INTRODUCTION AND BACKGROUND

The use of seclusion as a patient management strategy remains controversial (Wynaden et al. 2001a) and the source of ongoing debate. The debate focuses on legal, ethical, professional, attitudinal, and safety issues (Farrell & Dares 1996; Muir-Cochrane 1995; Tooke & Brown 1992; World Health Organization Collaborating Centre for Mental Health & Substance Abuse 1999; Wynaden et al. 2001a).

For the purpose of this study the definition of seclusion outlined by the Western Australian Mental Health Act (1996) was used. The Act describes seclusion as ‘sole confinement in a room that is not within the control of the person confined to leave’ (Division 8, Section 118). Secluding a patient is an important clinical decision (Holzworth & Wills 1999) as current psychiatric practice is based on the premise of providing care in the least restrictive environment (Australian Health Ministers 1998). The literature indicates that the decision to use seclusion results from factors, such as the increase in violence and patient acuity (Outlaw & Lowery 1994; Wynaden et al. 2001b); staff level of confidence to manage patient aggression (McGowan et al. 1999); staff : patient ratios and training (Mattson & Sacks 1978); and staff and administration’s ideology regarding the use of seclusion (Hopton 1995).

This study investigated the decision-making process of eight health professionals electing to seclude a patient. Previous research completed by the authors had shown that the attitudes held by staff towards the use of seclusion (Wynaden et al. 2001a) were not always reflected in clinical practice decisions (McGowan et al. 1998).

Decision-making is central to the practice of nursing (Tulloch 1995). The increasing acuity of patients, along with shorter periods of hospitalization, places increasing demands on nurses’ decision-making abilities, particularly nurses working in intensive care units (Corcoran-Perry et al. 1999). The literature on decision-making has increased significantly over the last three decades (Thompson 1999). For many years the literature focused on nurses’ responses to hypothetical patient situations (Benner 1984; Tanner 1987). However, the literature more recently has been broadened to include the use of clinical

ABSTRACT: The objective of this study is to provide new knowledge and understanding of the decision making used throughout the seclusion process. Seven mental health nurses and one doctor were each interviewed within 48 hours of making the decision to seclude a patient. The interviews were analysed using content analysis. This study provides valuable information regarding factors that are central to, and/or influence, the decision-making process surrounding seclusion. More importantly, the results demonstrate that seclusion is initiated only when all other less restrictive patient management strategies have proven to be unsuccessful with the patient.

KEY WORDS: acute psychiatric care, decision-making processes, psychiatric/mental health nursing, seclusion.
research evidence (Thompson 1999). Tanner (1987) identified two theoretical perspectives that have guided research on decision-making: the rationalist and phenomenological perspectives. Rationalism is based on the belief that all knowledge originates from reason and is not dependent upon experience (Tanner et al. 1993). In contrast, the phenomenological approach to decision-making occurs within the context of the clinical setting with events occurring simultaneously with the decision-making process incorporated into the analysis (Tanner 1987).

Holloway (1988) described the essence of nursing acutely ill patients as anticipatory to the management of problems that may confront the patient. Patients in acute care environments require constant monitoring and are cared for by nurses who have a high level of clinical knowledge. Benner (1984) claimed that clinical knowledge is gained from both the theoretical and the clinical context. According to Benner and Tanner (1987) ‘knowing’ (p. 26) is a critical component of the nurse’s ability to make sound clinical decisions. Knowing is getting an understanding of the situation in terms of salience, nuances and qualitative distinctions (Tanner et al. 1993). Sound judgements are particularly important in the decision-making process to seclude a patient. Under the Western Australian Mental Health Act (1996), seclusion can only be initiated by a senior mental health practitioner (a health professional with at least 5 years experience in the specialty of mental health) or by a doctor. This policy embodies the importance of ‘knowing’ in those empowered to make the decision to seclude.

This current study was completed at a 50-bed acute inpatient facility authorized under the Western Australian Mental Health Act (1996) and as such accepts both voluntary and involuntary patients. The facility comprises a 10-bed psychiatric intensive care unit (PICU) and two open wards (40 beds). There are 62 full-time equivalent nursing staff (registered and enrolled, comprehensive or mental health nurses).

All participants in this study secluded patients admitted to the PICU. Earlier research reported that during a 3-month period in 1999 18 episodes of seclusion involving 12 (11.6%) of 103 patients admitted to the PICU were recorded. The time any one of these patients spent in seclusion ranged from 20 min to 6 hours with a mean seclusion time of 106 min and a median seclusion time of 105 min recorded (Wynaden et al. 2001b).

OBJECTIVES OF THE STUDY

The study aimed to explore the decision-making process completed by staff surrounding the use of seclusion by: (i) identifying the ethical, legal, professional, environmental, attitudinal, and safety issues that impact on the decision-making processes, and (ii) describing health professionals’ perceptions of the therapeutic outcomes of their decisions.

METHOD

The study was a descriptive explorative study with a purposive sample of seven registered mental health nurses and one doctor. The logic of purposive sampling lies in selecting information-rich cases (Morse 1989; Patton 1990). The opportunity to gather data from participants’ everyday working environment led to the examination and description of participants’ involvement in the seclusion process.

The validity and ethical implications of the study were appraised by the Directorate’s Practice Development Committee and it was determined that the study should be registered as a quality improvement initiative because the findings would provide information to enhance role development and best practice outcomes. Staff members were advised that the study was being conducted and that staff responsible for secluding a patient would be approached to participate. Participants were given an information sheet explaining the purpose of the study. All participants were assured that their confidentiality would be maintained and their participation or non-participation would not effect their current or future employment. Informed consent was obtained from each participant who was then interviewed within 48 hours of making the decision to initiate seclusion of a patient.

Eight staff members were interviewed before saturation occurred and hence the recruitment of participants ceased. Interviews ranged from 30 to 45 min and no participant terminated an interview or withdrew from the study. Transcripts varied in length from five single-spaced A4 pages to eight pages. Each recorded interview was transcribed verbatim by one of the authors. Another member of the team read the transcribed manuscripts while listening to each tape, identifying any transcription errors and making corrections as necessary.

Data analysis

All data from the transcripts were analysed following the standards of qualitative data analysis procedure; that is, coding, finding categories and clustering (Streubert & Carpenter 1999). Transcripts were read line-by-line and significant words and phrases were categorized by three expert nurses. A consensus of categories was then formulated. Following this procedure the major thrust or intent of the transcripts was conceptualized (Field & Morse 1994).

Following content analysis, the research team met to discuss indicators that were used to define and code the
data into categories. Several terms were identified in the data that required further clarification and these terms were discussed with nurses in the clinical setting until a consensus definition was obtained. Field notes were taken by one of the researchers during the research team meeting.

Ensuring trustworthiness of data
Trustworthiness of the data was ensured by researcher checks with other members of the research team. An audit trail was maintained to document all aspects of the study, data analysis and description of the findings.

RESULTS
One female and seven male staff members participated in this study and all were trained in aggression management. Data analysis identified seven major categories: ‘assessment of situation’, ‘participants’ knowledge of patient’, ‘care during seclusion’, ‘termination of seclusion’, ‘care after seclusion’, ‘ability to achieve desired outcomes’, and ‘reflecting on the event’.

Assessment of the situation
The first category, assessment of the situation, referred to the first step in the decision-making process. The category consisted of three subthemes: contextual conditions, the ‘at risk’ behaviour of the patient, and utilizing a management hierarchy.

Contextual conditions
Contextual conditions referred to staff mix and the overall psychological environment of the unit. Staff mix was the number, level, gender, availability, and experience of staff on the unit. Some participants deemed that the staff mix was adequate to implement seclusion and therefore they were confident in managing the situation:

I did not have to ask for backup [from other areas] the staff were there [on the unit]. I advised the patient [that the seclusion was going to occur] and we did it [secluded the patient]. (p. 6)

I was confident in the other male nurse’s skills and even though we were one short of a restraint team it was alright. (p. 3)

Other participants described that in assessing the situation they were concerned with the staff mix on the unit, particularly when there were several inexperienced staff on duty:

The rest of the staff were female and it [the episode of aggression] happened quickly just on handover [change of shift]. We had two students it was their first day on the ward [unit] and a young graduate nurse, and a casual call nurse [agency staff]. So it was the sort of mix that those people would not be as quick as us [regular staff] to respond. They may have been fearful. We were a bit light on overall experience … There was an element of concern about that. (p. 5)

In addition, the participant was concerned that having several inexperienced staff working on the unit, on a regular basis, was becoming more common. Therefore, a decreased infrastructure of experienced staff meant that it was becoming more problematic to manage acutely ill patients in the unit environment:

My own experience gives me a degree of confidence. As far as the infrastructure [staff on unit], it is becoming more problematic. We are more frequently moving into a scenario of where there is one male on [duty] and the male thing is only a part of the issue. The other side of the issue is that the other staff on duty are agency staff or new to the service. There is a problem when staff are not confident, and able to react quickly. There is an increasing potential for risk because of the loss of experience and gender [male staff] in this area. Intervening in a team where people are not capable also carries risks. Feeling confident to manage violence is not totally a gender issue but it is exaggerated by that … We are losing more and more staff and it is getting more dangerous. We work with reduced staff and with much more violence. (p. 5)

The second aspect of contextual conditions was the overall psychological environment of the unit. Participants described the need to assess the impact of the patient’s behaviour on all of the other patients in the unit:

There were factors [to seclude] including at the time a very unsettled ward [unit]. (p. 6)

There were also other manic patients likely to become irritable and then the situation would escalate … We [staff] were not just looking at the patient [that was secluded] we had to look at the environment and other patients as well. (p. 7)

A major concern for participants was that the overall psychological environment of the unit would escalate and staff would not be able to control the patient’s behaviour, or a potentially volatile situation involving other patients may develop:

It was lunchtime there were decreased number of staff, [and] knives, and forks [were freely available in the dining room environment]. There were other manic patients likely to become irritable and then the situation would escalate … It was a matter of containment and looking at safety issues. (p. 7)

‘At risk’ behaviour of the patient
‘At risk’ behaviour of the patient was the second subtheme of participants’ assessment of the situation. ‘At risk’ behaviours were, for example, aggression and violence. One
participant recounted that the patient ‘had been aggressive, hostile, with clenched fists and was intrusive most of the morning’ (p. 8). Another participant gave this account:

I thought her behaviour [trying to abscond from ward] was dangerous behaviour and that was why I decided to seclude her … The patient was threatening, very threatening. She said she was going to bash my head and all of those things. (p. 3)

Furthermore, safety to self and safety to others was assessed by participants as part of the decision-making process:

The seclusion occurred as a result of his violence … Safety to self and safety to others was the basis of my decision. He made it clear that his violence was not going to abate and there were not many staff around. (p. 8)

Utilizing a management hierarchy
The third subtheme in assessing the situation was participants’ utilization of a management hierarchy. Participants used seclusion when all other management strategies were exhausted. These strategies included, for example, persuasion, encouraging the patient to regain control of their own behaviour, the use of medication, stepping-down techniques to avoid conflict, diversion techniques, use of alternative areas (e.g. the garden) to separate the patient:

If I could have isolated her from other patients in the ward [unit] I may not have had to use seclusion, but that was not possible [due to unit acuity]. (p. 4)

Another participant outlined the use of a management hierarchy:

We have a hierarchy of strategies we will use and seclusion is a long way down the hierarchy … You try to use distraction you use the extensive use of courtyards to try to separate people, to avoid conflict amongst people who are likely to irritate each other. You use all of these things prior to seclusion … PRN medication is used as an intervention right down the scale. (p. 7)

Participants also spoke of ‘de-escalating’ a situation: ‘[before secluding] you’ve tried to de-escalate their anger’ (p. 1.). If other management strategies failed patients were sometimes offered PRN medications, to try to calm them down, but many patients refused this offer:

Each time she was asked to have it [medication] or approached to have it she became very hostile and threatening. (p. 2)

Participants’ knowledge of patient
The second category identified as important to the decision-making process was participants’ knowledge of patient. One participant described how his knowledge of the patient was useful:

She was a karate fighter and this was an influencing factor in our discussion to seclude her. She also had a history of karate and judo behind her. We were very aware of that. (p. 2)

Participants’ knowledge of the patient could be historical knowledge, or recent knowledge gained from the patient’s current admission:

The patient had had many admissions and I have known her for 5 years. She is admitted about three times per year. (p. 7)

Another participant gave this account of their recent knowledge of the patient:

The patient had only been in the hospital for 24 hours but staff had spent a lot of time with her during that period … I wouldn’t say I knew her well, but we’ve spent a lot of time with her yesterday afternoon trying to talk her into taking oral medication … We could see how unwell she was, and we did not want to go down the route of having to restrain her. (p. 2)

Knowledge of a patient led some participants to use seclusion rather than use medication:

Today I did not try any medication prior to seclusion as previously medication has not helped. With her it is better to use time out and seclusion. (p. 4)

Knowledge of the patient also alerted participants of the need to protect some staff that participants perceived as vulnerable, most often, as a result of their lack of experience:

He is not my patient but the nurse who was allocated him [for the shift] was an inexperienced female … She probably felt a degree of apprehension as it [aggression] happened so suddenly. I was supportive, I am older and I am male. I had a week of previous engagement with him so he related to me. (p. 5)

Most participants described the use of medication as way down the management hierarchy. In some circumstances seclusion was chosen over the use of PRN medication. Some participants explained that the chemical restraint induced by the use of medication was more controlling for the patient than seclusion:

If we use PRN medication it is like we [staff] are trying to control the behaviour. What we are actually trying to do is have the patient to try to control their own behaviour so that they feel that even though they are out of control she actually has some control. (p. 7)

Another participant used seclusion rather than medication because of his knowledge of the patient. The patient was already disinhibited and the participant believed that the use of PRN medication would further increase his disinhibitions:
The patient was becoming increasingly excitable very much a behaviour-orientated excited rather than a psychotic-based excitable. As a diversion more than anything I persuaded him to take a shower. He did but then wandered the corridor naked, totally disinhibited. At that point I did not want to give him PRN medication as it can have a disinhibiting effect. I laid down firm guidelines with him, put him back in the bathroom asked him to dress ... He continued his behaviour, I placed him in an open side room. Two minutes later he came out so I placed him back and told him if he came out again he would be secluded. Two minutes later he did, so I secluded him. (p. 6)

Participants described that under certain circumstances they used seclusion as a form of behavioural modification rather than medicating the patient:

- The use of drugs or seclusion becomes subjective. I find I would rather use a behavioural technique than chemical restraint [PRN medication] ... He had been secluded this morning as well [rather than medicated]. (p. 6)
- Furthermore, the patient's reaction to the use of medication was considered in making this decision:
  - Six hours prior to the incident [seclusion] he [patient] was given medication by the night staff. That may have led to an increase in his frustration level. He resents medication and there is a lack of insight. (p. 5)
- Participants described using medication rather than seclusion when the extent of the patient's illicit drug use was not accurately known:
  - [Staff] knew that the patient had taken drugs and six glasses of beer but did not know the quality or quantity taken of drugs taken. I did not know this patient or her tolerance to medication, plus her amphetamine and alcohol use, which may have interacted with the medication we were using ... Under the circumstances secluding the patient was the best option. (p. 3)

Care during seclusion

The third category identified was care during seclusion. Participants' knowledge of hospital policies and procedures was central to this process:

- Guided by the policies and procedures, the restraint and seclusion followed the [hospital] protocol [for seclusion]. (p. 8)
- Once the patient had been secluded participants discussed the need for continual care, assessment, evaluation, and changing the management plan when necessary:
  - She was monitored every 15 minutes [hospital policy]. As the initial medications did not work I called the consultant [psychiatrist] and he suggested Acuphase 100 mg, which was given at 21:00 hours. At 22:30 hours she was still angry, banging the door. We said, 'it is late and other patients are getting disturbed'. So we asked her to calm down and gave her 100 mg chlorpromazine orally, which she took. By 23:00 hours she was tiring and calm and drifting off to sleep. At 23:30 hours we opened the door [ceased the seclusion and patient slept in open side room]. (p. 3)

Furthermore, participants discussed ongoing negotiation with the patient during their time in seclusion:

- I followed the management plan and she was in there for 30 minutes. We checked her as per regulation [at least every 15 minutes, more often as required] ... I always tell patients how long they are secluded and if they behave what will happen. I always explain. (p. 4)

**Termination of seclusion**

The next category was termination of seclusion. Participants considered that if the client's behaviour was 'manageable' and there was no longer any risk to the patient, other patients, or staff then seclusion could be terminated:

- We let him out as soon as it was safe to do so. I spoke to him and he was able to reply to me with far less anger and frustration. He was still unpredictable and for the rest of the shift he has been reasonably okay. There are still periods of [high] arousal but he can still be talked down. We have talked to him about how to solve problems and how to deal with them rather than just losing control. (p. 5)

Furthermore, prior to the termination of the seclusion participants described a process of giving feedback to the patient and of gaining a commitment from them to follow their management plan:

- Before seclusion is terminated we [staff] go through the process with the patient just to see how she feels in herself if she is calm or settled ... As a little prompt we will try to give some feedback that is positive in that these are the behaviours we are trying to target on the ward [unit] to minimize the disruption with you. (p. 7)

Care after seclusion

The next category identified in the decision-making process was care after seclusion. Post-seclusion care was important and it was directed at strategies related to the safety of the patient, other patients, and staff. In addition, it involved the care of the staff involved in the seclusion, and assessing whether the goals of the seclusion were achieved. Post-seclusion care consisted of three aspects: post-seclusion debrief, evaluation of the outcomes of seclusion, and consequences of seclusion.

**Post-seclusion debrief**

The post-seclusion debrief was directed to patients who were secluded as well as any other patients who may have witnessed the incident:

- We do a brief post-seclusion debrief, have a chat with them to assess their mental state, to see if they are okay. (p. 1)
Staff members were also debriefed:

The primary nurse was here and we [staff on unit] discussed it [the seclusion] as a group. (p. 4)

However, in some cases it was felt that due to the experience of staff on the unit a debrief was not necessary:

We did not debrief because both of us were very experienced with over 20 years in the area and it was automatic response and therefore, there was no need to discuss anything. (p. 7)

**Evaluating the outcome of seclusion**

Evaluating the effectiveness of seclusion is another aspect of care delivery following seclusion. Participants assessed whether the objectives of the management plan had been achieved and reflected on the effectiveness of the management plan to try to prevent any further use of seclusion with the patient:

It [seclusion] is part of a treatment we use from time to time. I try to look and see if our outcomes have been successful. Is there any other ways we could have done this [managed the patient] and how could we have done it better? (p. 7)

**Consequence of seclusion**

Participants discussed the consequences of using seclusion. These consequences were either observable patient behaviour changes or anticipated but not actualized changes. For example, one nurse observed this behaviour in the patient:

He was remorseful after the incident. When we had him restrained he expressed remorse that he had lost control. (p. 5)

**Ability to achieve desired outcomes**

The ability to achieve desired outcomes of seclusion was the next category and referred to changes in patient behaviours, safety, protection, and creating a ‘manageable’ situation:

He is still difficult, but he is controlling his behaviour. He has been able to discuss what made him angry and we have been able to help him. (p. 5)

The objectives were achieved. He was able to maintain his state following seclusion for 5 hours after. The acuity of the unit increased in the evening by becoming more volatile and that was unsettling for him. (p. 6)

Another participant gave this description:

I think it did work. The next day the patient was a lot calmer. I would say I achieved my goal of keeping the patient safe. (p. 3)

**Manageable**

Participants made frequent references to ‘patients being manageable’. These participants were re-interviewed to obtain a clearer definition of what they meant by the word ‘manageable’. This word was used to refer to two situations. Firstly, a ‘manageable’ situation was where the patient was able to be managed using alternative strategies and did not require seclusion. The patient was deemed ‘manageable’ if they were able to take control of their own actions and they were no longer a risk to themselves or to others. Moreover, for the situation to remain ‘manageable’ the patient needed to be able to follow nursing advice or direction. Finally the term ‘manageable’ was also used to describe the patient after they had been secluded (the outcome of seclusion):

I have not seen the patient today but according to staff she is more manageable and more amiable to us than last night. (p. 3)

**Reflecting on the event**

Reflecting on the event was the final category identified in the data. Reflection occurred throughout the seclusion process. Participants utilized reflection to evaluate the effectiveness of the seclusion, make changes to improve future seclusion events and evaluate their own decision-making processes:

It was a situation that had to be defused quickly or the risk to others was great. In the circumstance of what happened it was handled well. (p. 5)

Another participant reflected in this way:

I don’t like locking people up but it was a professional decision I made. It goes with the job. I believe it was 90% right, 10% I could have done better. It was not the wrong decision … Sometimes in this job you have to make decisions, we have to make snap decisions. I believe at the time it was the right decision. (p. 6)

Participants also reflected on how they handled the situation and this was most difficult when they did not know the patient prior to initiating seclusion:

I think it [the seclusion] could have been handled better. I think the mistake or the hesitancy [participant made in not initiating seclusion earlier] was because I don’t know this patient well. (p. 3)

Another factor reflected on by participants was having ‘no choice’. ‘No choice’ related to participants deciding that there was no other course of action that was available for the care and safety of the patient. Having ‘no choice’ enabled participants to seclude patients without experiencing any misgivings in regards to their actions:

When seclusion is initiated you’ve gone through every choice that you can go through, you’ve actually left with nothing by the time that you’ve made that decision to seclude. You’ve discussed options with the patients …
DISCUSSION

Seclusion remains a controversial management strategy (Holzworth & Wills 1999). In Western Australia, the decision to seclude is made by a health professional deemed to be functioning at an expert level. The results of this study demonstrate that expertise and knowledge are at the forefront of promoting least restrictive management options and that health professionals functioning at the expert level are less likely to initiate seclusion. This finding is supported by Holzworth and Wills (1999) who found that nurses with the fewest years of experience made the most restrictive decisions. In addition, Hantikainen (2001) asserted that novice nurses may have problems coping with patients displaying difficult behaviours and may resort to the use of restrictive management strategies.

The findings of this study showed that participants used a step-wise process in making the decision to seclude and that this process relied heavily on knowledge and experience. These professionals had acquired a high level of ‘knowing’ as described by Benner and Tanner (1987). Two major concepts were present in this step-wise process: being ‘manageable’ and having ‘no choice’. Participants frequently described that the patient, as well as the situation, was ‘manageable’. In keeping the patient ‘manageable’ participants used a management hierarchy, with seclusion being at the bottom of that hierarchy. The hierarchy included, for example, distraction techniques, the extensive use of courtyards or outdoor areas to separate patients, encouraging the patient to regain control of their behaviour, and communication techniques to avoid conflict. Participants continued down this management hierarchy, with the patient, until they reached the point of having ‘no choice’ but to seclude. In keeping the patient and the situation ‘manageable’, participants used key aspects of intuitive judgement outlined by Benner and Tanner (1987). One of these aspects, pattern recognition, was the participants’ ability to recognize relationships, for example when the patient started to display certain behaviours their ability for self-control was decreased. In addition, participants described that their decision to seclude was based on the fact that seclusion had been successful when used in similar circumstances in the past. According to Benner and Tanner (1987), the ability to make connections between objective features of the past and current situations is also an important aspect of intuitive judgement.

Several external factors were identified that impacted on the step-wise process used by participants to keep the patient ‘manageable’. These factors included, the level, experience, expertise, and numbers of staff, the increase and acuity of patients. Patients were sometimes secluded, earlier than they normally would have been, if there were several inexperienced female staff or a decrease in the usual number of male staff on duty. The decision was further accelerated up the management hierarchy if there were also agency or casual staff present. Participants described this staff mix as making the working environment unsafe and potentially dangerous. Therefore, safety became the paramount issue in the decision to seclude. This reason for initiating seclusion has long been a topic of debate (Muir-Cochrane 1995). If seclusion is used proactively as a means of protecting others from patients who may become violent, this may be perceived as an infringement on patient’s rights as accurate predictions of violence are questionable (Morrison 1993). While the concepts of beneficence and non-maleficence remain controversial their justification through the use of seclusion remains debatable in the current philosophy of mental health care delivery. Therefore, continuing education is needed among health professionals to better manage potentially violent patients. Moreover, participants' knowledge of the patient was important to the decision-making process. This finding suggests that if least restrictive practices are to be promoted with acutely ill psychiatric patients then health services and policy makers need to develop strategies that encourage experienced nurses to remain in the profession. The staff mix and the numbers of casual staff working in intensive care units may need to be reviewed.

Another finding was that participants often decided to seclude rather than medicate the patient. Seclusion has often been criticized because of the control it exerted over patients (Farrell & Dares 1996) and seclusion, referred to as solitary confinement in the penal literature, had been identified as an effective method to punish, control, or extinguish deviant behaviours (Bauer et al. 1993). In contrast, to these views, of seclusion as an agent of control, participants in this study used seclusion as an alternative to administering PRN medication, as a means of allowing the patient to regain control. Participants agreed that although deciding to seclude rather than to use PRN medications was a very subjective decision, they were swayed to use seclusion for several reasons. These reasons included an increased frustration level experienced by patients when they were given PRN medication, and allowing the patient to regain control over what was happening to them. Therefore, participants viewed the use of PRN medication as imposing the most restrictive management strategy on the patient. This is contrary to many earlier findings that suggested that seclusion was used to control patients who were unable to control themselves (Craig et al. 1989). Participants equated the use of PRN medication to taking control away from the patient, while they viewed seclusion
as allowing the patient the possibility of regaining control through negotiation to cease the seclusion.

Another factor impacting on the participants’ decision to seclude rather than to medicate was the unknown effect of giving medication to the patient. This was particularly pertinent when managing dual diagnosis patients who presented after using unknown quantities of drugs (e.g. amphetamines). As patients with a dual diagnosis are increasingly being cared for in the acute psychiatric setting, more research needs to be conducted to evaluate alternative management strategies with this group of patients when they present with behaviours that are assessed as ‘risk behaviours’.

Reflection was an important component of the clinical decision-making process as the situation often occurred suddenly, without much warning for participants. Hence, reflection provided participants the opportunity to review what had happened and how in the future they could better manage similar situations.

Limitations
This study was completed at one health service and therefore the results may be influenced by the philosophy of care that governs the use of seclusion at that service. However, the findings do provide a new understanding of the decision-making processes surrounding seclusion and may be useful to all health professionals.

CONCLUSION
This study provides a valuable insight into the decision-making process completed by health professionals when secluding a patient. The depth and scope of the decision-making process reinforces the importance of who in the health care system is given the power to make such decisions. This study supports current practice in many health services that the person should be functioning at the expert level.

The findings provide insights into why health professionals initiate seclusion with some patients and many of these reasons are directed at allowing the patient to regain self-control. However, the findings also support previous findings that some patients may be secluded for utilitarian principles of doing the greatest good for the greatest number of people (Muir-Cochrane 1995) and further discussion needs to occur to find alternative answers to managing clients secluded under this premise. The attraction and retention of highly skilled staff appears to be critical to answering this problem.

ACKNOWLEDGEMENT
The authors would like to thank the eight health professionals who participated in this study and Larry Ayoub.

REFERENCES


Western Australian Mental Health Act (1996). Western Australian Government Printers, Perth, WA.

