treatment intervention to control agitation and reduce sensory stimuli.

After decades of research and debate, these polarised views have reached a degree of consensus. Most would now agree that seclusion is potentially harmful, contradictory to recovery models of care, and surrounded by serious ethical and moral issues. A recently released report in the US, Achieving the Promise: Transforming Mental Health Care in America, (July 2003) stated that:

...the use of seclusion... in mental health treatment settings creates significant risks for adults and children with psychiatric disabilities. These risks include serious injury or death, re-traumatizing people who have a history of trauma, loss of dignity, and other psychological harm. Consequently, it is inappropriate to use seclusion...for the purposes of discipline, coercion, or staff convenience. (pg. 34)

Furthermore,

Seclusion [is a] safety intervention of last resort...[it is] not a treatment...In light of the potentially serious consequences...it is inappropriate to use [this] intervention instead of providing adequate levels of staff or active treatment. (pg. 34)

Human rights issues have also been raised where seclusion practice is seen to sit uneasily with international human rights principles, although seclusion itself does not breach current human rights law.

This report discusses the findings of the Commission’s two year review of seclusion from human rights, policy and practice perspectives. It examines the magnitude of seclusion use in New Zealand, provides an explanation of that magnitude by explaining the context of the acute unit, and investigates arguments surrounding human rights, duty of care, and therapeutic value.

2 Use of Seclusion in Mental Health Services, Mental Health Commission (1999)
7 From The President’s New Freedom Commission on Mental Health, USA.
CHAPTER TWO: WHAT IS SECLUSION?

2.1 THEORY AND RATIONALE

In theory, persons requiring seclusion are usually considered out of control, aggressive and in need of containment and isolation in a controlled, restrictive setting under close observation and monitoring by appropriately qualified and experienced staff. Seclusion involves:

- **Containment** – A person is contained within a room where the door is shut and freedom to exit is decided by clinical staff.
- **Isolation** – The person is in a room alone.
- **Reduction in sensory input** – The room is reasonably bare, often containing no more than a bed and sometimes a toilet.

The theoretical rationale for the use of seclusion varies depending on whether seclusion is viewed as a valid therapeutic intervention in itself, a method of containment of a psychiatric emergency, or a form of punishment that maintains physical and, at times, psychological control over the secluded person.

2.1.1 Seclusion as therapy

As a therapy, seclusion is often seen as a ‘treatment’ that ‘improves’ ‘illness’; for,

[containment limits the environment of the client, protecting her or him from self-injury or hurting others. This is said to provide the client with feelings of safety and reassurance. Isolation removes the client from personal interactions that may tax the client’s coping abilities. [Reduction in sensory input] may calm clients who have escalating psychotic behaviours. Inherent in these principles is the assumption that clients are secluded because they are unable to control their behaviour.][9](pg. 37)

Few would argue that the individual components of seclusion (containment, isolation, and reduction in sensory input) are not helpful at certain times. The question is: do all service users who are placed in seclusion require containment, isolation and a reduction in sensory input; or do they require only one or two of these components to improve their condition or protect others?

2.1.2 Seclusion as containment

Seclusion is often used as a risk management procedure where **potentially** violent persons are secluded to ‘decrease opportunities [for them] to do damage to themselves, others, or the environment’ (pg. 33).[10]

The validity of the containment rationale rests on the argument that there is a lack of effective alternatives to control violent people on the ward and containment by seclusion is simply the most pragmatic of interventions. Containment is however only one component of seclusion, as suggested above. The need to contain a person may not necessitate the need for isolation and the reduction of sensory input as well.

2.1.3 Seclusion as punishment

Punishment is an emotive word that ‘conjures up feelings of abuse, neglect, tyranny and persecution’.[11]

And although few would condone punishment as an appropriate justification for seclusion, there are arguments that suggest punishment may be a legitimate means to modify behaviour. Tardiff,[12] for example, suggests that seclusionary time out can be therapeutic if used briefly in behavioural programmes. Of course,

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seclusion is supposed to be an emergency procedure used when people are highly agitated and unable to control their behaviour. If seclusion worked, from a behavioural standpoint, one would expect service users to experience seclusion only once or twice, but this pattern has not been observed. Multiple seclusion events are common for extended amounts of time.\textsuperscript{13}

\section{2.2 STATUTE AND GUIDELINES}

The Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act) requires that every service user is entitled to the company of others, except in certain circumstances when they may be placed in seclusion. The Act also states that seclusion may be used for the ‘care’ or ‘treatment’ of the service user, or protection of other persons in the ward (section 71). In other words, legally, seclusion can be used as a therapy and as a containment procedure, while it cannot be used as a form of punishment.

In terms of monitoring and quality assurance, each hospital or service must keep a register of seclusion (section 129b). The responsible clinician has the authority to use seclusion in accordance with the provisions of the Act and any concerns regarding the use of seclusion can be referred to the Director of Mental Health, who can direct District Inspectors to investigate any concerns.

In regards to operational guidance, the Ministry of Health has a \textit{Restraint Minimisation and Safe Practice Standard (2001)}, which replaces the \textit{Procedural Guidelines for the Use of Seclusion (1995)} as the primary reference document for practice. Seclusion is defined as a form of restraint and the Standard sets out twelve outcome measures, one of which deals specifically with seclusion. Many of the 1995 Procedural Guidelines for seclusion are contained in the appendices to the Standard.

\textsuperscript{13} Based on findings from the seclusion survey conducted by the Ministry of Health and the Mental Health Commission (2001).
What did the seclusion project involve?

The Commission’s review of seclusion involved a variety of components, each adding to our understanding of seclusion practice in the New Zealand mental health setting.

These components were:

1. A survey of all District Health Boards (DHBs) conducted with the Ministry of Health capturing data for the 2000/01 financial year.

2. An analysis of the literature on seclusion.

3. A review of key policy documents that relate to seclusion practice.14

4. Consultation with practitioners and site visits to selected DHBs.

A detailed discussion of methods is contained in Appendix C, which outlines the survey process and analysis, the literature analysis (including a full list of references), and the process used for policy analysis, consultation and site visits.

14 See Appendix B for a list of these.
Detailed analysis of the four data components revealed that seclusion was used widely and often across DHBs. And although it was generally perceived as a negative intervention by both services users and clinical staff, its use was influenced by systemic, resourcing, architectural, management and practice constraints.

4.1 THE MAGNITUDE OF SECLUSION PRACTICE

Although seclusion varied over time and between DHBs, all DHBs surveyed used seclusion, with 37% of service users under the Act experiencing time in a seclusion room. On average, secluded persons spent 50 hours per month in seclusion. Monthly hours ranged from 1 to 600 hours, while most seclusion events were between 8-24 hours in duration. Biographical data indicates that males and females are secluded at about the same rate and Māori tend to be secluded more than others.

4.2 THE CONSEQUENCES OF SECLUSION ON PEOPLE

The research evidence does not support seclusion as a treatment or therapy. Rather, seclusion can be seen as an adjunct to treatment. The research literature also sees seclusion as a containment procedure that can be psychologically damaging for some people. Qualitative literature indicates that feelings of helplessness, punishment and depression are common, as are feelings of anger, frustration, confusion and fear. Martinez et al’s quantitative study confirms these findings as widely applicable. They found that 76.5% of people felt punished, 63.8% felt fearful, 64.4% felt worthless, and 54.3% of people felt a loss of control. These findings contradict the therapeutic rationale for seclusion that has long been the primary justification for its use.

Investigations of solitary confinement in prisons provides further evidence to challenge the ‘seclusion as therapy’ argument; for although solitary confinement is intended primarily as a punishment, the impact on people is the same as seclusion. Scott and Gandreau, for example, found that solitary confinement led to declining mental functioning, hallucinations and delusions, while psychologists at the Maine State Prison in 1975 argued that excessive time in solitary confinement caused depression, withdrawal and psychotic behaviour. More recently, Grassian and Friedman (pg.278) stated, *‘the more recent literature on [solitary confinement] has also nearly uniformly described or speculated that solitary confinement has serious psychopathological consequences’. Any form of solitary confinement then, seclusion included, can be psychologically damaging for those who experience it.*

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20 Solitary confinement is defined as containment, isolation and sensory deprivation. In other words, it is the prison term for seclusion.
But seclusion also impacts on clinical staff. There are many reports of staff trauma and unease with seclusion practice, especially where the journey from the open ward to the seclusion room is fraught with resistance and physical restraint is necessary along with forced medication. From a therapeutic standpoint, any form of coercive practice has the potential to damage the therapeutic relationship between clinical staff and service user, for the power differential is highlighted in these circumstances. The therapeutic mode of care is replaced by a custodial mode of care.

Perhaps seclusion is best conceived as a safety mechanism rather than a therapeutic intervention. The Health and Safety in Employment Act 1992 defines the right to workplace safety. Section 6 of this Act states that employers have a duty to ensure the safety of employees. Furthermore, employers have the duty to identify and regularly review potential hazards (Section 7), to eliminate a hazard if practicable (Section 8), and if it is impossible to eliminate the hazard, the employer must take steps to isolate it from an employee (Section 9). In relation to seclusion, this means seclusion could be justified in terms of minimising a workplace hazard, thus legitimating the ‘seclusion as management’ philosophy to some degree. Obviously, a balancing act is required in terms of service user and staff rights. No clear indication is given in statute to how this can be achieved.

Finally, gender and cultural issues create their own unique set of circumstances in relation to seclusion. Safety issues are paramount for women, especially in a mixed sex environment and the de-escalation intervention process may be different. Women may, for example, prefer talking therapies. Specific issues also emerge for various cultural groups, where seclusion may, or may not, be seen as culturally appropriate. Likewise, the process of how seclusion occurs may need to take into account cultural differences. Male staff touching a Muslim woman would not be appropriate, for example. Also important are issues for refugees and asylum seekers who may have had traumatic experiences.

In spite of these evident concerns, seclusion is still perceived as a ‘necessary evil’ by many clinical staff. To explore why seclusion is perceived this way, and why seclusion events in New Zealand mental health services are reasonably common with long durations, the context of the acute unit must be understood.

4.3 WHAT FACTORS INFLUENCE SECLUSION PRACTICE?

There are a number of factors that influence seclusion practice, including systemic constraints, resource limitations, architectural issues, staffing and management processes, and service user characteristics. Key factors however are:

- **Unclear policy and guidelines** – Guideline documents do not clearly define seclusion or differentiate it from other practices, such as Night Safety Orders (the locking of bedroom doors at night within an acute unit). As a consequence ultra vires practice is common. The Restraint Minimisation and Safe Practice Standard (the Standard) does acknowledge ultra vires seclusion practice (section 1.3.12 pg. 7) but gives little guidance on how to clarify the issue, especially in regards to monitoring.

Also, the Mental Health (Compulsory Assessment and Treatment) Act 1992 does justify the use of seclusion as a ‘treatment’. The Standard, however, indicates that seclusion is a containment procedure that can be used to manage potentially violent or destructive behaviour. This discrepancy needs clarification. If seclusion is a ‘treatment’ then its rationale becomes one of therapy. If seclusion is a ‘containment’ procedure, then its rationale is one of management, with no expectation that the service user will get ‘better’ through the procedure.

The intention that lies behind the use of seclusion could significantly influence its frequency of use. Seclusion as a therapy would encourage use, as it ‘makes people better’. Seclusion as a containment procedure, however, should discourage use, as it takes on a custodial perspective against the philosophy of nursing care and therapeutic intervention.

- **Overcrowding** – Seclusion can be influenced by high demands on a service, which causes overcrowding within the acute setting, thus increasing the likelihood of agitated behaviour amongst service users.

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26 Mental Health Act Commission – Response to Women’s Mental Health: Into the Mainstream, Strategic Development of Mental Health Care for Women, December 2002.
Overcrowding also alters the nature of nursing care by creating an environment that requires extensive management. Cleary et al (pg. 509)\textsuperscript{27} suggests:

Recently, claims have been made that psychiatric nurses do not interact in a therapeutic manner ...The need to maintain ward order, to manage patients, other staff and the environment, places pressure on nursing staff who cope by utilising a custodial model of care thereby creating a barrier to effective therapeutic interaction.

An overcrowded acute ward can be seen to encourage the use of seclusion as a containment procedure, to manage risk and to manage available resources.

- **Poor ward design** – A ward that lacks quiet rooms, personal space, and is not conducive to staff-service user interaction tends to increase the likelihood of agitation and hence seclusion. There is an inverse relationship between a ward environment that enables easy observation and the level of agitation by service users. Old psychiatric institutions tended to have large open spaces, bright lighting and seats arranged so nurses could easily observe people. Unfortunately, such spaces are often counter to therapeutic needs and can increase the degree of agitation experienced on a ward. Conversely, a ward environment that has a lot of private space also demands greater interaction from staff in order to maintain the necessary level of observation.

Issues of dignity and cultural appropriateness are also impacted by ward design, which could also increase the levels of agitation within the ward; the use of surveillance cameras, and the availability of toilets and showers for example. These issues are of particular concern to Māori and Pacific people.

- **Low or inflexible staff numbers** – Low staff numbers compromise the care and philosophy of care by increasing the demand upon nurses to ‘manage’ the ward environment and thus interact less with service users. So although Higgins\textsuperscript{28} suggests that a staff-service user ratio of 1:1.5 was ideal to minimising seclusion use, staff availability and quality of interaction may be more important. The tendency for seclusion to be used least at night when staff-service user ratios are often high supports this view.\textsuperscript{29} Low staff numbers do influence the availability of staff and the quality of interactions however.

Low staff numbers can also increase real and perceived risk on the ward. Real risk can be increased where regular observation of people in seclusion is compromised. Perceived risk can be increased where clinical staff become more anxious about managing the ward environment and place people in seclusion as a risk management procedure.

- **Inexperienced staff** – Experienced staff are key to best practice. Considerable skill is required to use alternative interventions such as de-escalation and specialling (one-to-one or two-to-one nursing). Likewise, managing the ward environment and being able to interpret early signs of agitation can only be learnt over time.

The interpretation of behaviour by staff is also culturally bound. Agitation can be displayed differently depending on the group in question. This can increase the likelihood of seclusion use as a risk management procedure. Māori and Pacific people are most likely to be affected in this regard.

- **Poor staff retention** – Retaining quality staff is important because there is a need to ensure continuity in the care environment. Good care requires good relationships and communication between staff and service users and these can only be built over time. Seclusion often results from misunderstanding and inaccurate perceptions of risk. Moreover, staff retention aids the development of information sharing between the acute unit and community services as relationships are built between key personnel.

- **Poor information sharing** – Seclusion can occur when appropriate information is not shared with a service. Information about agitation risk, best treatment options and so on need to be shared between community services and acute units. Lack of information can lead to inappropriate use of seclusion.

- **Service user acuity** – Service users who are extremely agitated and pose serious risks to self and others leave clinical staff with few alternatives but to use some form of containment or restraint. Seclusion rooms may be the only facility available where such a person can be contained safely. The evidence points to high levels of acuity amongst those presenting to acute inpatient units and a view...


that seclusion is a necessary tool to manage profound levels of disturbance and agitation, which may be drug induced.

Seclusion is supposed to be a ‘last resort’ intervention. However, in practice the resources, staffing constraints and the operational environment limit the use of alternative practices (e.g., quiet lounges, specialising, time out, confinement without isolation or reduced sensory input). Seclusion reduces risks and ambiguity for staff and is a procedure justified by legislation and policy. Within such an environment, seclusion can become an all too easy intervention. This raises serious questions about human rights and the duty of care.

4.4 HUMAN RIGHTS AND DUTY OF CARE ISSUES

As a form of detention, seclusion practice does require commentary from a human rights perspective. The Human Rights Commission’s 1991 report to the Prime Minister (“Mental Health - Patient Rights and the Public Interest”) sets out a detailed discussion of the interface between mental health detention and human rights law.

More recently, the Human Rights Commission, as a component of the National Action Plan, has looked again at the issue of detention, which includes issues relating to seclusion in the mental health setting. That report is to be submitted to the Prime Minister by the end of 2004. This brief commentary on human rights and seclusion is a continuation of a debate initiated over a decade ago and is part of a growing human rights discourse in New Zealand.

In 1991, the Human Rights Commission stated:

International instruments on human rights set the standards by which all people should be permitted to live. The ideal standards for treatment of mentally ill people are delineated in a number of them. Although the Commission acknowledges that conforming with all the principles laid down in the instruments is difficult, and providing a service that satisfies everyone even more so, nevertheless attempts should be made to meet the criteria outlined. (pg. 59)

The Mental Health Commission does not suggest that the seclusion legal framework breaches human rights law. The Commission does suggest that seclusion practice sits uneasily with a number of international agreements to which New Zealand is a signatory. For example, The Universal Declaration of Human Rights (Article 5) and the International Covenant on Civil and Political Rights (Article 7) both prohibit practices that can be perceived as torturous, cruel, inhumane or degrading, whether as a treatment or punishment. New Zealand was also one of 119 countries to ratify the Convention Against Torture and other forms of Cruel, Inhuman and Degrading Treatment (CAT). The CAT defines torture as:

...any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as...punishing him for an act which he or a third person has committed ...when such pain and suffering is inflicted by or at the instigation or with the consent or acquiescence of a public official or other person acting in an official capacity.30


Although seclusion is not legally sanctioned in New Zealand as a punishment, it is clearly perceived as a punishment by many service users and the potential harm is the same regardless of whether seclusion is used for therapy, containment or punishment.

The term ‘torture’ is however debatable and rests on the interpretation of the phrase ‘severe pain or suffering’ in the CAT. Case law in the UK has concluded that solitary confinement in itself is not torture but the conditions of the confinement may lend themselves to cruel and inhumane treatment; for example, where persons are placed in a room that lacks sanitation.31 Individual responses to such conditions may vary, so whereas insanitary conditions are tolerable for some, they may be intolerable, cruel and inhumane for others. What can be said, then, is that in rare cases seclusion places some people at risk of cruel, inhumane and degrading treatment, which can lead to significant psychological harm.

In regards to the duty of care, staff within inpatient units have an obligation to protect all service users from potential harm. This is particularly pertinent where service users are committed under the Act and deprived of their liberty. The environment of the acute unit, or any other mental health facility, should be therapeutic not custodial.

4.5 MONITORING

Seclusion incidents are recorded in a register that can be scrutinised by District Inspectors (required under section 129b of the Act). The Standard also requires that a specific form be used, and that 10 minute and two-hourly observations are made and noted. It is up to the discretion of District Inspectors as to the frequency of seclusion monitoring. No central monitoring of seclusion currently occurs.

As mentioned above, although guideline documents acknowledge that ‘practices similar to seclusion occur in many health and disability settings...including night safety orders... “time out” and isolating consumers for the protection of themselves and/or others’ (The Standard, pg. 7), these practices do not receive the same level of scrutiny as seclusion proper. It is up to each individual service to develop policies and procedures to ensure these practices are used appropriately. Also, given the research evidence sees seclusion as potentially psychologically damaging, seclusion events should therefore be classified as ‘critical incidents’.

Critical incidents are defined as an ‘event that is physically, psychologically, spiritually or culturally harmful or potentially harmful to a client or other person’ (pg. 2). This reclassification would add an additional layer of quality assurance and add robustness to the monitoring of seclusion practice.

For the potential impact seclusion can have on a person there do not appear to be sufficient checks and balances in place to encourage best practice. Evidence does suggest, however, that close monitoring may provide an incentive for this to occur.

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32 ‘Critical Incidents’ are now referred to as ‘Reportable Events’ by the Ministry of Health.
33 Guidelines for Reporting and Review of Incidents in Mental Health Services: Revised Version (December 1995), Ministry of Health.
Conclusion

Over the last three decades, researchers, clinicians and service users have put forward a range of views on seclusion. These views are the product of research, clinical practice and personal testimony. And as diverse as these views are, a consensus is now emerging that questions the legitimacy of seclusion practice in the modern mental health setting. As a therapeutic intervention, seclusion was portrayed as solitude – calm, serene and contemplative. Evidence now suggests that seclusion poses significant risks to service users, including death, re-traumatisation, loss of dignity and other psychological harm. As a punishment, seclusion has been portrayed as remedial, although this rationale is not sanctioned under New Zealand law.

Seclusion as a containment procedure requires more careful examination. This rationale is sanctioned in statute[34] and is justified by quite reasonable arguments. Containment is seen as a mechanism to protect the service user and others from harm, and until better alternatives arise, containing people in seclusion rooms is perceived as a ‘necessary evil’. Questions can be asked regarding the degree of restriction imposed by seclusion, though. Does seclusion impose an unnecessary degree of restriction on people where least restrictive practice is the most desirable model of care? In other words, does containment of a person also necessitate the need for isolation and reduced sensory input? Seclusion appears to be an all-or-nothing approach and consequently the degree of restriction may pose unjustifiable infringements on rights, freedoms and privileges.

Finally, as a form of detention, seclusion requires human rights considerations. It is important to note that there is no evidence that seclusion practice breaches New Zealand human rights law. Seclusion practice does sit uneasily with international human rights instruments however. Human rights considerations can be seen to add a layer of protection in seclusion practice.

These things considered, the issue at hand appears not to be a question concerning the appropriateness of seclusion practice, but rather how extreme violence, or the risk of extreme violence, can be managed within a psychiatric acute ward? If this is the true problem, then the focus changes. All factors that relate to violence should come under scrutiny, this includes the origin of violence, ways to divert, predict and prevent its occurrence.[35] Our examination of the acute ward context gives some insight into factors that may influence agitation on the ward. Outside of the ward, crisis prevention strategies such as greater access to support workers, psychotherapy, alternative treatments, peer support and recovery education options may prevent crises from occurring.[36] Minimising the pressure on acute wards by building community capacity and intersectoral cooperation could also resolve many of the systemic issues that influence ward agitation and violence.

The Commission would like to see a significant reduction in seclusion use and its eventual eradication. The pathway towards eradication would require several years of development work including research, staff training programmes, which would promote ways to prevent seclusion and identify humane alternatives, and a strengthened monitoring regime. The last of these is of utmost importance for it would allow the measurement of progress towards eradication. Redefining seclusion as a ‘critical incident’ or ‘reportable event’ would add to a strengthened monitoring programme.

It is noteworthy that under the existing Restraint Minimisation and Safe Practice Standard (2001) least restrictive practice is a requirement, and demonstrated competence focusing on de-escalation skills and the minimisation and elimination of restraint is emphasised. The Commission supports these requirements wholeheartedly, but sees stringent monitoring as the most useful tool to encourage best practice and clarify the pathway towards eradication.

[34] The Mental Health (Compulsory Treatment and Assessment) Act 1992.
The Minister of Health Hon Annette King, the Ministry of Health and the Mental Health Commission agree that this review of seclusion in mental health services is the beginning of a path forward, which will enable us to understand seclusion better and substantially reduce its use.

The Mental Health Commission is to ask the Ministry of Health and Standards New Zealand to redefine seclusion in current guideline documents, ensuring that all practice that embodies confinement, isolation and a reduction in sensory input is acknowledged as seclusion.

The Ministry of Health is developing an auditable requirement for each District Health Board to establish a debriefing system which provides that each seclusion event is followed by a formal debriefing of staff and the person secluded, and a formal report is prepared for file and the relevant District Inspector for his/her consideration.

By June 2006 the Ministry of Health will capture detailed data surrounding seclusion events as part of the Mental Health Information National Collection (MHINC).

To enable the progress towards significant reduction in seclusion use to be monitored, the Commission is to request the Ministry to include rates of seclusion use in DHB service profiles.

Collaborative work will be undertaken between the Mental Health Commission, the Human Rights Commission and the Health and Disability Commissioner to clarify the human rights issues around the use of seclusion.

These initiatives will make a substantial contribution to a unified understanding of what seclusion is and the establishment of a stringent monitoring regime to enable information on seclusion to be compared and benchmarked. As a result, we will be able to assess our progress toward the reduction and the eventual eradication of seclusion.
Alty and Mason’s (1994) Benevolent-Malevolent Scale Model

**APPENDIX A**

**SECLUSION**

**THERAPY**

**BENEVOLENT**
- Relationship formation
- Maturation
- Mastering of Space
- Isolation
- Decrease in Sensory Input
- Protection of Milieu
- Place where Other Therapies Applied
- Emergency Medication
- Facilitates Diagnosis
- Safety of Self
- Repression of Aggression
- No Other Alternative
- Mitigating Staff Anxiety
- Elective Seclusion
- Durations of Seclusion

**MALEVOLENT**
- Social Control

**CONTAINMENT**

**BENEVOLENT**
- Safety of Self
- Safety of Others
- Safety of Property
- Internal/External Control
- Repression of Aggression
- No Other Alternative
- Mitigating Staff Anxiety
- Elective Seclusion
- Durations of Seclusion

**MALEVOLENT**

**PUNISHMENT**

**BENEVOLENT**
- Paternalism
- Behaviour Modification
- Ethological Model
- Institutional Control
- Sensory Deprivation
- Revenge/Sadism

**MALEVOLENT**
Key Seclusion Documents

Key documents that relate to seclusion and its operation are:

- Guidelines for Effective Consumer Participation in Mental Health Services (1995)
- Guidelines for Cultural Assessment in Mental Health Services (1995)
- Guidelines for Reducing Violence in Mental Health Services (1994)
- Guidelines for Clinical Risk Assessment and Management in Mental Health Services (1998)
- Restraint Minimization and Safe Practice (Feb 2001)
- Guidelines for Reporting and Review of Incidents in Mental Health Services: Revised Version (December 1995)
- Guidelines for Discharge Planning for People with Mental Illness (1993)

The ordering for these documents is not random. They are organised to match the process of a consumer moving through an acute unit and back into the community. These documents provide an overview of processes, procedures and approaches within mental health services. The important point is that seclusion is not an isolated process, and as such, the procedural guidelines for seclusion (or the Restraint Minimisation and Safe Practice Standard) should not be considered the only relevant guide document.

The Ministry of Health has been updating these documents. The Restraint Minimisation and Safe Practice Standard, for example, replaces the Procedural Guidelines for the Use of Seclusion.
Methods and Methodology

1. SURVEY

Process
The Mental Health Commission and the Ministry of Health conducted a joint survey of all DHBs starting in June 2001. The Commission was responsible for the development of the survey and the data analysis. The Ministry was responsible for sending out the survey and collecting the returns.

The survey had four sections relating to the management of seclusion – admissions statistics, information on service users who were placed in seclusion, and general feedback from the service about seclusion and the survey itself. From this information, a spreadsheet database was developed with quantitative analysis identifying key trends, such as the level of seclusion in New Zealand, both at national and regional levels; the biographical make-up of people who were secluded; duration in seclusion; details of the acute ward environment; and information on the management of seclusion.

Issues
The survey process was constrained by a number of factors. The most significant of these was that more than one version of the survey questionnaire was sent out to DHBs. Of those who filled out the survey, approximately half filled out version 1, while the other half filled out version 3. While both versions had the same general format and schemata, there were fundamental differences in the way the data was categorised.

Section 3, for example, which related to information on service users that have been in seclusion, was a concern. Version 1 categorised the data in terms of individual service users, their biographical categories, and the amount of time spent in seclusion per month. Version 1 allowed for an analysis of full biographical statistics per service user, and the hours that each person had spent in seclusion on a monthly basis. Version 3 categorised each individual episode of seclusion by category of hours spent in seclusion and biographical categories, but there was no way of knowing which person (e.g. Māori, aged 31, male) had been put in seclusion and for how long. This not only made it difficult to compare accurately between survey versions, due to the incongruity of format, but it also made it difficult to get the individual service user profiles from those services that had answered survey version 3.

2. LITERATURE ANALYSIS

Aspects of constant comparative analysis and meta-synthesis were used to formulate the findings of this report. Meta-synthesis is a means whereby “scholars [can] find ways to apprehend and re-present different representations to achieve fuller knowing” (Sandelowski, 1993:3). It has been justified by Jensen and Allen (1996) in the following way:

Although informative, isolated studies in and of themselves, like the pieces of a jigsaw puzzle, do not contribute significantly to our full understanding of the phenomenon of interest. In order to advance knowledge and influence practice, a synthesis of representations is essential. This synthesis of findings across studies is a type of secondary analysis particular to qualitative research, which provides a powerful approach to theory development.

Meta-synthesis is significantly different than reviewing the literature. A literature review attempts to cover the range of work done on a particular area (e.g., seclusion). The more work that is covered, the more thorough the literature review is perceived to be. Also, within literature reviews methodologies are commented on to show the strengths or weaknesses of certain research approaches. Literature reviews typically describe the research domain.
By contrast, our approach conceptualises the literature by seeing the literature as data able to be merged or synthesised to achieve a higher level of understanding. This approach is not too dissimilar to the Hegelian approach to theory development (thesis + anti-thesis = synthesis). Essentially, a research article may be broken down into component parts through a process of qualitative coding. Similar and dissimilar codes are compared constantly. Codes are refined through an iterative process of moving between data and our emergent synthesis. Eventually, codes and the concepts they represent are positioned logically into a suggested model of the phenomenon under study.

Data Selection

There are a number of issues relating to sampling. The boundaries of the study must be clearly defined. In our study, the boundaries can be seen as ‘inappropriate use’ and ‘overuse’ of seclusion as indicated in the Mental Health Commission’s seclusion discussion document (Use of Seclusion in New Zealand Mental Health Services, 1999). This defines the issue under study. The sampling of literature was also based on a clear definition of seclusion. We suggested that seclusion is comprised of three key components: containment, isolation and reduction in sensory input.

Theoretical sampling was used to guide the ongoing selection of data and refine theory development. This approach is fundamentally different from random sampling, the normative sampling technique. Theoretical sampling is used to discover concepts and their properties, and to reveal interconnections in a theory. Random sampling is used to “obtain accurate evidence on distributions of people among categories to be used in descriptions or verifications” (Glaser and Strauss, 1967:62-3). Given this distinction, sample size is less relevant for our purposes. Our aim is to suggest theory and to verify it only within the confines of the study itself.

Constraint Composition Analysis

Constraint composition analysis is a useful way of understanding the imperfections in research. It states that constraints are built into all researches; these accumulate over the course of a study and eventually lead to a problem being resolved (Haig, 1987 in Yee, 2001). Constraints can take many forms; time is a good example of a constraint. The less time one has the more innovative one must become to complete the project. Lack of specific data is another common constraint.

The dearth of New Zealand-based research on seclusion was a clear limitation of this study. Constraint composition analysis allows us to understand research in a real world context and shows us how research limitations can shape a research report.

Credibility

The term credibility is used in qualitative research more often than validity because the latter is bundled with meanings associated with quantitative (or positivistic) work. Jensen and Allen (1996) describe credibility as an inherent component of rigour when they write:

...rigor is essential to achieve credible and consistent descriptions of the phenomenon. The general themes of credibility, auditability, and fittingness persist as criteria for scientific rigor. The truth value of qualitative account synthesis would reside in the discovery of human phenomena or experiences as they are lived and perceived by subjects, rather than in the verification of a prior conceptions of those experience. Thus, a meta-synthesis is rooted in the original data and is credible when it re-presents such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognize it from those descriptions or interpretations as their own. Consequently, achieving credible interpretations is fostered if original studies provide exemplars.

[Our study] meets the criterion of fittingness when the findings can fit into contexts outside the studies and when the findings are grounded in the life experience studied and reflect their typical and atypical elements. Furthermore, an interpretive synthesis is auditable when the same or comparable conclusions can be achieved, given the data. Findings are internally validated through the quotes of the studies’ participants and the metaphors used to describe these experiences and externally validated through comparisons with theoretical literature. Lastly, confirmability is achieved when auditability, truth value, and applicability are achieved.

(Proquest electronic document)
Other Methodological Issues

Questions must be asked regarding the comparability of research literature that adopt different methods and underlying philosophies. How comparable can these studies be? Can they be synthesised at all? The answer to this question is partially answered in the above section on credibility, where any study that captures human experience should be recognisable to people in the field. If a synthesised study captures a recognisable process, then the methodological or philosophical differences between studies becomes irrelevant. In essence, if the social world is seen as integrated and seamless by ordinary people, then a theory that is equally so is credible.

3. POLICY ANALYSIS

Key policy documents relating to seclusion were collected. These included service policy, DHB policy and the guiding documents from central government (e.g., Restraint Minimisation and Safe Practice Standard, and others listed in Appendix B). DHB and service policies were compared to central government guideline documents to identify similarities, differences, and the findings from the literature analysis were utilised to identify the degree of relevance to operation.

4. CONSULTATION AND SITE VISITS

Throughout the seclusion project, consultation and advice was taken from a variety of groups. In particular, the Mental Health Commission’s clinical and service user reference groups commented on significant parts of the project. An external service user advisor also contributed to the project and an external academic peer reviewer assessed the literature analysis.

Site visits were conducted after the survey, literature and policy analyses were complete. From this information, four DHBs were selected to test our findings and ground our analysis. The selection criteria included geographical variation, demographic profile variation, and the magnitude of seclusion. Letters were written to the CEOs of each selected DHB and following acceptance of our visit, seclusion data on each specific DHB and letters of introduction were sent to relevant mental health services. Site visits included one-to-one discussion with service managers, clinical staff and consumer advisors. Open forums were held in one DHB. A tour through acute wards was also requested, which included an examination of seclusion areas.

Notes were taken during each session and these were analysed using qualitative methods against our emergent framework developed from the literature and policy analysis, survey findings and a priori consultations.
5. BIBLIOGRAPHY


An Executive Briefing on Adult Acute Inpatient Care for People with Mental Health Problems (Briefing 16), Sainsbury Centre for Mental Health (2003)


*Night Safety Procedures*, Ministry of Health (June 1995)


*Standards on Restraint Minimisation and Seclusion*, Ministry of Health (2001)


Resources for the Reduction of Seclusion

A Toolkit for Reducing/Eliminating the Use of Seclusion and Restraint in Psychiatric Inpatient Settings, available from Professor Judith Cook, Mental Health Services Research Program, Department of Psychiatry, University of Illinois at Chicago.


