



## The Use of Seclusion in Mental Health Treatment Facilities in New Zealand: A Position Paper

November 2013

### Purpose of this paper

The use of seclusion is controversial, involving widely differing views and evoking strong emotions. This position paper briefly describes the views of Kites Trust Board and staff on the issues concerned, and the principles and rationale on which these views are based.

It is intended that Kites Trust Board and staff affirm these views and disseminate them to service users, mental health professionals and other interested parties.

### Kites Trust's position

Kites asserts that the use of seclusion should be eliminated from all psychiatric facilities for the following reasons:

- It is a violation of human rights
- It is traumatising for all involved and especially for the person being secluded. This trauma can have serious negative effects for many years
- It can seriously damage any trust people may have in mental health services and diminish the likelihood they will seek treatment from them in the future.

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017<sup>11</sup> specifies a clear commitment by government to the reduction and elimination of the use of seclusion. Kites strongly supports this aim, but also accepts that reduction rather than elimination is likely to remain the mainstream objective for the immediate future. Therefore without compromising its commitment to elimination, Kites will continue to seek collaboration on the reduction of seclusion towards its elimination, and contributing to policy development.



## Seclusion

Seclusion is defined in the New Zealand Health and Disability Services and Standards (Ministry of Health 2008)<sup>i</sup> as 'where a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit' ('consumer' in this context refers to someone subject to compulsory assessment and treatment). This sparse definition raises questions that have emotive and varying meanings for the people involved, and tends to cloak the harsh realities of the practice. Many people, especially those who have experienced it, regard the term 'seclusion' a misnomer, more accurately described as 'solitary confinement'. The same applies to 'seclusion room' i.e. rooms designated for seclusion use, with 'cells' considered by many a more accurate description in both physical appearance and experience. Placing someone in seclusion is traumatic for the person being secluded, staff, and other consumers. It often involves the use of physical force by several staff and risk of injury for all involved. Rooms for seclusion are a standard feature of locked psychiatric facilities, including acute, forensic and adolescent units. As implied in the definition, these rooms are locked to prevent freedom to exit voluntarily.

The use of seclusion is monitored and regulated according to Ministry of Health Guidelines (Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992)<sup>ii</sup>. Most facilities have internal reviewing systems and policies in place where reduction is an explicit objective, as well as conforming to Ministry of Health reporting standards. The Guidelines (Appendix One) specify four circumstances where seclusion may be appropriate, all in essence concerned with the control of harmful, disturbed or disruptive behaviour not amenable to other interventions. There are a substantial number of programmes developed internationally aimed at seclusion reduction. Almost all of these focus on introducing behavioural techniques that anticipate and defuse potentially disruptive or disturbed behaviour attributed to psychiatric illness. This is usually in the context of wider management techniques for the facility or unit as a whole.

Seclusion is permitted where a person is subject to compulsory mental health assessment and treatment. Its use is prescribed, regulated and monitored by the Ministry of Health. Historically seclusion was more or less routine for people on compulsory admission to a psychiatric facility and many working in mental health considered it therapeutic. There has been a substantial attitudinal shift in mainstream provider views, a much wider and better understanding of its traumatic and often long-term impact, not only on people who are secluded but their families and the staff involved, and greater awareness of its implications for human rights. The issue of seclusion has to be considered in the wider context of concerns about compulsory mental health treatment where views are more diverse and polarised, but it is now accepted in virtually all quarters that reduction in seclusion usage is a minimum goal. This goal is documented in current Ministry of Health documentation, in particular in 'Rising to the Challenge' cited above, and has achieved some success.

## Summary

In the past, seclusion was used extensively in mental health facilities with people subject to compulsory treatment. Attitudes internationally to the use of seclusion have changed considerably over recent years with better understanding of the nature of severe distress, the short and long term harmful effects of this practice and increased awareness of its implications for human rights. These are evident in ***The Convention on the Rights of People with Disabilities***, particularly Article 14 Liberty and Security of the Person and Article 15 Freedom from torture or cruel, inhumane or degrading treatment or punishment.<sup>1</sup>

Moves to reduce use of seclusion have gained momentum in recent years and focus on introducing behavioural interventions that prevent or minimise situations arising that escalate disturbed or disruptive behaviour. Although New Zealand continues to use seclusion, reduction and elimination of its use is now strongly promoted as an objective and this is achieving some sustained success.

There is substantial literature on this topic including: formal regulations and related material from the Ministry of Health; reports on research and good practice; and, most importantly, accounts by survivors and others of their experience of its use, providing rich insight into the impact of this practice on recipients.

Kites Trust is committed to and advocates for the complete elimination of seclusion in mental health facilities. However, Kites is also keen to explore and if appropriate lead further cooperation and collaboration in any programmes which are aimed at reducing its use, ameliorating its harmful effects and committed to eliminating the practice.

---

<sup>1</sup> Ministry of Health, New Zealand. Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012-2017<sup>1</sup>

<sup>1</sup> Seclusion is defined in the New Zealand Health and Disability Services and Standards (Ministry of Health 2008)

<sup>1</sup> Ministry of Health Guidelines (Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992)

<sup>1</sup> The Convention on the Rights of People with Disabilities, Article 14 Liberty and Security of the Person and Article 15 Freedom from torture or cruel, inhumane or degrading treatment or punishment