

Submission to independent follow-up review of seclusion and restraint practices in Aotearoa New Zealand

20 May 2020

Introduction

Thank you for the opportunity to provide a submission to your follow-up review to identify where seclusion and restraint practices in Aotearoa New Zealand have progressed, and where improvements are still required.

We note there have been several positive steps towards the reduction of seclusion since your first report *'Thinking outside the Box? A review of seclusion and restraint practices in New Zealand'* in 2017:

- the Mental Health and Addiction Inquiry, *He Ara Oranga*, heard people talk about the harm and powerlessness they experienced through practices of seclusion and restraint and recommended full legislative review
- the government has committed to the repeal and review of the Mental Health (Compulsory Assessment and Treatment) Act 1992 'the Act'
- the Ministry of Health has consulted on an update to the guidelines that support the implementation of the Act, and
- the Health Quality and Safety Commission have been leading a quality improvement programme to reduce seclusion and restraint.

Overall, however, there is much work to be done, particularly for Māori. There is no indication we are close to achieving the national zero-seclusion goal by 2020 and the Mental Health Commissioner's monitoring indicator report for 2017/18 suggests services have much work to do to improve seclusion practices.¹

¹ Health and Disability Commissioner. (2019). *New Zealand's Mental Health and Addiction Services: Monitoring indicator update 2017 & 2017/18*. Wellington, New Zealand: Health and Disability Commissioner.

Our submission primarily concerns the practices of mental health services, and discusses the following points:

- The importance of hearing and learning from those with lived experience to inform your findings and recommendations.
- Honouring Te Tiriti o Waitangi by actively engaging with Māori to inform the findings of the review, question and assess how DHBs are working to reduce the rate of seclusion and restraint for Māori and provide specific recommendations targeted at reducing the high rates for Māori.
- Investigate and assess DHB practices and systems that can support or hinder zero-seclusion.
- Brief comment on some of the recommendations from the 2017 review, including the option of staged reduction targets for seclusion.

The Mental Health Foundation (MHF) is not a service provider but our feedback includes the voice of those with lived experience of the Act, including of seclusion and/or restraint practices, gained through a) consultation hui in 2019 with Māori tāngata whai ora, whānau and clinicians, and b) specific feedback given to us in response to this current review.

Comment on the 2020 review – terminology, process and scope

Terminology

We suggest the review uses the term 'tāngata whai ora' (meaning a person seeking health) rather than 'patient'. The term 'patient' is clinically focused and reinforces a medical model of health, and is inconstant with the shift towards a holistic and trauma-informed approach to care and wellbeing.

People with lived experience

'Thinking outside the box?' (2017) notes people who have experienced seclusion and restraint practices shared their thoughts and views as part of the review, but it is not clear how many people you heard from or what weight was given to their feedback compared to that of health professionals or staff at mental health facilities. People who have experienced seclusion and restraint practices will have important insights into what needs to change, and this should be taken into account in the current review. In doing so, as with usual good practice, consideration should be given to what support may need to be available to people who share their stories as the process may be distressing for some. Seeking lived experience views during COVID-19 but also in the months post-COVID-19 may also pose additional challenges and stresses that you will no doubt be cognisant of. We understand the Health Quality and Safety Commission are in the process of developing narrative videos with tāngata whai ora about their experiences of seclusion and what they think could have avoided it, which will be pertinent to this review.

Māori tāngata whai ora

The Human Rights Commission, in commissioning this review, must recognise the importance of Te Tiriti o Waitangi and, with its stated Te Tiriti-based aspirations, seek to achieve equity for Māori and maximise their wellbeing. As one person with lived experience puts it: "I think this part [reducing the high rate of seclusion for Māori] is going to take the most work and needs a lot of pushing or developing, redesigning, training...".

The experiences of one Maori tāngata whai ora just this year, shared with us as part of this submission, demonstrates the lack of understanding by staff about the importance of Te Tiriti and building cultural competency:

"I was questioning the nurses...and was sobbing stories about how I felt I was getting the much shorter end of the stick as a Māori in the system. It usually went back to 'there's a lot of other cultures we have to think about, not just Māori'...or....'we have to be respectful to other cultures too'. I felt the security guards understood more than the healthcare professionals and they were from different backgrounds. Some seem quite defensive of the mental health system and fail to even attempt to take down their guard to allow a different perspective."

While our comments in this section focus on mental health services, our feedback applies to all other detention contexts within the scope of this review, including under Police, Corrections and Oranga Tamariki.

Firstly, we recommend the current review seek out and give weight to feedback from tāngata whai ora, clinicians and services, particularly those who demonstrate culturally safe care so we can all learn from their good practice examples.

Second, it would be useful to better understand how DHBs are working to reduce the rate of seclusion and restraint for Māori. This should include an assessment of how services are incorporating evidence-based practice to reduce seclusion and restraint for Māori, such as enhancing Māori leadership, prioritise the involvement of Māori staff in care and treatment, build early intervention by specialist Māori staff into clinical pathways, increase Māori peer support staff, upskilling the Māori and non-Māori workforce (including cultural competency training, supervision and support), and increase the use and availability of tikanga Māori approaches and cultural healing practices.²

Thirdly, we recommend the review seeks to include specific findings about how to reduce seclusion and restraint for Māori. This will allow the report to recognise the complex array of factors that influence the high rates of seclusion and restraint for Māori (e.g., the impacts of racism/racial stereotyping and inter-generational trauma, poor access to community-based mental health care, and Māori being more likely to be acutely unwell when entering in-patient facilities etc). Wide-reaching recommendations addressing systematic problems should be considered, such as the responsiveness and cultural safety of early intervention and community mental health services, as well as more practice-specific recommendations such as kaupapa Māori models of care to support tāngata whai ora.

² Wharewera-Mika, J., Cooper, E., McKenna, B. et al. (2013). *Strategies to reduce the use of seclusion and restraint with tangata whai i te ora*. Auckland: Te Pou o Te Whakaaro Nui. <https://www.tepou.co.nz/uploads/files/resource-assets/strategies-to-reduce-the-use-of-seclusion-and-restraint-with-Maori.pdf>

Scope

Similar to the above, the review could consider assessing a broad range of DHB practices and systems and how they support, or do not support, a zero-seclusion environment. This should include a range of evidence-based strategies³, for example:

- strong leadership to reduce and eliminate seclusion, including peer and cultural leadership
- organisational commitment to eliminating seclusion and culture change with emphasis on recovery, equitable outcomes, trauma-informed care and human rights
- workforce competence and capability to deliver effective responses for people experiencing agitation, aggression, substance intoxication, or withdrawal, and psychosis
- development of the peer support workforce
- adequate staffing levels, resourcing, support and supervision
- engagement and comprehensive assessment with tāngata whai ora as early as possible to support an individualised wellbeing plan that is responsive to people's distress (two-thirds of seclusion episodes occur within 48 hours of admission).

We received the following feedback from people with lived experience that you may wish to consider within the scope of the current review:

- a) The over-use of medication should be considered a form of restraint ('chemical restraint'), both within in-patient and community-based settings, and the increased risk of chemical restraint being an unintended consequence of efforts to reduce seclusion:

³ Te Pou o Te Whakaaro Nui. (2018). Evidence update for reducing seclusion in New Zealand

<https://www.tepou.co.nz/uploads/files/resource-assets/Seclusion%20evidence%20FINAL%20november%202018.pdf>

"I also observed community nurses, seem to be keeping their clients on meds. For maybe longer than necessary. I recall one such case. Where I'd suggested that one person I was supporting could possibly have a reduction in their meds. I don't think this occurred at all. Now I realise I'm not a clinician. But I wondered if this could be considered a community version of seclusion. Which might also be a breeding ground for stigma." *Lived experience feedback*

"the way my medication was prescribed and my side effects monitored made me feel unheard, devalued and like my body didn't even belong to me....I reckon whatever horse tranquiliser they gave me in seclusion was scary, unnecessary and the dose was too high for my body." *Lived experience feedback*

- b) Although the Act allows the use of force in certain emergency situations, in practice, force is used for a range of purposes, sometimes unlawfully, such as forcing a person to comply with assessment and treatment - "When used in this sense it isn't 'restraint' at all; it is physical assault. I feel this is something we need to acknowledge and be very clear about, rather than pretending it doesn't happen" (*Lived experience feedback*). This suggests the review could take a broad mandate in investigating current practices that use force.

Comment on relevant recommendations from 'Thinking outside the box?'

Recommendation on commitment to reducing and eliminating seclusion

The MHF fully supports the Zero seclusion project aiming to eliminate seclusion by 2020. As the project assesses its future direction, we consider there is scope for staged reduction targets going forward that are realistic and can get buy-in from clinicians and DHBs as achievable outcomes, for example, a 20 percent reduction by 2022, 50 percent by 2024, and 90 percent by 2026.

In addition, if a zero-seclusion goal is to be achieved, it should be supported by mental health legislation that prohibits seclusion practices. As *He Ara Oranga* notes, while legislative change cannot be the sole driver of changes in practice, if government commitment to recovery and people-centred services is to be meaningful, it must be supported by our mental health laws. However, there is a risk progress on legislative reform could be left to languish with no clear timeframe announced, and with no cross-party commitment to such a review. It would be useful for the current review to acknowledge the need to not lose traction on the gains made and the importance of progressing legislative changes promptly.

We were pleased to see the draft guideline revisions for the Act (as of January 2020) acknowledge seclusion has no therapeutic value and can be damaging and traumatising. Lived experience feedback given to us is that the consequences of seclusion and restraint can be devastating.

"...restraint, physical assault and seclusion present significant problems in terms of reinforcing existing fears or earlier trauma. Someone who has survived childhood abuse will potentially be severely retraumatised by these practices. A person with psychotic beliefs around persecution and torture is likely to feel that their worst fears have now been realised – they are really being forced to do things against their will. Someone who is [suicidal and depressed] may have an even greater wish to die." *Lived experience feedback.*

In our submission to the Ministry's draft guidelines we recommended a new target date for the elimination of seclusion be included in the guidelines and clinicians should be strongly encouraged to be aware of this goal and engage with DHBs and inpatient services as they work towards it.

'*Thinking outside the box*' noted the high levels of risk aversion by DHBs and clinical staff. We also see the role of the media and public scrutiny in contributing towards risk averse cultures within DHBs, particularly biased media reporting and stigmatising descriptions of people with mental distress as violent, dangerous and unpredictable. Some graphic and over-reported narratives published by media outlets paint pictures of a mental health system where tāngata whai ora are violent aggressors and medical staff helpless victims.

These narratives can appear to substantiate the need for seclusion and restraint as safety mechanisms in the public mind. In reality, both medical staff and tāngata whai ora are disadvantaged by an under-resourced mental health system which can rely on the over-use of seclusion in lieu of more therapeutic, yet time-consuming, methods of de-escalation. Readers of these media narratives only see one side of the story.⁴

"We have seen media reports (e.g. on *Stuff*) of staff who have suffered physical injuries. Patients likewise sustain injuries, and if they are being held against their will, they are not in a position to visit a GP or the media in order to have such injuries independently recorded." *Lived experience feedback*.

"Violent and dangerous people are chucked in the same crazy basket as me – what a stigma. My arm got hurt during restraint even when I wasn't once violent towards any staff member there – that shit was unnecessary and can be easily covered up the 'must have been crazy' to have my arm hurt by a healthcare professional. No apology for that either way. If it were the other way around and I hurt one of them, I wonder if it would be addressed differently." *Lived experience feedback*.

Recommendation for national oversight and prolonged use of seclusion

We support the need for a national multidisciplinary oversight mechanism particularly to avoid long-term use of seclusion. We see an opportunity for the new Mental Health and Wellbeing Commission to contribute to a national monitoring role, such as part of the multidisciplinary mechanism you recommend. This would appear to fit within the powers of the Commission as outlined in the current Bill to "publicly report on any matters concerning the mental health and wellbeing of people in New Zealand; and make recommendations to any person (including any Minister) on any matters concerning mental health and wellbeing".⁵

⁴ See Stuff (2019) *Experts say mental health patients are not to blame for a rise in violence in hospitals* for a full discussion of this issues

<https://www.stuff.co.nz/national/health/112228412/focus-mental-health-patients-are-being-unfairly-scapegoated-for-a-rise-in-violence-in-hospitals-around-the-country-js->

⁵ Section 12 of the Mental Health and Wellbeing Commission Bill

<http://legislation.govt.nz/bill/government/2019/0188/latest/LMS281163.html>

We also note the Ombudsman, in his National Preventative Mechanism role under the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), monitors and inspects places of detention, including mental health inpatient and forensic facilities.

In lieu of legislative reform, we remain concerned that procedures outlined in *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*, place no limitation on the long-term use of seclusion and restraints, although some safeguards are in place.

Your recommended changes to section 7.1. of the Ministry's seclusion guideline has been incorporated (the number of clinicians to authorise the termination of seclusion has changed from three to two) but the recommendation to amend section 7.2 does not appear to be incorporated. We consider this could be done quickly and prioritised to be achieved in 2020.

Recommendations on DHB data and inconsistency of practice

In response to an Official Information Act request in 2019 to DHBs on the use of seclusion and restraints in mental health units, we received such variation in information from each DHB due to different reporting methods that it made comparisons between DHBs impossible. We note the Health Quality and Safety Commission is undertaking work with DHBs to capture and understand trends and variations in seclusion practices, including producing a publicly available data dashboard.

In our submission on the revised guidelines we asked the Ministry of Health to explore whether changes to the seclusion reporting template (in *Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992*) could be amended to provide a checklist of factors that may provide insight into the factors that influenced the use of seclusion for each case, such as de-escalation, tikanga Māori approaches, peer support workers, and use of alcohol and other drug detox facilities etc. Currently there is a blank space to give a detailed account of the event but this is unlikely to prompt health professionals to provide all the necessary details to understand what led to the use of seclusion in the first place.

Recommendations on seclusion environments

While seclusion is a permitted activity, we support your 2017 recommendations about the physical environment of seclusion rooms and access to basic provisions that may also help to mitigate the harms of seclusion. That these basic requirements are at times not being met is highlighted by a 2019 Health and Disability Commissioner opinion⁶ that found a woman in seclusion at Southland DHB was denied clothing and bedding, and the lights were left on overnight.

The quote below detailing a person's recent experience of seclusion also suggests the lack of basic care and compassion of those in seclusion continues to be a problem:

"It was a tough experience because I felt I was tranquilised and then pretty much forgotten about – didn't have the energy to go and get water or food even if I was hungry or dying of thirst and I felt forgotten about....collapsed while showering and was left lying on the bathroom floor because I couldn't get up because I was still coming off that stuff. And no one knew or came to check. A friend I made in there was a saviour at the time because she was bringing me water, orange juice, food...and checking on me, where the nurses only checked on me when it was time to take my blood pressure."
Lived experience feedback

Lived experience feedback also supports the recommendation for tāngata whai ora to be allowed to keep some personal belongings inside seclusion rooms. One person described to us a situation in 2018 where a woman at an in-patient facility was forced to removed her taonga (treasured) bone carving that was her connection to her deceased grandfather as this was hospital policy and she attempted to end her life/self-harm each time her bone carving was forcibly removed.

⁶ Health and Disability Commissioner case 17HDC00410. Note the events took place in 2013.

Finally, we emphasise the need for seclusion procedures to incorporate cultural practices to support the wairua (spirit) of those in seclusion rooms, and to record this so practice is consistent between staff shifts, and where possible, services should consult with Māori (e.g. peer support or clinicians) to help assess the individual needs of Māori in seclusion.

Summary

Thank you again for the opportunity to provide feedback, especially the voice of lived experience, to help inform this expert follow-up review. We recognise the commitment and progress being made by key groups to achieve zero-seclusion in Aotearoa New Zealand, but there is some way to go and independent expert reviews such as this are fundamental to supporting the ongoing commitment needed in this area.

If you have any questions regarding our submission please contact Olivia Stapleton, Senior Policy Analyst, at olivia.stapleton@mentalhealth.org.nz or on 022 362 7674.



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About the Mental Health Foundation

The MHF's vision is for a society where all people flourish. We take a holistic approach to mental health and wellbeing, promoting what we know makes and keeps people mentally well and flourishing, including the reduction of stigma and discrimination (particularly on the basis of mental-health status).

The MHF is committed to ensuring that Te Tiriti o Waitangi and its Articles are honoured, enacted, upheld and incorporated into our work, including through our Māori Development Strategy. We are proud that Sir Mason Durie is a Foundation patron.

The MHF takes a public health approach to our work, which includes working with communities and professionals to support safe and effective suicide prevention activities, create support and social inclusion for people experiencing distress, and develop positive mental health and wellbeing. Our positive mental health programmes include Farmstrong (for farmers and growers), All Right? (supporting psychosocial recovery in Canterbury, Kaikōura and Hurunui), Pink Shirt Day (challenging bullying by developing positive school, workplace and community environments), Open Minds (encouraging workplaces to start conversations about mental health) and Tāne Ora (working with tāne Māori and their whānau to build wellbeing skills). Our campaigns reach tens of thousands of New Zealanders each week with information to support their wellbeing and help guide them through distress and recovery.

We value the expertise of tāngata whai ora/ people with lived experience of mental distress and incorporate these perspectives into all the work we do. Established in 1977, the MHF is a charitable trust, and our work is funded through donations, grants and contract income, including from government.