Mental Health Foundation OF NEW ZEALAND
mauri tū, mauri ora

The absolute minimisation of restraint across mental health settings

Position statement

September 2023

Phone: 09 623 4810 | www.mentalhealth.org.nz

Eden 3, Ground floor, 16 Normanby Road, Mount Eden, Auckland
PO Box 10051, Dominion Road, Auckland 1446

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Restraint should be absolutely minimised in mental health settings across Aotearoa

Policy & Advocacy
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The Mental Health Foundation (MHF) does not support the use of restraint in mental health services, and we advocate for:

1. In the short term, additional scrutiny and improved national reporting to stop the inequitable use of restraint practices on certain population groups, particularly tāngata whaiora Māori.
2. In the long term, the absolute minimisation of restraint practices within ten years of the forthcoming new mental health legislation coming into force.

Purpose

This paper sets out the MHF position on the current and future use of restraint in specialist mental health facilities in Aotearoa.

What are restraint practices?

Restraint is the use of any action to limit a person's normal freedom of movement in mental health settings. It is designed to be used as an emergency measure to manage and control aggressive behaviour or agitation in mental health settings (RANZCP, 2021). The Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Mental Health Act) permits the use of force, with section 122B outlining the circumstances in which force may be used and that it must only be "such force as is reasonably necessary in the circumstances."

The following types of restraint practices are used in Aotearoa mental health settings:

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1. **Personal restraint**, where a service provider uses their own body to intentionally limit the movement of a person.[1]

2. **Physical restraint,** where a service provider uses equipment, furniture or devices that limit a person's normal freedom of movement,[2] such as using straps to tie someone to a bed or chair by their wrists, waist, shoulders and/or ankles, and using mittens to stop people using their hands.

3. **Chemical restraint,** where medication is used for the sole purpose of controlling a person's behaviour or restricting their movement.

Restraint data is not consistently or routinely collected or reported on in Aotearoa, but inspectors and academics have observed an increase in the use of restraint (Office of the Ombudsman, 2020), despite it resulting in injury and causing further psychological trauma and cultural harm to tāngata whaiora.

MHF position

While the current legal framework is in place, the MHF recommends additional non-statutory scrutiny be introduced, including local and national review, monitoring and reporting to significantly stop the inequitable use of restraint practices against populations groups, especially Māori.

Specifically, we recommend:

- **Framing the use of restraint practices within inpatient units as a service failure, with each incident triggering an external review and debrief with the person, whānau, peers and clinicians.** The review should explicitly examine racial and gender bias and seek to determine what service and practice improvements and resources are needed to provide safe and effective alternatives.

- **Introducing national guidelines for the consistent collecting and reporting of restraint practices across regions and by service user demographics and making this information publicly available.** Data should be collected on types of restraint practices, the absolute numbers of restrained people, how many

[1] In other jurisdictions personal restraint is called physical restraint.
[2] In other jurisdictions physical restraint is called mechanical restraint.

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> times they were restrained and for how long, counts of restraint incidents and people restrained per day per 1 million population, and statistics on duration for each type of restraint incident (Newton-Howes, 2020).

- **Annual review and publication of the effectiveness of implementing strategies (e.g., Six Core Strategies) to reduce restraint practices and their impact on injury and assault rates.**

It is unacceptable that despite a strong national standard that requires inpatient services' strategic plans to have an objective that aims for a restraint-free environment (Health, 2021), there remains no consistent reporting of national restraint data, or an understanding of the divergence in the use of restraint practices across regions and their use on Māori and Pacific Peoples in particular.

> *I would note that good data is absolutely essential if any meaningful change is to be achieved. I would also suggest that transparency is a critical element for achieving any change.* (Shalev S. , 2020)

In the long term, the MHF supports the absolute minimisation of restraint practices. This should be enforced through legislative reform and come into effect no later than 10 years from commencement of new legislation. We believe a firm legal commitment is necessary to provide the impetus needed to make substantive gains, in a timely manner, to the way people are supported when they are severely mentally unwell.

This position contrasts with the MHF's support for the elimination of solitary confinement (seclusion) in law as soon as possible. We believe Aotearoa is now in a position to ban solitary confinement because there has been more than a decade's deliberate work to change practices and a target date set for its elimination. A similar programme of work is still required to enable Aotearoa to absolutely minimise restraint practices as much as we can and as fast as we can.

Our position on restraint practices accepts:

a) restraint practices are a broad category that exist across a spectrum of activity (from locking a door to sedative medication), and

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b) there may be an exceptionally small number of cases where the use of limited restraint practices might be necessary for a short period of time, for example for a person's safety. However, this should only occur within a legal system that upholds strict regulation and scrutiny of these cases to ensure any restrictions on a person's rights are absolutely necessary, applied in the least restrictive manner and for the shortest time possible.

The MHF supports the recent Government announcement for regions to create multi-agency response units for mental health crises that are health-based, peer-led, and include the support of the police where necessary. The MHF has long supported responses where police presence at mental health crises are the exception and not the rule. The manner in which people are supported in a crisis is crucial to their recovery (Boscarato, 2014). Police are not usually best-placed to respond to those in crisis because their involvement often leads to coercive pathway into care, in some cases with the use of force, such as handcuffs or other restraint practices.

Rationale

1. Restraint practices have no therapeutic benefit and can be harmful

It is recognised that restraint practices have no therapeutic benefit and can be harmful both for people experiencing mental distress and staff (Manatū Hauora-the Ministry of Health, 2023). The types of harm include psychological trauma (including re-triggering existing traumas), physical injury, death, cultural harm[3] and damage to therapeutic relationships (Kinner et al., 2017; Brophy et al., 2016). Solitary confinement and restraint practices also diminish people's sense of autonomy and dignity (Barnett, Stirling, & Pandyan, 2012).

No use of restraint practices is completely safe. Personal restraint has physical health risks for the person being restrained that can result in injury or death (Newton-Howes, 2020). In general, people with experience of severe mental distress factors have

[3] Cultural harm has been defined as "conduct that results in, or contributes to, the breakdown of the spiritual, moral, physical and emotional wellbeing of indigenous peoples or members of other groups sharing an ethnicity or cultural identity and includes racist conduct." From https://royalsociety.org.nz/assets/Uploads/Code-of-Prof-Stds-and-Ethics-Revision-2.pdf, accessed 19 July 2022.

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poorer physical health, which puts them at higher risk of physical harm occurring during a restraint incident.

Children and young people are uniquely vulnerable to restrictive practices, which can cause physical harm, negatively affect their development and risk creating or reviving trauma. Research has shown that young people are at a higher risk of injury or harm resulting from restraint practices (Mohr, Petti, & Mohr, 2003).

2. Use of restraint practices breaches Te Tiriti o Waitangi

Restrictive practices used against Māori are a violation of Te Tiriti o Waitangi. Use of restraint practices on Māori infringes on rangatiratanga and wairuatanga and it further harms and perpetuates the fear many Māori have of the mental health system and services.

3. Restraint practices are inconsistent with international declarations

Aotearoa New Zealand has been criticised for the ongoing use and high rates of seclusion and restraint in our mental health services, both by the United Nations Committees for the CRPD (UN Disability Committee 2014) and the Convention Against Torture & Other Cruel, Inhuman and Degrading Treatment (UN Committee Against Torture 2015), and by local monitoring organisations such as the New Zealand Human Rights Commission (2020) and the Ombudsman (2020), which, along with the Disabled People's Organisations Coalition (DPO Coalition), form the Independent Monitoring Mechanism (IMM).[4] The IMM has also called for the repeal and replacement of the current Mental Health Act and the reduction and then elimination of seclusion and restraint (DPO Coalition, Ombudsman and Human Rights Commission-Te Kāhui Tika Tangata, 2022).

4. Successful approaches show restraint practices are not a necessary element of psychiatric care

There are local, national and international efforts to minimise or abolish restraint practices. Examples of such efforts include initiatives such as the Heidenheim Mental Health Service in Germany (Zinkler, 2016), Trieste in Italy (Mezzina & Vidoni, 1995), the

[4] The IMM works to promote, protect and monitor implementation of the CRPD in Aotearoa New Zealand with the aim of helping to make disability rights real.

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York Retreat in England (Charland, 2007) and the Soteria project initiated in the United States (Mosher & Bola, 2002). These longstanding, successful non-coercive approaches suggest that practices such as mechanical restraint are not a necessary element of psychiatric care. Each project has regional variations, but the central principle is to respect individual human rights and abolish restraint practices.

5. **Evidence restraint practices are not used in line with best practice guidance in Aotearoa**

Restraint practices have been framed as a 'last resort' in guidance for some time but evidence suggests they are used before other non-restrictive approaches have been tried and failed (Shalev S. , 2017). We are concerned that 'last resort' implies restraint is still a legitimate option and is too open to interpretation by practitioners. There is evidence that in Aotearoa these practices are not used during emergencies or as a last resort and for the shortest time possible (Shalev S. , 2020), and that inconsistent use of terminology and definitions across regions justify variations in practice.

Internationally, people subjected to physical restraint perceive it as punitive, abusive, and unethical, and locally, tāngata whaiora have told us it had been misused on them, for example to control unwanted (but not dangerous) behaviour or as punishment. Tāngata whaiora told us they felt restraint practices are used to control their behaviour rather than to manage safety.

> *"…they just chemically restrain people you know if you don't behave…the way they want you to behave. They just pump you full of medication and then you definitely don't say anything or do anything, you just sit in the corner dribbling, literally dribbling. …."*
> (Participant at tāngata whaiora hui)

> *"If they…do do restrictive practice or they put you in seclusion there's no accountability there. They're not accountable to anyone but themselves…there needs to be an external party involved that oversees the accountability because at the moment they're using restrictive practice… for me they used it to control my behaviour when it didn't suit their needs… it wasn't around risk it was around controlling behaviour."*
> (Participant at tāngata whaiora hui)

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"…I get it if someone's extreme danger to self or others there needs to be some kind of restriction…if there has been a restriction they need to be able to prove that in court of law that yes that person was an absolute danger to self or others"
(Participant at tāngata whaiora hui)

Appendix

National rates of restraint practices

The little restraint data that is collected is done so manually from Te Whatu Ora (formerly, district health boards). This data from 2020/21 is incomplete, as data was unavailable from four of the former district health boards and there are inconsistencies in the data. The incomplete data available however shows 1,934 individuals were restrained for a total of 6,769 restraint events (Manatū Hauora-the Ministry of Health, 2023).

A 2020 independent report into seclusion and restraint practices in Aotearoa notes national data on restraint use was not currently collected, but plans were underway to introduce national reporting (Shalev S. , 2020).

The same report did spotlight the use of restraint practices by one DHB by way of illustration:

> *Between September 2019 and February 2020 restraints were used 358 times. More than half of these uses were with female service users, and 42% were Māori service users. The majority of restraint uses involved personal holds, but close to a third (114) of the uses involved prone restraints, where the person is held chest down, including several very lengthy holds – 1463 minutes in one case, 290, 100 and 125 minutes in others.*
>
> *These, clearly, are incredibly long times, especially considering that because of the health risks associated with prone restraints, international good practice suggests that they should only be used in exceptional, emergency situations.*

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In a comparative study, Newton-Howes et al (2020) used data collected from DHB OIA material to compared against international rates of *mechanical restraint* in 2017. The study found New Zealand had the lowest rates across the four countries (restraint events per million population per day were 0.03 (New Zealand) to 98.8 (Japan), Australia (0.17 events per million) and the United States (0.37 events per million) fell between these two extremes). Variation as measured by restraint events per 1000 bed-days was less extreme but still substantial. Within all four countries there was also significant variation in restraint practices across districts. Variation across time did not show a steady reduction in restraint practices in any country during the period for which data were available (starting from 2003 at the earliest).

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