Mental Health Foundation OF NEW ZEALAND
mauri tū, mauri ora

Ending solitary confinement across mental health settings

Position statement

November 2023

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Position paper: Solitary confinement should not be used in our mental health services.

Policy & Advocacy
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The Mental Health Foundation (MHF) advocates for the end of solitary confinement (seclusion) in mental health services across Aotearoa New Zealand.

This prohibition needs to be supported by adequate resourcing of services and changes to delivery models and practice approaches, building on the decade-long Zero Seclusion project and success of services that have eliminated solitary confinement at times.

Ending solitary confinement can result in better outcomes for tāngata whaiora, whānau and health workers.

Purpose

This paper sets out the MHF position on the use of solitary confinement in mental health facilities across Aotearoa New Zealand.

What is solitary confinement?

Solitary confinement (or seclusion) is any practice where a person experiencing severe mental distress is isolated from other people (apart from staff) and confined, often in a low-stimulus environment/room which they cannot freely leave.

This practice is permissible under the Mental Health (Compulsory Assessment and Treatment) Act 1992, but the law stipulates it should only be used as a last resort.

We use the term "solitary confinement" to describe the use of seclusion in mental health facilities across Aotearoa New Zealand because it more accurately reflects what people experience when they are locked in spaces they cannot leave. We think *seclusion* may hold some positive connotations that do not align with the experience of being held in solitary confinement.

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Solitary confinement in Aotearoa New Zealand

According to the Ministry of Health's Office of the Director of Mental Health and Addiction Services Regulatory Report (2023):

- Between July 2021 and June 2022, 9.9 percent of those using adult mental health services in Aotearoa experienced solitary confinement.
- The total number of people who experienced solitary confinement has decreased by 26.9 percent since 2009. However, the number of Māori who have experienced solitary confinement has increased by 47 percent over the same time period.
- Māori were 5.5 times more likely to be put into solitary confinement than non-Māori, and for longer periods of time on average. This represents an increased rate over time, and with the rate for non-Māori having decreased, it demonstrates increasing inequity in the use of solitary confinement.
- Those aged between 20-29 were the most common age group to be put into solitary confinement.
- Males are still twice as likely as females to experience solitary confinement overall.
- Those aged 19 and under also experience solitary confinement, with a total of 90 rangatahi/young people having 184 solitary confinement events during the year.

Positively, some regions have made significant progress to reduce solitary confinement, with some eliminating it altogether for a period (Health Quality and Safety Commission, 2021).

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MHF position

The MHF advocates for the elimination of solitary confinement practices within mental health services across Aotearoa New Zealand.

Rationale

Solitary confinement is harmful to tāngata whaiora.

Solitary confinement is completely inappropriate, traumatic and harmful for consumers, whānau, visitors and health workers. It poses significant risks to tāngata whaiora including death, re-traumatisation, loss of dignity and other psychological harms (Gagnon, Kern, & Mathur, 2022; Siennick, Brown, Mears, & Clayton, 2023; Andrew, Fisher, & Beazley, 2019; Hawsawi, Power, Zugai, & Jackson, 2020; Ombudsman, 2022). It contradicts recovery-focused and trauma-informed approaches and violates human rights (Te Pou, 2022; Chieze, Hurst, Kaiser, & Sentissi, 2019; Mellow, Tickle, & Rennoldson, 2017).

Feedback from tāngata whaiora in 2020 illustrates the consequences of solitary confinement 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.* (tangata whaiora, 2020)

Solitary confinement violates Te Tiriti o Waitangi and the UN Declaration on the Rights of Indigenous Peoples (UNDRIP).

The disproportionately high rates of solitary confinement experienced by tāngata whaiora Māori in mental health services, as well as the longer periods of confinement, breach several articles of the UNDRIP and Te Tiriti o Waitangi. In 2020 and 2022, almost half of those who experienced solitary confinement were Māori (Te Hiringa Mahara, 2022; Office of the Director of Mental Health and Addiction

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Services, 2023), and in 2021, 45 percent were Māori (Manatū Hauora - Ministry of Health, 2022).

These persistently higher rates for Māori show that our mental health system legitimises unconscious bias and institutional racism towards Māori (Government Inquiry into Mental Health and Addiction, 2018), as well as minimising their ability to exercise tino rangatiratanga/autonomy. The continued use of solitary confinement is actively harming Māori health outcomes and does not respect or value mātauranga Māori ways of healing, or ways to uplift wairuatanga. These are all direct breaches of Te Tiriti o Waitangi, and Aotearoa New Zealand's obligations as a signatory to the UNDRIP.

United Nations bodies have called for the elimination of solitary confinement in mental health units.

The United Nations Committee on the Rights of Persons with Disabilities has called for the elimination of the use of solitary confinement and restraints within mental health units (Committee on the Rights of Persons with Disabilities, 2013; Committee on the Rights of Persons with Disabilities, 2014; Committee on the Rights of Persons with Disabilities, 2014). The United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment has called for an "absolute ban" on the use of 'seclusion' and restraint in mental health facilities (United Nations Human Rights Council, 2013), and has called the use of solitary confinement on children in mental health units, for any duration, as constituting cruel, inhuman or degrading treatment or punishment or torture (United Nations Human Rights Council, 2015).

Aotearoa New Zealand ratified both the United Nations Convention against Torture & Other Cruel, Inhuman or Degrading Treatment or Punishment and the Convention on the Rights of Persons with Disabilities in 1989 and 2008 respectively.

Ending solitary confinement is possible and will benefit tāngata whaiora, whānau and health workers.

There is a misconception that using restrictive practices such as solitary confinement is necessary to protect tāngata whaiora, staff and the wider public from harm. In reality, both health professionals and tāngata whaiora are disadvantaged by an under-resourced mental health system which relies on the over-use of solitary confinement in lieu of more therapeutic methods of de-escalation.

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The elimination of solitary confinement is possible and sustainable, even in urban centres with diverse populations, and can result in better outcomes for all, including a reduction in the number of staff assaults and injuries (Te Hiringa Mahara, 2022). This is supported by New Zealand-based evidence suggesting changeable environmental factors such as service delivery models and practice approaches are key factors in supporting reductions in solitary confinement rather than external factors like sociodemographic distribution of tāngata whaiora and clinical factors (Lai, Jury, Long, & et al., 2018).

Te Toka Tumai Auckland District Health Board (DHB) significantly reduced its rates of solitary confinement in mental health and addiction services from 30 in 2019-2020 to eight in 2021 (Health Quality and Safety Commission, 2021).

> *As Te Toka Tumai Auckland DHB has been working towards zero seclusion, there have been fewer incidents of violence – towards both staff and service users – in terms of restraint and seclusion. (Health Quality and Safety Commission, 2021)*

The Health Quality and Safety Commission has been supporting regions (formerly DHBs) to implement system and practice changes to help people in distress as alternatives to solitary confinement. They have learnt that effective ways to support people in distress include bringing them into a quiet space, actively listening to their concerns and needs, learning about what happened to them, discovering their triggers and what calms them, offering them food or a drink and involving their whānau early on, and throughout, if the person wishes, and offering cultural support, peer support and sensory modulation (Health Quality and Safety Commission, 2022).

Other regions that have successfully reduced solitary confinement, and at times sustained no solitary confinement, include Waitematā, Whanganui, South Canterbury and West Coast (Te Hiringa Mahara, 2022).These regions, in reducing solitary confinement, have also seen a reduction in calls to crisis teams, use of restraints and sedating medications, and assaults against staff and tāngata whaiora within inpatient units (Te Hiringa Mahara, 2022).

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